

**Freedom Physical Therapy Patient Information**  
**Workers Comp**  
**Patient Information**

SSN: \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(last) (first, MI) (nickname)

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip)

Home phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list the ways that you have heard of us: \_\_\_\_\_

**Workers Comp Information**

Workers Comp Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Workers Comp Company Address: \_\_\_\_\_

Nurse or Case Worker Name: \_\_\_\_\_ Claim No: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Phone No: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Date of accident: \_\_\_\_\_

**Physician Information**

Referring Physician: \_\_\_\_\_ Office phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Office phone: \_\_\_\_\_

Reason for referral: \_\_\_\_\_ Date of injury/surgery/accident: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Freedom Therapy Solutions, Inc. or insurance company to release any medical information required to process my claims.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# Freedom Physical Therapy Consent and Financial Policy

## Consent for Care and Treatment

I consent to physical therapy services at Freedom Physical Therapy, Inc. I know that if I have any questions or concerns about my care, I should be sure to ask the physical therapist about them. I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel.

## Financial Policy

**Payment:** All payments including copay, coinsurance and deductible are due on the date of service. We accept cash, checks, Visa, MasterCard, American Express and Discover credit cards. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

**Coinsurance/Deductible:** If you have an insurance plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been lead to expect your insurance company will pay. Please note that any payment made on the date of service is considered a **DEPOSIT** toward your **ESTIMATED** patient balance. Because this is an estimate, there is always the possibility that you will be responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency.

**Insurance:** We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations, effective annual calendar renewal date or any pre-authorization requirements. Freedom Physical Therapy cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

**Cancellation Policy:** Therapist time is reserved for your appointment-if you are unable to keep your appointment we kindly ask that you provide us with 24-hour advanced notice of cancellation. **If you fail to cancel a scheduled appointment 24 hours in advance, or "no-show" an appointment, we reserve the right to assess a \$50 cancellation fee.**

I have read and understand the above Freedom Physical Therapy Consent and Financial policy and agree to all terms.

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Printed Name of Guarantor (if applicable)

\_\_\_\_\_  
Signature of Patient (or Guarantor)

\_\_\_\_\_  
Date

# Freedom Physical Therapy

## Medical Screening and History Questionnaire

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Age \_\_\_\_\_

Occupation: \_\_\_\_\_ Description of work: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Pacemaker  Yes  No

Smoker?  Yes  No

Pregnant?  Yes  No

Alcohol use?  Yes  No

Do you take blood thinners?  Yes  No Are you allergic to latex?  Yes  No

Do you take corticosteroids?  Yes  No Other allergies? \_\_\_\_\_

Recent illness? If yes, please explain \_\_\_\_\_

Rate your general health: (*circle*) Excellent Good Average Fair Poor

How often do you exercise weekly? (Circle) 0 1 2 3 4 5 6 7

Have you had any falls in the past year? \_\_\_\_\_ How Many? \_\_\_\_\_

### **Past Medical History: Please *circle* each condition that you have or have had.**

<b>Cancer</b>	<b>Diabetes</b>	<b>Liver Disease</b>	<b>Stroke</b>	<b>Ulcers</b>	<b>Asthma/Allergies</b>
<b>Kidney Disease</b>	<b>Heart Disease</b>	<b>High Blood Pressure</b>	<b>Angina/Chest Pain</b>		
<b>Fibromyalgia</b>	<b>Lung Disease</b>	<b>Osteoporosis</b>	<b>Osteoarthritis</b>	<b>STD</b>	
<b>Rheumatoid Arthritis</b>	<b>Depression</b>	<b>Blood Clots</b>	<b>Chemical Dependency</b>	<b>OB/GYN</b>	

During the past month, have you often been bothered by feeling down, depressed or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Is this something you would like help? YES, YES but not today, NO

### **Currently I am experiencing: (Circle all that apply)**

**Fever/chills/sweats Dizziness Poor balance (falls) Unexplained weight loss Numbness/Tingling**  
**Changes in appetite Difficulty Swallowing Headaches Shortness of breath**  
**Malaise/Fatigue Nausea/Vomiting Increased pain at night Depression Infection**  
**Changes in bowel or bladder function**

**Past Surgical History: (List all and dates)** \_\_\_\_\_

**List All Current Medications and Dose** \_\_\_\_\_

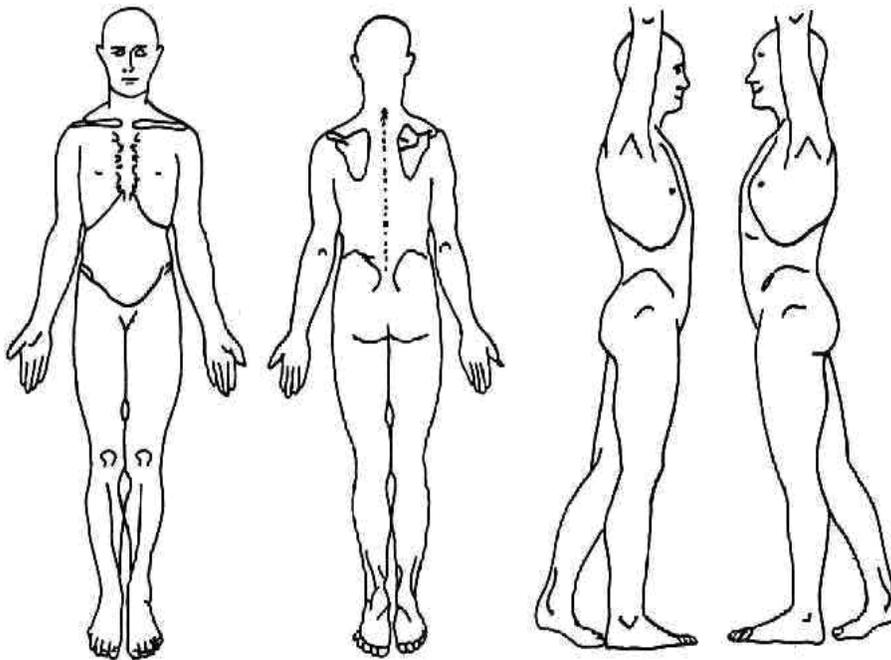
Please mark the areas where you currently feel symptoms on the chart

Use the following symbols to describe your symptoms:

OOO Dull Aching Pain

++ Shooting/Sharp Pain

// tingling/numbness



**Current Symptoms:** When did they start? \_\_\_\_\_ How? \_\_\_\_\_

Please describe your current symptoms: \_\_\_\_\_

**Using the 0 to 10 pain scale, with 0 being "no pain" and 10 being the "worst imaginable pain" describe**

\_\_\_\_\_ Current Pain    \_\_\_\_\_ Worst Pain    \_\_\_\_\_ Lowest pain  
0    1    2    3    4    5    6    7    8    9    10

Have you had this problem before? \_\_\_\_\_ Any treatment received? \_\_\_\_\_

How long did it take to feel better? \_\_\_\_\_

My symptoms are    \_\_\_Improving    \_\_\_Getting Worse    \_\_\_About the same

My symptoms \_\_\_\_\_Come and go    \_\_\_Are Constant    \_\_\_Change with activity/Positions

Aggravating Factors: (Pain made worse by) \_\_\_\_\_

Easing Factors (Pain made less by) \_\_\_\_\_

Have you received any tests for this condition: \_\_\_\_\_ Any treatment? \_\_\_\_\_

As the day progresses, do your symptoms    \_\_\_increase    \_\_\_decrease    \_\_\_stay the same

Does your pain awaken you at night? \_\_\_\_\_Yes \_\_\_\_\_No    Is your pain relieved with rest? \_\_\_\_\_Yes \_\_\_\_\_No

I, the undersigned, state that I have answered this health history completely and to the best of my knowledge. I attest that this form has been reviewed with my physical therapist prior to beginning my care.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
P.T. Signature

\_\_\_\_\_  
Date

# Freedom Physical Therapy

## Patient Acknowledgment of Receipt of Privacy Practices Notice

I, \_\_\_\_\_, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligation concerning the use and disclosure of my protected health information.

In accordance with HIPAA regulations, we need to know what phone numbers we may leave a voice message. Please note below if there are any phone numbers that we may **NOT** leave messages on in reference to insurance/payment issues or issues regarding your therapy.

Please Leave Messages On The Following Phone Numbers: \_\_\_\_\_

Please **Do Not** Leave Messages On The Following Phone Numbers: \_\_\_\_\_

Please check the box(es) below regarding which method of appointment reminders you would prefer.

Text

What phone number would you like us to text? \_\_\_\_\_

Call

What phone number would you like us to call? \_\_\_\_\_

Email

If the email differs from the one previously given, what email would you like us to email?

\_\_\_\_\_

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

Freedom Physical Therapy, Inc.

Attn: Wendy Feid

28105 Three Notch Road

Mechanicsville, MD 20659

Phone: 301-290-5090

Fax: 301-290-5091

You may also contact the Secretary of the US Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the US Department of Health and Human Services.

---

Patient Signature

Date

---

Printed Name

Relationship to patient