Patient Information

Please answer the following questions as accurately as possible.

Name: _____ DOB: _____ Sex: □ Male □ Female

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Name: _____ Phone: _____

Injury Area: _____ Date of Injury: _____

Referring Provider: _____ PCP: _____

How did you find us: _____

Current Condition / Chief Complaint:

Problem for which you are seeking physical therapy: _____

_____

When did the problem begin? _____

What happened? _____

How are you taking care of the problem at home? _____

Have you had this problem before? ☐ Yes ☐ No

If yes, when? _____

Functional Status / Activity Level (check all that apply)

☐ Difficulty with bed mobility (rolling, sitting)

☐Difficulty with transfers (bed to chair)

☐ Difficulty with self-care (dressing, bathing)

☐ Difficulty with work activities

☐ Difficulty with home management (cooking)

☐ Difficulty with recreational activities

Difficulty with walking: ☐ level ground ☐ uneven surface ☐ stairs ☐ ramps

Clinical Tests: (check all that apply)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Density ☐ Other _____

WHERE were these done? _____ WHEN were these done? _____

Are you seeing/have you seen anyone else for this problem:

☐ Chiropractor ☐ Massage Therapist ☐ Orthopedist ☐ Podiatrist ☐ Neurologist ☐ Other

Home Health Services ☐ Yes ☐ No Date of last visit? _____

Pain Please rate your pain on a scale of **0** (no pain) to **10** (worst possible pain)

Average pain: _____ At its ***best***: _____ At its ***worst:*** _____

What makes your pain better? _____

What makes your pain worse? _____

Describe your pain: ☐ Dull ☐ Sharp ☐ Constant ☐ Intermittent ☐ Shooting ☐ Burning

☐ Radiating ☐ No pain ☐ Other _____

Social History:

Are you? ☐ Right handed ☐ Left handed

Language: ☐ English ☐ Interpreter needed? ☐ Language _____

With whom do you live? ☐ Spouse ☐ Alone ☐ Children ☐ Spouse & others ☐ Other

Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed ☐ Disabled

Living Environment

Do you use? ☐ Crutches ☐ Cane ☐ Walker ☐ Standard Wheelchair ☐ Power Wheelchair

Oxygen? ☐ Supplemental ☐ Continuous - Liters per minute _____

Does your home have? ☐ Stairs, no railing ☐ Stairs, with railing ☐ Ramp ☐ Elevator

☐ Elevated toilet seat ☐ Grab bars ☐ Tub bench ☐ Shower chair ☐ Other: _____

Social Habits:

☐ Regular Exercise ☐ Smoking ☐ Sports: _____

☐ Recreational hobbies: _____

General Health Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

For Women Only:

Is there any chance that you are pregnant? ☐ Yes ☐ No

Medical / Surgical History: (check all that apply)

	√		√		√		√
Arthritis		Blood Disorder		Seizures/Epilepsy		Kidney Disease	
Head Injury		Heart Problems		Circulation Problems		Stomach Problems	
Fractures		Prostate Disease		High Blood Pressure		Skin Disease	
Osteoporosis		Thyroid Problems		Low Blood Pressure		Other	
Osteopenia		Back/Neck Surgery		Neuromuscular Disease			

Have you had any recent surgery or hospitalization? ☐ Yes ☐ No

When? _____ Surgery Type: _____ Surgical Precautions? _____

Allergies: _____

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you had little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home? ☐ Yes ☐ No

Has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Current Medications: Please include all medications (prescribed and over the counter)

Medication	Dosage	Times per day	Reason for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Consent Form

Patient Name: _____ Date: _____

Consent to Treat: The patient has the right to informed participation in decisions involving his/her healthcare. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her physical therapist. The patient shall not be subjected to any procedure without his/her consent or consent of his/her legally authorized representative.

Treatment of Minors: I, as parent/guardian of a minor receiving treatment at ***Conifer Physical Therapy***, agree to fill out the *Parental Consent for Medical Treatment of a Minor Form*.

_____
Initials

Liability: I know and agree that ***Conifer Physical Therapy*** is not responsible for loss and/or damage to personal valuables.

Financial Policy: We will gladly discuss your proposed treatment plan and discuss any questions relating to your insurance coverage. You must realize, however, that your insurance is a contract between you and your insurance company. We must emphasize that as your provider, our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy we extend to our patient, there is no guarantee of payment.

NOTE: You should contact your insurance company if you have any concerns about your coverage.
All charges are ultimately your responsibility from the date of service rendered.

Payment of co-pays or co-insurance amounts are required at the time of your visit. If we are informed that your insurance deductible has not been met, we may ask that you make a payment at each visit until the deductible amount is satisfied.

Cancellation Policy: Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrivals of greater than 10 minutes may result in a shortened treatment session or cancellation. **There is a $60.00 charge for a cancellation without 24 hours' notice.** Please be aware that other patients are waiting to get on the schedule and when you cancel at the last minute, it affects not only your treatment, but also the therapist and the patient waiting for an appointment. Attending your scheduled appointments is also crucial to successful treatment and recovery from your injury or illness.

_____
Initials

Notice of Privacy Practices: A copy of the **Notice of Privacy Practices** is available in the front waiting area and a hard copy may be obtained upon request. I understand that ***Conifer Physical Therapy*** may use or disclose my personal health information (PHI) for the purpose of carrying out treatment and obtaining payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand I have the right to revoke this consent by notifying the practice in writing.
Are you seeing anyone else for any type of therapy OR have you seen anyone THIS YEAR for therapy?

☐ Yes ☐ No If yes, who: _____

☐ Home Health ☐ Pelvic Floor PT ☐ Any other physical therapy clinic

Have you been seen at Conifer Physical Therapy, Inc. before? □ Yes □ No

☐ I consent to rehabilitation and related services and I grant permission to be treated at ***Conifer Physical Therapy.***

☐ I hereby consent to the use and disclosure of my PHI as noted in Conifer Physical Therapy's **Notice of Privacy Practices.**

☐ I have read, understand, and agree to the above information and policies.

☐ I hereby authorize payment to be made directly to Conifer Physical Therapy, Inc. for services rendered to me and further authorize the release of any medical records necessary to facilitate my treatment, to process medical claims and/or as otherwise permitted or required in the **Notice of Privacy Practices**. I understand fully that in the event of my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

Signature: _____ Date: _____

Patient Balance Statements: Payments are due at the time of service. If, after 30 days, you have a balance due, Conifer Physical Therapy will send a statement by mail. We will send a statement every 30 days if you have a balance due. If 90 days passes and you still owe a balance, Conifer Physical Therapy will send the bill to a collection agency.

Collections: We currently use an external company to assist us in collecting overdue balances. It is important that patients keep up with statement and account balances and discuss any issues you may have satisfying your account with our billing staff. After a 90 day period, the account will be sent to collections. You will be responsible for any additional fees incurred as a result of the collections process. This may include, but is not limited to: fees, interest, court costs, and attorney fees. Once sent to collections, you (and your family when applicable), will be dismissed from the practice, pending payment in full or completion of your account balance through a payment plan.

☐ I agree to the above statements regarding account balances.

Signature: _____ Date: _____

HIPAA RELEASE FORM

Medical Information Release Form

Patient Name _____ Date of Birth _____/_____/_____

Release of Information:

☐ I authorize the release of information including the diagnosis, records, examination and claims information. This information may be released to:

- ☐ Spouse Name _____
- ☐ Children Name(s)_____
- ☐ Parent(s) Name(s) _____
- ☐ Athletic Trainer _____
- ☐ Other_____

☐ Information is not to be released to anyone.

The **release of information** will remain in effect until terminated by me in writing.

MESSAGES

Please Call ☐ My home ☐ My cell ☐ My work

_____ _____ _____

If unable to reach me by phone:

- ☐ leave a detailed message
- ☐ leave a message asking me to return your call

Signed _____ Date: _____/_____/_____