Freedom Physical Therapy Workers Comp Patient Information

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:_____

Parent(s) name and contact information:_____
(if minor)

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: _____

The above information is true to the best of my knowledge. I authorize my workers compensation 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.**

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

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

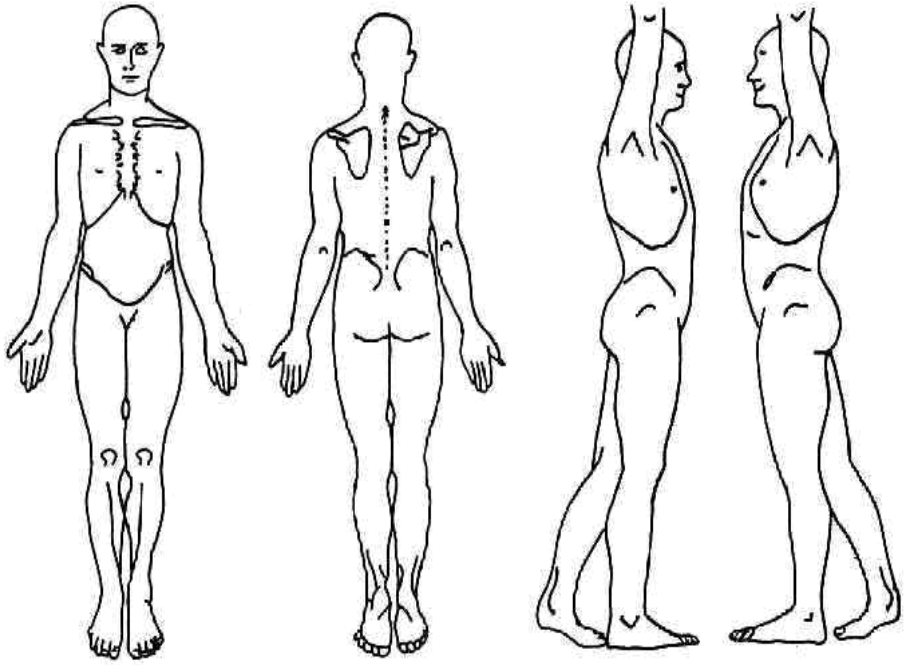
Past Surgical History: (List all and dates)_____
_____

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. Most of the calls would be regarding scheduling, but we may also leave messages in reference to insurance/payment issues or issues regarding your therapy. Please note below if there are any phone numbers that we may **NOT** leave messages on. If you don't want us to leave messages at all, please note "no messages" on the line below.

_____

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
28103 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