Patient Symptoms Report and Diagram

Name: _____ DOB: _____/_____/_____

Please circle the appropriate number below showing how bad your pain is now:

Now:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**
At Worst:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**
At Best:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**

1. **What is the purpose of Today's Evaluation?**

_____ _____

2. **Are you still working?** □ **Yes** □ **No** if not when was the last day on the Job**?** _____

3. **Occupation:**_____

4. **When (roughly what date) did your present pain start?** _____

5. **How did symptoms start?** (Check appropriate box)

□ No apparent cause	□ Gradually	□ Twisting	□ Bending
□ Lifting	□ Fall	□ Pulling /Pushing	□ Suddenly

□ Injured during workDate:____/_____/_____	□ Injured in auto accident Date:____/_____/_____	□ Injured at sportsDate:____/_____/_____

6. Have you had similar pain in the past? □ Yes □ No □ Date ____/_____/_____
7. Have you been hospitalized for your pain problem? □ Yes □ No Date ____/_____/____
8. How do you describe your pain? □ Constant □ Intermittent

9. What describes the nature of your symptoms?

□ Sharp	**□ Shooting**	**□ Burning**
□ Dull ache	**□ Numb**	**□ Tingling**

10. What activities make the pain?

	Better	**Worse**	**No Difference**	**Comments**
□ Exercise				**□During** **□After**
□ Lying down				**□ supine** **□ right side □ left side**
□ Sitting				**□How long**

□ **Standing**				□**How long**
□ **Walking**				□**Distance**
□ **Bending**				□**forward / backward** □ **right side** □ **left side**
□ **Overhead activities**				
□**Lifting / pushing / pulling**				
□ **Coughing/ Sneezing**				
□ **Pain Medications**				
□ **Other**				

11. What medications are you currently taking?

12. Have you received any of the following tests? **Date:**

□ **Diagnostic x-rays**	□**CT(computedtomography) scan**	□**Electromyogram(EMG)**
□**Discogram**	□ **MRI(magnetic resonance imaging)**	□ **Others _____**

13. In general would you say your overall health right now is…

□ **Excellent**	□ **Very good**	□ **Good**	□ **Fair**	□ **Poor**

14. Medical history (Circle Yes or No)

Allergies	**Y / N**	**Currently Pregnant**	**Y / N**	**Kidney Problems**	**Y / N**
Anemia	**Y / N**	**Depression**	**Y / N**	**Metal Implants**	**Y / N**
Anxiety	**Y / N**	**Diabetes**	**Y / N**	**Multiple Sclerosis**	**Y / N**
Arthritis	**Y / N**	**Dizzy Spells**	**Y / N**	**Osteoporosis**	**Y / N**
Asthma	**Y / N**	**Emphysema/Bronchitis**	**Y / N**	**Parkinsons**	**Y / N**
Cancer	**Y / N**	**Fractures**	**Y / N**	**Rheumatoid Arthritis**	**Y / N**
Cardiac Conditions	**Y / N**	**Gallbladder problems**	**Y / N**	**Seizures**	**Y / N**
Cardiac Pacemaker	**Y / N**	**Hepatitis**	**Y / N**	**Speech Problems**	**Y / N**
Chemical Depender	**Y / N**	**High Blood Pressure**	**Y / N**	**Strokes**	**Y / N**
Circulation Problem	**Y / N**	**Incontinence**	**Y / N**	**Thyroid Disease**	**Y / N**
Tuberculosis	**Y / N**	**Vision Problems**	**Y / N**	**Other:**	

15. Fall History:

□ Injury as a result of fall in the past year: Yes / No When: _____.

□ Two or more falls in the past year: Yes / No When: _____.

16. Surgical History: (If additional space needed use the back of this sheet) □ Date:____/_____/_____

□Body region: _____ □ Surgery type: _____

17. Do you have any additional information that would be helpful in understanding your problem?

Patient signature: _____Date: _____

Patient Health Information Consent Form

The patient understands and agrees to allow Free Body Physical Therapy to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

The patient has the right to examine and obtain a copy of his/her own health records at The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections, please keep in mind that when requesting records a fee may apply. The patient may request to know what disclosures have been made. Should any restrictions be submitted in writing, our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Free Body Physical Therapy has the right to refuse care.

Consent for Treatment: I authorize and consent to any Physical Therapist from Free Body Physical Therapy to perform Physical Therapy evaluation and treatments. I certify that no guarantee or assurance has been made as to the results that may be obtained. I have read and understand the above. I understand that I may stop treatment at any time.

Insurance Information: I authorize a release of any medical and/or patient information needed to determine benefits or benefits for related services to any insurance company, any other third party payer, state medical assistance agency and/or any other governmental private payer responsible for paying such benefits. I agree to pay for all my charges not covered.

I hereby give my consent to Free Body Physical Therapy to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physical therapist. I also understand that I will not be able to revoke this consent in cases where the physical therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Free Body Physical Therapy.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. This policy will remain effective for the patient for the current plan of care and any future plans of care unless noted.

Printed Name: _____ Date: _____

Signature: _____

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PHYSICAL THERAPY

Patient Payment Consent/Cancellation Policy

Patients are responsible for payment at the time of service. Payment at time of service includes the patient's insurance co-payment, and co-insurance if applicable to insurance plan. Patients are responsible for contacting his or her insurance plan prior to initiating therapy to inquire about insurance coverage for physical therapy services.

Patients may opt out of using insurance coverage and opt in for a cash pay option at any time if insurance does not cover physical therapy, or if coverage fees are outside of the patient's budget. Cash pay visits are $120.00 for the initial evaluation, and $100.00 for all follow up visits. Payment for cash pay visits is due at the time of service.

Cash, and credit cards are accepted. Checks are not accepted.

Patients are expected to notify Free Body Physical Therapy within 24 hours of his or her appointment to cancel, or reschedule. This in consideration for those patients who are waiting to receive care. Patients who **No Show or Cancel in less then 24 hrs** will be charged a **$60.00 fee** each time they **No Show or Cancel in less then 24 hrs**. After 2 No Shows, Physical Therapy will be discontinued & your physician notified.

Please sign below:

I (print name)_____have read and agree to the Free Body Physical Therapy terms and conditions of payment as stated above.

Signature _____

Date_____

Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

At Free Body Physical Therapy, we are committed to treating & using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, & how & when we use or disclose that information. It also describes your rights as they relate to your protected health information.

Understanding Your Health Record/Information

Each time you visit Free Body Physical Therapy, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that the services billed were actually provided,
- A tool in educating health care professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of the state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess & continually work to improve the care we render & the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the property of Free Body Physical Therapy, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Information Practices upon request,
- Request communications of your health information by alternative means or at alternative locations, except to the extent that action has already been taken

Our Responsibilities

Free Body Physical Therapy is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revise notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer, Marc Guillen at:
If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:
Office for Civil Right
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations
-*We will use your health information for treatment.*
For Example: information obtained by a physical therapist or other member of your health care team will be recorded and used to determine the course of treatment that should work best for you. Your therapist will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took & their observations. In that way, the therapist will know how you are responding to treatment.
We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from this clinic.
-*We will use your health information for payment.*
For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
-*We will use your health information for regular health operations.*
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
Directory: Unless you notify us that you object, we will use your name, facility location, general condition, & race for directory purposes. This information may be provided to members of the clergy & to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
Research: We may disclose information to researches when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in a response to a valid subpoena.
Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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PHYSICAL THERAPY

New Patient Intake Form

Patient Name:	DOB:
Address:	City/Zip:
Phone:	Cell Phone:
Email:	
Emergency Contact:	Relation to Patient:
Emergency Contact Phone:	
Referring Physician Name:	Referring Physician Phone:
How Did You Hear About Us?	

Insurance Information

Policy ID #:	Group #:
Policy Holder:	DOB:
Insurance Provider:	Provider Phone:

Worker's Compensation

W/C Carrier:	W/C Phone:
W/C Address:	W/C City & State:

Auto Injury

Attorney Name:	Attorney Phone:
Attorney Address:	Attorney City & State:

We strive to provide you with the most accurate benefit information. However, this is not a guarantee of coverage. Should you feel that the information provided to you may be in error we encourage you to contact your insurance carrier. Co-Payment amounts are specified by the terms of the member's benefit agreement and are the patient's responsibility at the time of service.

I hereby authorize the above information as accurate. Any remaining unpaid balance will be my responsibility.

Signed: _____ Date: _____