INTRODUCTION PATIENT CASE HISTORY

PATIENT INFORMATION

Name: (First MI Last) _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Mobile #:** _____

Email: _____ **Gender:** _____ **Marital Status:** Single / Married / Other

Date of Birth: _____

Referred By: (Name): _____ Family / Friend / Co-worker / Doctor / Other Source

Major Concern: _____

Primary Care Physician: _____

Dr. Address: _____ **Dr. Phone Number:** _____

EMERGENCY CONTACT INFORMATION

Name: (First , Last) _____ **Mobile #:** _____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

____Insurance ___Worker's Comp ___Self-Pay (*Cash*) ___Personal Injury/Auto _____Other

PRIMARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

ID #: _____

Group #: _____

Insured Name: _____

SECONDARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

ID #: _____

Group #: _____

Insured Name: _____

Evaluation Date: _____

It is Usual and Customary to Pay for Services Rendered Unless Otherwise Arranged

COMMUNITY CARE PHYSICAL THERAPY

Name: _____ Height: ____ Ft. ____ In. Weight _____ Lbs.

What body part are you here for today? Left Right

When did this problem begin?

Was there a specific injury? Yes No (if yes, please describe): _____

Have you ever had physical therapy for this problem? Yes No

Have you had physical therapy this calendar year? Yes No

Have you had home care physical therapy for this problem? Yes No If yes, when were you discharged?

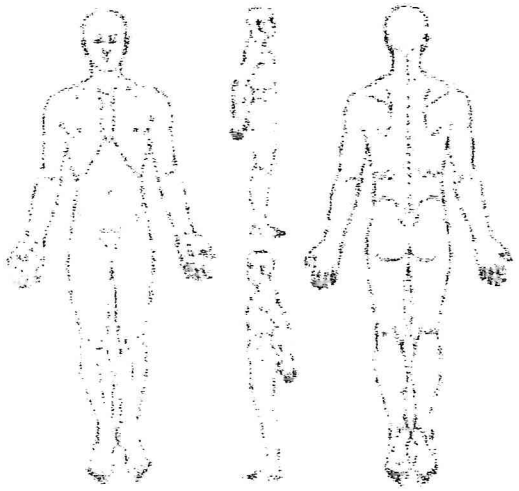
Is your injury work related? Yes No Is your injury related to a motor vehicle accident? Yes No

What is/are your main complaint(s)? Pain Numbness Stiffness Balance loss Other: _____

If you have pain, please rate your pain on a scale of 0 to 10 with 0 being no pain and 10 being the worst imaginable:

At this current time: /10 Worst in the past 24 hours: /10 Best in the past 24 hours: /10

Please mark on the diagram with an **X** where it hurts
Please mark any areas of numbness with **O**



Medical History: Please check any conditions that you have

Diabetes	Stroke	TIA (mini stroke
Heart Arrhythmia	Coronary Heart Disease	High BP
Heart Attack	High Cholesterol	Depression
Rheumatoid Arthritis	Liver Disease	Kidney Disease
Neuropathy	Acid Reflux	Osteoarthritis

Cancer Type: _____

Other: _____

☐ **I do not have any medical problems**

List any orthopedic surgeries that you have had (including year):

List any other surgeries that you have had:

Are you allergic to latex? ☐ *Yes* ☐ *No* **Do you have a pacemaker or defibrillator?** ☐ **Yes** ☐ **No** *Do you smoke? Yes No*

Do you exercise regularly? Yes No Female Patients: Is there any possibility that you are pregnant? Yes No

Review of Systems: Are you currently having, or have you had, problems with: None Numbness or Tingling? Yes N
Lungs or Breathing? Yes No Bleeding Disorders? Yes No Heart or Chest Pain? Yes No GI ulcers? Yes N

Do you have any medication, food or environmental allergies? Yes No If Yes, please list: _____

Diagnostic Testing: Have you had any of the following tests for you current problem:
X-Ray MRI CT scan EMG / Nerve Conduction Study Other: _____
Results (if known):

Medications: Do you currently take any medications, vitamins, supplements or herbs: Yes No
If yes please fill out attached medication sheet or provide a current list.

Goals: Please list the goal(s) that you hope to achieve by attending physical therapy: _____

The above is true and correct to the best of my knowledge

Patient Signature: _____ Date: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION
APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information and/or billing records:

— to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

— to another party if they are potentially responsible for payment of your services.

— within our practice for quality control or other operational purposes.

Our office may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message with be left on your answering machine. By signing this form you are giving us authorization to contact you with these reminders and information.

Your Rights To Limit Uses or Revoke Authorization

You may restrict the individuals or organization to which your health care information is released or revoke your consent at any time; however, your revocation must be in writing. We are not required to agree to your restrictions. However, if we agree, the restriction is binding on us. We will not be able to honor your revocation request if we have already released your health information before receiving your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose may be subject to re-disclosure by anyone who has access to this information and may no longer be protected by the federal privacy rules.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed and you have a right to review that notice before you sign this consent form (§164.520). You may inspect or copy information that we use to contact you to provide appointment reminders or other health care information at any time (§164.524). We reserve the right to change our privacy polices. If we make changes we will notify you when you come in for treatment or by mail.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from our practice.

I have read your consent policy and authorize use or disclosure of my health information in the manner described above. I am also entitled to a copy of this or a detailed notice upon request.

_____ _____

PATIENT NAME PRINTED DATE

_____ _____

PATIENT SIGNATURE (or parent if minor) CLINIC REPRESENTATIVE SIGNATURE

_____

PERSONAL REPRESENTATIVE PRINTED (optional)

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT.

COMMUNITYCARE
PHYSICAL THERAPY

Insurance and Payment Policy

Our multi-discipline practice makes the best effort to know what financial responsibility our patients have at the time of service, as well as limitations of their insurance policies. We will charge according to the information we have at that time. However, there are constant changes in plans and other factors which may not give us the correct information. Should a discrepancy occur once an Explanation of Benefits (EOB) is received, you will either receive a credit on your account or be billed the difference. Deductibles are the responsibility of the patient at the time of service.

Our health center treats you, the patient, not your insurance, and will lay out a treatment course that is in your best interest. Should you exhaust your benefits, or your insurance company does not deem care medically necessary prior to the end of the treatment plan prescribed, you will be responsible for those visits on a cash-case basis.

Periodically, usually monthly, we must perform an examination to monitor your progress. This examination is at the discretion of the doctor(s) and you will be responsible for any additional charges according to your insurance. Again, our health center is treating you, not your insurance, and these examinations are necessary to give you the best care.

Furthermore, there will be a **$25.00 cancellation fee** which will go into effect on January 1st, 2025, for any appointment cancelled less than 24 hours prior to scheduled appointment time. We thank you for understanding.

I have read the above Insurance and Payment Policy. I understand that benefit quotes are not a guarantee of payment by my insurance company, and I will be responsible for any copay/co-insurance, deductibles, and services not covered or deemed medically necessary.

PRINT PATIENT NAME _____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY _____ STAFF WITNESS _____

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