Physical Therapy
& Wellness Institute

Patient Information

Name: ______________________________SSN #:___________________ Email: ________
Address: _______________________City:_______________ State: ___ Zip: _________
Home Phone(___)___________Wk Phone (____)_____________Cell(___)________________
Please which telephone number you prefer to be reached, if necessary? Home / Work / Cell
Date of Birth: _____ Age: _____ Sex: _____ Marital Status: (circle) S M D W
If a dependent child, is the child a full-time student: (circle) Yes /No
Emergency Contact Person: ______________________ Phone #: (____)__________

Work Information **(Where do you work, what do you do)**
Employer/Business: ___________________________________Occupation:___________________
Address of Employer: ____
Employer contact:(*workers comp*) _________________Employer Phone #(___)______________
Rehab Nurse/ Case Manager:________________________Phone #:________________________

Injury: **(Please Circle One) Workman's Comp/Auto/Sports/Other**
Which insurance should we bill? ____
Date of Accident:____________Mechanism of Injury:_______________Injured Body Part:___________

Primary Insurance **(Who is paying? If you have your card, don't fill out, we will copy it)**
Name of Policy Holder:________________________Policyholder Birth date: ________________
Relationship to Policyholder: (circle) self spouse dependent child
Insurance Name:____________________Phone #_____________Insurance Address: ___________
Policy #/ Claim #: _________________Contact Person: ________________________________
***Note: If injury due to a motor vehicle accident, please provide secondary insurance info below**.

Secondary Insurance **(Required for Medicare/Work/Auto injuries)**
Name of **Policy Holder**: ________________________Policyholder Birth date: ____________________
Relationship to Policyholder: (circle) self spouse dependent child
Insurance Name: ___________________ Phone #________________Insurance Address: ___________

Referral Sources: **(Referred From Who?)**
Referring Physician's Name: _____________________Address:_____________________________
Family Doctor's Name: _________________________Address: ______________________________
Attorneys Name: _______________________________Address: ______________________________
Case Manager: _________________________________Address: ______________________________
Chiropractor/Other: _____________________________Address: ______________________________
Have you received physical therapy during current year? ______ If yes, how many visits? ______
Have you received chiropractic services during the current year? _____ If yes, How many? _____

Pain Rating
Right now *(no pain)* 0 ____________5____________10 *(the worse since it started)*

Pain rating at worst yesterday: ___/10 What makes it worse: ____________What helps the most:________

Falls
Have you fallen in the past 12 months? ___________ If yes, how many times? ___________
Did you sustain any injury in the fall(s)?____

Medical History: *Some illnesses and conditions are genetically transferred. It is useful for us to know what condition you have or have had in the past. Please tell us:*

Condition	I Had	When	Family
Osteoarthritis	______	_____	_____
Osteoporosis	______	_____	_____
Rheumatoid Arthritis	______	_____	_____
Lumbago	______	_____	_____
Rheumatism	______	_____	_____
Back problems	______	_____	_____
Neck problems	______	_____	_____
Sprain/Strain	______	_____	_____
Headaches	______	_____	_____
Joint Pain	______	*Which Joint*	_______________
Parkinson's Disease	______	______	______
Diabetes	______	______	______
Obesity	______	______	______
Depression	______	______	______
Hypertension	______	______	______
Heart Disease	______	______	______
Peripheral Vascular Dis	______	______	______
Reflex Sympathetic Dyst.	______	______	______
Hemiplegia (Right/left)	______	______	______
Incontinence	______	______	______
Seizures/Epilepsy	______	______	______
Cancer;	______	______	______

*(**if yes**),what type of cancer?* ____

*Where was the cancer located?*____

*What type of treatment was given?*____

Any other medical condition we should know about? ____
____

Do you have a pacemaker? yes / no

*Medications:*____
____

How did you hear about us?

My doctor referred me here _____

List provided by my doctor _____

Phone book _____

Other (explain) _____

Insurance list _____

Website: _____

Friend/Family _____ Their name: ____

My Goals in coming to Physical Therapy are:

To Get rid of my Pain _____

To Get Stronger _____

To Improve Range of motion ______

To get better with my home activities ______

To Improve Sports Performance: _____

To Improve my Work abilities : _____

Thank you for taking the time to fill out this paperwork. We will now do whatever it takes to help you get better and improve performance.

(H:\Forms\Patient Information Form_5_10)

(Rev 3/2005)

Patient Agreement for Services and Release of information

Because services are provided to me by PTW, I agree to the following:

1. **Treatment Authorization:** Since my state of health requires of PTW, of my own free will, I agree to actively participate in these services such as assessment, treatments, personal care, and therapeutic exercises prescribed by my physician, and given by the Physical Therapy staff of PTW. I understand that PTW has specific policies, and that these policies include that services can be stopped at any time by my request, the request of my physician, and/or the decision of PTW. I agree to follow all the terms of these PTW policies.

2. **Non-Discrimination:** PTW and the patient agree that services are given without regard to race, color, sex, age, national origin, or handicap.

3. **Release of Information:** I give PTW my permission to give needed information from my records to any of my insurers and to all other agencies, institutions, or individuals from whom I have received health or social services for the release of information to PTW.

4. **Medicare-Title XVIII of the Social Security Act:** I understand that I need to give information so that PTW can apply for and receive payment under this Medicare Act. By signing this, I certify that information given by me is correct.

5. **Authorization for Phone Contact:** I hereby authorize the staff of the PTW to leave information on my phone answering machine regarding insurance information, confirmation of appointments, and contacts regarding further scheduling. I also authorize PTW to leave the aforementioned information with a family member.

6. **Cancellation of Scheduled Physical Therapy Visits:** Most local Physical Therapy centers charge a $25.00 no-show fee for individuals who do not meet scheduled appointments (no-shows). At the Physical Therapy & Wellness Institute, we fully expect all our respected patients and members to abide by the common courtesy of a phone call is a scheduled visit needs to be changed. Chronic no-shows will be discharged from our program.

7. **Documentation of Good Faith to Obtain Written Acknowledgement:**
   I made **<u>good faith effort to obtain the patient's written acknowledgement</u>** of our Notice of Privacy Practices or protected health information by (check all that apply):

   [ ] Showing the patient the Notice of Privacy Practices posted in our office to read prior to receiving treatment.
   [ ] Asking the patient to sign this acknowledgement form.
   [x] Other (explain in detail) <u>Issued PTW's Privacy Policy</u>

   Date: ___________ Signature of PTW Staff member:_______________________

Patient Agreement:
I agree to attend when scheduled.
I agree to be respectful towards other patient's privacy.
I agree to give good effort in my rehabilitation program.
I agree that **it is my responsibility** <u>to know and understand</u> the restrictions and guidelines regarding Physical therapy treatment <u>under my medical insurance plan</u>.
I agree **that I am financially responsible** for the any balances accrued from this treatment <u>should</u> my insurance deny my benefits or release of payment to The Physical Therapy and Wellness Institute.

PTW Agreement:
We agree to have staffing available to attend your needs.
We agree to give you the privacy that you expect.
We agree to provide you with quality Physical Therapy to help you achieve a higher level of performance at your body repair shop.
I am the patient, or the responsible party, signed below. I read and understand this agreement.

Signature:_____________________________________ Date:______________________

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