



1730 Dickerson Blvd, Suite I
 Monroe, NC 28110
 Phone: 704-283-6700 Fax: 704-283-6713
 www.physicaltherapycenter.org

Patient Information:	
Last Name _____ First Name _____ MI _____	
Address: _____	
Address 2 _____ City _____ State _____ Zip _____	
Home Phone _____ Work Phone _____ Cell Phone _____	
Date of Birth _____ SSN _____ Gender _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Email Address _____ Who can we thank for referring you? _____	
Emergency Contact:	
Last Name _____ First Name _____ Relationship: _____	
Phone Number: _____	
Employer:	
Full Time/ Part Time/As needed/Retired	
Name _____ Phone _____ Address _____	
Address 2 _____ City _____ State _____ Zip _____	
Affected Area:	
Problem Description _____ Date of Injury _____ Last MD Visit _____	
Referred by _____ Primary Care Provider _____	
Motor Vehicle Accident: Y / N In what state? _____	
Physicians: <i>Please list all physicians that you would like us to send your evaluation reports to.</i>	
MD Name _____ Practice Name _____ Phone _____	
MD Name _____ Practice Name _____ Phone _____	
Primary Insurance: <i>only complete this section if you do NOT have your insurance card present.</i>	
Insurance _____ ID # _____ Group # _____	
Primary Subscriber: Name _____ Relationship _____ Date of Birth _____	
Secondary Insurance: <i>only complete this section if you do NOT have your insurance card present.</i>	
Insurance _____ ID # _____ Group # _____	
Primary Subscriber: Name _____ Relationship _____ Date of Birth _____	

I authorize the release of any medical or other information necessary to process this claim I authorize payment of medical benefits to the Physical Therapy Center for Physical Therapy services provided to patient.

Signature: _____ Date: _____
Parent or Guardian signature required if under 18

REFERRALS

This office cannot provide treatment to Medicare patients without a physician's order. All Medicare patients must provide a physician's order for treatment at the time of their initial visit. If an order cannot be obtained prior to your scheduled appointment, please call us to reschedule.

If your insurance coverage is an HMO plan, requiring authorization for treatment from your Primary Care Provider (PCP), we will assist you in maintaining a current treatment authorization; however, you must be aware that it is primarily your responsibility to know the limits on duration of treatment that your PCP has authorized and to work with your physician's office in obtaining extensions, should they be necessary, on authorizations that may expire during the course of treatment.

INSURANCE BILLING

As a courtesy to our patients we will submit all claims for your treatment to your insurance carrier(s). We will verify your insurance coverage and notify you of any deductible and/or estimated co-payment amounts for which you are responsible. Information we receive from your insurance carrier is not guaranteed to be accurate and there is no guarantee of payment by your carrier.

CANCELLATION POLICY

All appointments not canceled twenty-four (24) hours in advance will be subject to a \$25.00 service charge. Your compliance with this policy is very important, as someone else may be able to use your reserved time.

If you have questions or concerns regarding any of the above policies, please feel free to discuss these with our office staff.

I have read the above statements and fully understand the policies of the Physical Therapy Center regarding insurance claims and my responsibilities, physician referrals, cancellations and missed appointments. My signature acknowledges that I agree to the terms of this statement regarding payment for services and cancellations authorizing the Physical Therapy Center, LLC to treat the named patient.

Signature: _____ Date: _____

Insurance Benefits:

As a courtesy to you, our patient, the Physical Therapy Center, LLC will verify your insurance benefits for Physical Therapy. Please note that benefit information given to us by your insurance provider is **NOT** a guarantee of benefits, all claims will be formally reviewed upon submission. It is the primary responsibility of the patient to be familiar with his/her insurance benefits, therefore we advise all patients to also verify their own insurance coverage for Physical Therapy.

If you have any questions regarding this policy and/or your insurance benefits, please ask a member of our Staff.



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Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by the Physical Therapy Center, LLC or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

The Notice of Privacy Practices is available for viewing upon patient request.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. The Physical Therapy Center, LLC may or may not agree to restrict the use or disclosure of your protected health information. If the Physical Therapy Center, LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

The Physical Therapy Center, LLC reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this consent form and acknowledge that I have been given the opportunity to review the Physical Therapy Center, LLC Notice of Privacy Practices. I give my permission to the Physical Therapy Center to use and disclose my health information in accordance with it.

Name of Patient (Please Print)

Signature of Patient Representative

Patient Signature

Relationship of Patient Representative to Patient

Date

MEDICAL SCREENING FORM

DATE : _____

Circle YES or NO...

Have you or any immediate family member ever been told you have:.....

	<u>Self</u>	<u>Family</u>
Cancer ?	Yes...No	Yes... No
Diabetes ?.....	Yes ...No	Yes.... No
High blood pressure ? ...	Yes ...No	Yes.... No
Heart disease ?	Yes...No	Yes.... No
Angina/chest pain ?.....	Yes...No	Yes.... No
Stroke ?	Yes...No	Yes.... No
Osteoporosis ?.....	Yes ...No	Yes.... No
Osteoarthritis ?.....	Yes...No	Yes.... No
Rheumatoid arthritis ?....	Yes...No	Yes.... No

In the past 3 months have you had or do you experience:

- A change in your health ? Yes No
- Nausea/Vomiting ? Yes No
- Fever/chills/sweats ? Yes No
- Unexplained weight change ? Yes No
- Numbness or tingling ? Yes No
- Changes in appetite ? Yes No
- Difficulty swallowing ? Yes No
- Changes in bowel or bladder function ? Yes No
- Shortness of breath ? Yes No
- Dizziness ? Yes No
- Upper respiratory infection ? Yes No
- Urinary tract infection ? Yes No

Surgical History: (please include all surgeries and their dates).

Patient Name _____ Date of Birth _____

Circle YES or NO...

Do you have a history of:

- Allergies/Asthma ? Yes No
- Headaches ? Yes No
- Bronchitis ? Yes No
- Kidney disease ? Yes No
- Rheumatic fever ? Yes No
- Ulcers ? Yes No
- Sexually transmitted disease ?.. Yes No
- Seizures ? Yes No

Are you currently:

- Pregnant ? Yes No
- Depressed ? Yes No
- Under Stress ? Yes No

Are your symptoms: (check one)

- Getting worse The same Improving

How are you able to sleep at night? (check one)

- Fine Moderate difficulty Only with medication

Check all that apply...

Do you have a problem with ... (check all that apply)

- Hearing Vision
 Speech Communication

Do you or have you in the past smoked tobacco?

YES NO

If yes, _____ Packs **X** _____ Years.
 Last tobacco use _____

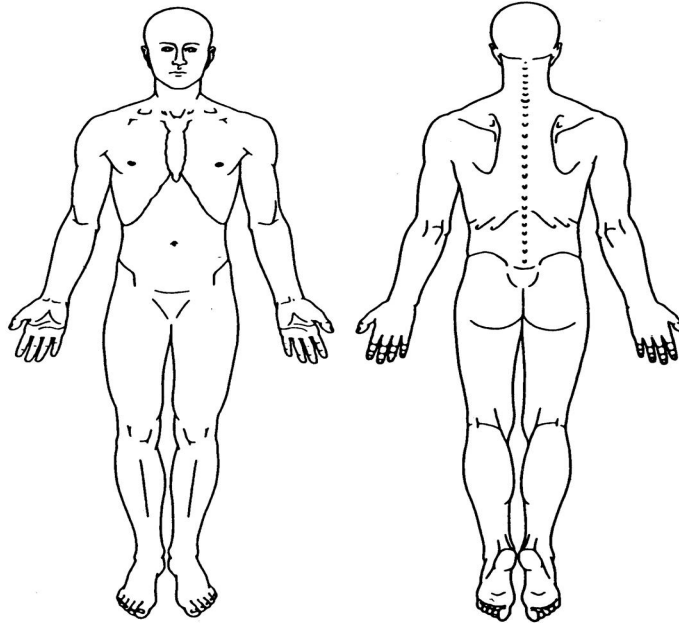
Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____

Have you had any diagnostic testing? MRI <input type="checkbox"/> X-Ray <input type="checkbox"/> CT Scan <input type="checkbox"/> Other _____

Please clearly indicate where your pain is located using the picture below.



What best describes your pain?

Sharp ___ Dull Ache ___ Numb ___ Shooting ___ Burning ___ Tingling ___

How often do you experience symptoms?

Constantly (76-100%) ___ Frequently (51-75%) ___ Occasionally (26-50%) ___ Intermittently (>25%) ___

Instructions: Rate your major area of pain on the 0-10+ Pain Rating Scale. Write the number of your pain at the present time and your best day and your worst day over the past 30 days.

- 10+ Maximal (this is the worst possible pain you could EVER imagine)
- 10 Very, Very Strong
- 9
- 8
- 7 Very Strong
- 6
- 5 Strong
- 4 Somewhat Strong
- 3 Moderate
- 2 Weak
- 1 Very Weak
- 0.5 Very, Very, Weak
- 0 Nothing At All (No pain at all)

Please answer the following questions relating to YOUR pain:

Pain Now ___/10+

At it's Best ___/10+ It gets better when I: _____

At its Worst ___/10+ It gets worse when I: _____

