UNITED REHAB PHYSICAL THERAPY P.C.

Patient Demographic Form

Demographics: Please fill out or copy of Photo ID:

First Name: __________________ Middle Initial: ______

Last Name: __________________ DOB:_____________

Address:____

____

How did you hear about us? _________________________

Reason for this Visit:________________________________

Referred By:_______________________________________

Contact Information:

Home Phone:_____________ **Cell:**______________________

E-Mail:____

Marital Status: Single / Married / Other / NA

Employment Status: Employed / Full time/ Part time Student

Emergency Contact Name & Phone Number:

____

____

Insurance Information

Primary Insurance: Fill out or copy of insurance card

Insurance Carrier: __________________________________

ID Number: ____

Relationship to insured:_______________________________

Provider Relations Ph#: ______________________________

Secondary Insurance: fill out or copy of insurance card

Insurance carrier: __________________________________

ID Number: ____

Relationship to insured: ______________________________

Provider Relations Ph#:_______________________________

Is the reason for you visit related to: □ Auto injury □ Work injury □ other injury, then please provide the following info:

Insurance Carrier:_________________________ Claim Number:______________________ Date of njury:_________________

Attorney Address: (if any) Attorney Name:____Phone:____________________

Attorney Address:____

I certify that all of the following information above is true and accurate to the best of my knowledge

Patient/ Guardian Signature Date:

____ ______________________________

Acknowledgement of Receipt of Notice of Privacy Practices, Financial Policy and/or Medicare Financial Responsibility Disclosure

Patient Name: **Date of Birth:**

Release of Information & Consent for Treatment

All information provided herein is true and correct.
I am aware of my diagnosis and wish to receive treatment UNITED REHAB PHYSICAL THERAPY P.C. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I consent to Physical Therapy and related services and I understand, acknowledge and affirm that such Physical Therapy, rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to UNITED REHAB PHYSICAL THERAPY P.C. to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.
I authorize UNITED REHAB PHYSICAL THERAPY P.C. to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. The signature below certifies that I have read and understand the above information.

Initial: _________________

Assignment of Benefits

I authorize payment directly to UNITED REHAB PHYSICAL THERAPY P.C. for services and to bill and release payment directly to UNITED REHAB PHYSICAL THERAPY P.C. for any physical therapy, rehabilitation, orthotic or prosthetic services provided. This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _________________

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for UNITED REHAB PHYSICAL THERAPY P.C. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initial __________________

Payment Guarantee

I agree to pay UNITED REHAB PHYSICAL THERAPY P.C. for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Intake & Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of UNITED REHAB PHYSICAL THERAPY P.C.

Initial _________________

Financial Policy and/or Medicare Financial Responsibility Disclosure (Acknowledgment)

I hereby acknowledge that I have received a copy of the Financial Policy and/or Medicare Financial Responsibility Disclosures.

Initial: _________________

Patient or Guardian Signature: **Date:**

Patient Intake Questionnaire

Chief Complaint/Current Complaint

Name:____ D.O.B:_______________________

Reason for your visit? ____

Date of onset of your current symptoms? ____/______/________ or since how long? ____ Days/Weeks/Months/Years

Type of injury: Is your current health injury/symptoms related to any of the following

□ Car Accident □ Workers compensation injury □ Exacerbation of previous injury □ Slip & Fall

□ Sports injury □ Other injury/ medical condition ____

Is your current condition related to Post OP/Surgery? □ No □ Yes -Date of surgery ___/_____/__________

Type of Surgery?

____

History of current condition:

How did your symptoms start? □ Sudden □ Progressive worse □ Exacerbation of previous injury

Is your problem getting worse since it started? □ Yes □ No

Did you experience similar symptoms in the past? □ No □ Yes - when____

Are any other doctor/chiropractor/ others treating you for this problem? □ No □ Yes - who______________________

Have you had any X-rays, MRI's, CAT Scans for your current condition/injury? □ No □ Yes – where_________________

What treatments are you currently receiving for your current problem? □ Medications □ Injections □ Chiropractic

□ Physical Therapy □ Acupuncture □ Massage Therapy □ Other:____________________________

Did you have any history of prior injuries? □ Car accidents □ Work injuries □ No □ Yes - when_______________

Past Medical History

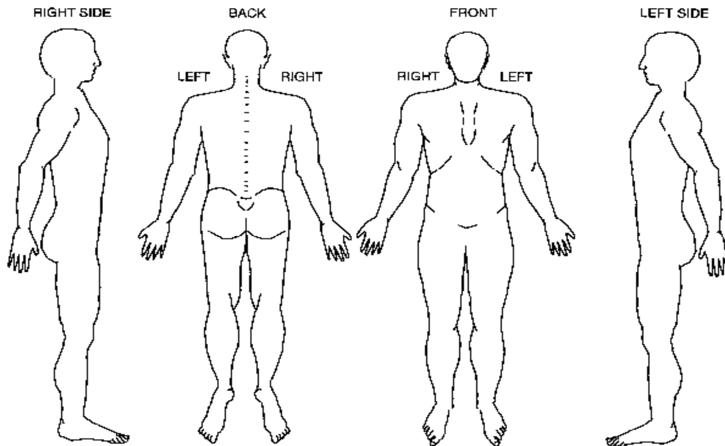
□ Heart disease	□ Hypertension	□ Stroke/CVA	□ Diabetes
□ Seizures/Epilepsy	□ Arrhythmias	□ Bleeding disorder	□ Neuropathy
□ Weight gain/loss	□Asthma	□HIV/AIDS	□Cancer
□Systemic Lupus	□Hepatitis	□Rheumatoid Arthritis	□Arthritis
□Tobacco packs/day___________	□Drug or Alcohol Dependence	□Other: _________________	

□Latex Allergy **□Pacemaker** **□Pregnancy** **□Metallic Implants**

Pain History

On an average day, how intense is your pain? **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Unbearable pain)**

MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



How often do you experience pain?

□(A) Constant (76%-100%)

□(B) Frequent (51%-75%)

□(C) Occasional (26%-50%)

□(D) Intermittent (25% or less)

What activities increase your pain?			Type of pain:	
□ Bending	□ Lifting	□ Morning	□ Aching (1)	□ Radiates (5)
□ Reaching	□ Running	□ Afternoon	□ Burning (2)	□ Sharp (6)
□ Sitting	□ Standing	□ Evening	□ Deep (3)	□ Stabbing (7)
□ Walking	□ Working	□ Night	□ Dull (4)	□ Stiff (8)

Functional Scores					
NECK DISIABILITY INDEX;		DASH;		LEFS;	
SPADI;		OSWESTRY;		Other;	

Functional Limitations

Neck; Turning the neck, bending the neck, looking up and down □Mild □Moderate □Severe

L-Spine; Sitting, bending, lifting, twisting □Mild □Moderate □Severe

Shoulder; Reaching overhead, reaching behind, washing, lifting/carrying, pushing/pulling □Mild □Moderate □Severe

Elbow; Lifting, carrying, pulling, pushing □Mild □Moderate □Severe

Hand; opening a tight jar, turning key/doorknob, prepare a meal, push/pulling, lifting/carrying □Mild □Moderate □Severe

Knee; Standing, walking, stair climbing, running □Mild □Moderate □Severe

Prior Level of Function

□No limitations □Mild Limitation □Moderate □Severe

Occupation:____ **Right Handed?**____ **Left Handed?**____

Current Work Status; □Working □Not Working Last Date Worked; ________________