Patient Information Form

Appt __ /__ /__ @ __: ___ **Therapist:** _____

Patient Name (as it appears on card): _____ DOB: _____

Patient Address: _____

Email: _____ Phone #: _____

Diagnosis: _____ Referring MD:_____

Auto Related? □ Yes □ No Currently in Home Health? □ Yes □ No Is this Workmans Comp? □ Yes □ No

If yes, please provide Claim #, Adjuster name and phone#_____

Has patient had PT/OT this year? □ Yes □ No Approx. # of visits: _____

Primary Insurance: _____ Plan (if BC/BS): _____

ID#: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Relationship: □ Self □ Spouse □ Child □ Other _____

Claims Address: _____

Provider Contact #: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Relationship: □ Self □ Spouse □ Child □ Other _____

Claims Address: _____

Provider Contact #: _____

EMERGENCY CONTACT: _____

Phone #: _____ Relationship: _____

Would you like to receive appointment reminders? Please choose: □ Text □ Voice □ Email □ None

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FOR OFFICE USE ONLY – HIGHLIGHT INCOMPLETED ITEMS, WORK UNTIL COMPLETE

VERIFY: DL ___ INS Card___ Verified Pt Demographics___ NPPW____ MD RX: _____ MD Primary (PCP)____ HHC DC Letter___ WC___DOI___ Assigned Treating PT ____ Email Appointment Reminders ____ Auth___ MD entered_____ Assigned facility_____ NSS Notification____ Outcome form_____

Intake verified by: (Print Only) _____ Date: _____

Cancellation Policy

There is a $25.00 charge for any appointments that are cancelled with less than 24 hours advanced notice or for failing to arrive for an appointment without any notice. Please keep in mind that Medicaid/AHCCCS requires us to send notification of patients who are not consistent with their treatment, which can potentially put your coverage in jeopardy. Due to this requirement, if you are not consistent with your care, and your insurance requires us to follow these guidelines, we are obligated to send notice regarding your consistency with treatment to your physician and insurance provider. Thank you for your attention to this.

Signature: _____ Date: _____

HIPAA Privacy Notice and Patient Rights Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain **privacy rights** regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians' certifications

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I also acknowledge that I have been given the opportunity to review my **patient rights** which includes treatment without discrimination or exclusion based on race, color, national origin, age, disability, sex, religion, or any other protected status. I also understand that I have the right to be provided interpretation services, both verbal and in writing during my treatment.

I understand that I have the right to file a grievance with Empower Physical Therapy's Compliance Officer or with the U.S. Department of Health and Human Services, Office of Civil Rights if I believe that Empower Physical Therapy has failed to provide these services or has discriminated in another way based on race, color, national origin, age, disability, or sex.

Patient Name (Print): _____

Signature of Patient or Responsible Party: _____

Relationship to Patient: _____ Date: _____

PATIENT MEDICAL HISTORY

Name: _____ Date of injury or onset of symptoms: _____

Referring Physician: _____ Family Physician: _____

Height: _____ft _____in Weight: _____lbs. (This information is required for insurance reporting purposes)

How did your symptoms begin (gradually, suddenly, injury specifics)?

_____

Have you had surgery for this problem / injury: □ Yes □ No Type of Surgery: _____
Date of Surgery: _____

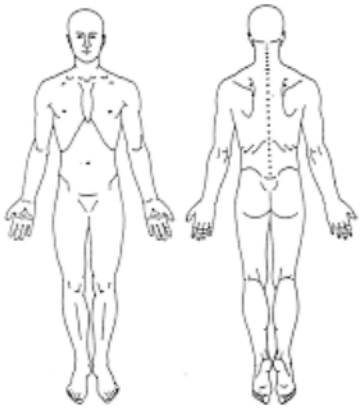
List your current medications. Include prescriptions, over the counter, herbs, and vitamins.

Medication	Dosage	Frequency	Medication	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you allergic to any medications or latex? If yes, please specify: _____
Please list symptoms you are currently having (i.e., pain, swelling, weakness, etc.):

_____

Please mark pain areas below using the legend
Sharp: ///, Burning: XXX, Aching: +++
Throbbing: ###, Pins/Needles: - - -



Please circle your pain level
0 = no pain, 10 = Need to go to the ER
0 1 2 3 4 5 6 7 8 9 10

What is your main complaint functionally? _____

Check all the activities that you have trouble performing as a result of your present condition: □ Bathing □ Child Care □ Dressing
Eating □ Homemaking □ Yard Work □ Standing
Sitting □ Sleeping □ Walking □ Working □ Other
_____

How long can you tolerate the following?

	< 30 min	1-2 hrs.	3-4 hrs.	No problems
Walking	_____	_____	_____	_____
Sitting	_____	_____	_____	_____
Standing	_____	_____	_____	_____

What treatment have you previously received for this injury/episode?
□ Physical Therapy □ Occupational Therapy □ Chiropractic Care
□ Other _____

Please circle if you have had any of these tests performed for this injury/episode: □ Bone Scan □ X-Ray □ MRI
□ CT scan □ EMG/NCV □ Myelogram □ Other _____

Do you have or have you had any of the following?

□ Allergies	□ Chemical Dependency	□ Fracture/Suspected Fracture	□ MRSA
□ Alzheimer's	□ Circulation Problems	□ Gallbladder Problems	□ Multiple Sclerosis
□ Anemia	□ Current Infection	□ Headaches	□ Muscular Disease
□ Anxiety	□ Currently Pregnant	□ Hepatitis/HIV/AIDS	□ Obesity
□ Arthritis	□ Depression	□ High Blood Pressure	□ Osteoarthritis
□ Asthma	□ Diabetes (Type I or II)	□ High Cholesterol	□ Osteoporosis
□ Autoimmune Disorder	□ Diabetes (Gestational)	□ Incontinence	□ Parkinson's
□ Cancer	□ Dizzy Spells	□ Kidney Problems	□ Rheumatoid Arthritis
□ Cardiac Conditions	□ Emphysema/Bronchitis	□ Lupus	□ Seizures
□ Cardiac Pacemaker	□ Fibromyalgia	□ Metal Implants	□ Smoking

□ Other (which could affect treatment) _____

Patient/Guardian Signature: _____ **Date**: _____

Consent for Care and Treatment

I give my consent for treatment by the staff at Empower PT for physical therapy services and necessary treatment considered medically necessary as prescribed by my physician.

I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at Empower PT.

Patient/Guardian Signature_____ Date _____

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to Empower PT for medical benefits to which I am entitled, including Medicare, private insurance, and third-party payers for services performed during the course of my treatment.

I authorize Empower PT to release all information necessary including medical records to secure payment for Physical Therapy services provided by Empower PT staff.

Patient/Guardian Signature_____ Date _____

Email: _____

EMERGENCY CONTACT NAME: _____

Phone #: _____ Relationship: _____

Would you like to receive appointment reminders? Please choose: □ Text □ Voice □ Email □ None

RELEASE OF INFORMATION: ***We are legally required to follow privacy practices. Please list who we have your permission to disclose any of your Medical Information with other than your referring Physician that has ordered your Physical Therapy.***

I hereby authorize Empower Physical Therapy to release and disclose all Medical History to:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

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