

# NEW PATIENT FORM

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(PLEASE PRINT CLEARLY)

Date: \_\_\_\_\_

Patient Name:(Last)\_\_\_\_\_ (First)\_\_\_\_\_ (M.I.)\_\_\_\_\_

Date of Birth:\_\_\_\_\_ Social Security:\_\_\_\_\_ Sex: Male / Female

Mailing Address:\_\_\_\_\_

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

Status: Married / Single / Divorced / Separated / Widowed Student: No / Full-Time / Part-Time

Employment: Full / Part-Time / Not Working / Retired Employer:\_\_\_\_\_

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

Referring Physician:\_\_\_\_\_ Phone:\_\_\_\_\_

Injury Type: Work / Auto / Home / Other \_\_\_\_\_ Attorney Involved: Yes / No

Attorney Name:\_\_\_\_\_ Phone:\_\_\_\_\_

Who may we thank for your referral other than your Doctor:\_\_\_\_\_

Please initial the following that apply:

\_\_\_\_\_ **Consent for Treatment of a Minor:** As a parent and/or legal guardian, I authorize Physical Therapy Specialist to treat the minor patient named above while I am not present.

\_\_\_\_\_ **Consent for Care & Treatment:** I the undersigned do hereby agree and give my consent for Physical Therapy Specialist to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

\_\_\_\_\_ **Assignment of Insurance Benefits and Financial Policy:** I hereby authorize Physical Therapy Specialist to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered. We bill your medical insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If you insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company request a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

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Patient Signature (Parent or Guardian Signature)

Date



## NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Workers Compensation:** We may release medical information about you for worker's compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if we are asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so that they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

### YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

**Your Right to Inspect and Copy:** To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use to disclose about you for treatment, payment, or health care operations. *(We are not required to agree to your request.)* **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice, and will post the current notice in our facility.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

**OTHER USES OF MEDICAL INFORMATION:** Other uses and disclosures of medical information not covered by this notice or the law that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my Signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date



## CANCELLATION AND NO-SHOW POLICY

We take treatment cancellations seriously at **Physical Therapy Specialist** because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor has prescribed a set frequency of treatment. Showing up as scheduled for these visit is your most important job. Working together we can help you achieve your goals in treatment.

**We require 24 hours notice in the event of a cancellation:** It is your responsibility, when you call in; to have an alternative time in mind to insure that you will receive your full prescribed number of treatments that week. Cancellations make it necessary for you to receive a treatment by one of our therapists, other than the one you originally scheduled with.

**There is a \$25.00 charge for cancellation without proper notification (meaning a 24 hour notice).** This charge will not be covered by insurance, but will have to be paid by you personally.

Please understand that your pain will probably vary during your course of treatment. Some conditions can seem to be a reason not to come in: whether your feeling better or worse. It is important to come in and work with the Therapist to re-assess and treat you; and possibly progress your program.

When a patient doesn't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or physical therapist; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will do our best to have you back to full function swiftly. We're looking forward to working with you.

I have read this document and full understand my responsibilities.

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Patient Signature

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Date

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Type of Injury / Condition \_\_\_\_\_

Onset / Injury Date \_\_\_\_\_

Type of Surgery & Date \_\_\_\_\_

Next Doctor's Appointment? \_\_\_\_\_

Describe previous treatment for this condition \_\_\_\_\_

Have you received chiropractic treatment this year? Yes / No

### Have you had any imaging performed:

- |                                |                                     |
|--------------------------------|-------------------------------------|
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> CT Scan    |
| <input type="checkbox"/> MRI   | <input type="checkbox"/> Doppler    |
|                                | <input type="checkbox"/> Ultrasound |

### Have you recently noted:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Weight Loss /Gain | <input type="checkbox"/> Nausea / Vomiting           | <input type="checkbox"/> Fatigue                     |
| <input type="checkbox"/> Weakness          | <input type="checkbox"/> Fever / Chills / Sweats     | <input type="checkbox"/> Numbness / Tingling         |
| <input type="checkbox"/> Pregnant / IUD    | <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Change In Vision Or Hearing |
| <input type="checkbox"/> Pain At Night     | <input type="checkbox"/> Cramps In Legs When Walking | <input type="checkbox"/> Insomnia                    |

### Do you have now or have you ever had any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Surgeries  | <input type="checkbox"/> Loss of Consciousness       | <input type="checkbox"/> Fractures                     |
| <input type="checkbox"/> Sprains / Strains                                      | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Blood Pressure Problems       |
| <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Motor Vehicle Accident        |
| <input type="checkbox"/> Circulation Problems / Clots                           | <input type="checkbox"/> Asthma / Breathing Problems | <input type="checkbox"/> Lung Disease                  |
| <input type="checkbox"/> Easy Bruising / Bleeding                               | <input type="checkbox"/> Leg / Ankle Swelling        | <input type="checkbox"/> Urinary Problems / Infections |
| <input type="checkbox"/> Indigestion / Heartburn                                | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Allergies / Skin Sensitivity  |
| <input type="checkbox"/> Any previous injury that may affect current care _____ |  |  |

Explain & give approximate dates for any items indicated above \_\_\_\_\_

Are you currently taking medications? Yes / No Name or Type of Medication \_\_\_\_\_

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other \_\_\_\_\_

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? \_\_\_\_\_

What are your physical or fitness goals: \_\_\_\_\_

Is there anything else you would like to include or ask your physical therapist? \_\_\_\_\_

\_\_\_\_\_  
**Patient or Personal Representative Signature**

\_\_\_\_\_  
**Date**

