PHYSICAL THERAPY CENTRAL

PATIENT INFORMATION

Patient Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Employer: _____ **Work Phone:** _____

Preferred Contact Method for Appointment Reminders: ☐Home Phone ☐Cell Phone ☐Text Message

Email Address: _____ **Soc. Sec.#** _____

Please keep in mind that communication via email over the Internet is not a secure form of communication.

By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Spouse's Name:** _____

Financial Responsibility: ☐Self ☐Other (If Other, please complete Guarantor Assignment Form)

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

PCP/Referring Physician: _____ **Referred to PTC by:** _____

Have you had Home Health Care in the last 30 days? ☐Y ☐N Home Health provider: _____

Have you had physical therapy treatment since January of this year? ☐Y ☐N # of visits _____

Have you had chiropractic treatment since January of this year? ☐Y ☐N # of visits _____

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above named patient, performed by the staff at Physical Therapy Central (PTC) and/or as directed by my referring services.

Patient/Guardian Signature: _____ **Date:** _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy#_____ Group#_____

Secondary Insurance Carrier: _____Policy#_____ Group#_____

*****A copy of your insurance card(s) will be kept on file. It is the patient's responsibility to provide PTC current insurance information.

Is this physical therapy care the result of an injury related to an Auto Accident, 3rd Party incident or Employment? ☐Y ☐N

**If YES, please fill out the Accidental Injury Questionnaire

AUTHORIZATION

I assign payment to PTMS 3.0, LLC. and authorize the filing of claims to my insurance company for payment of services rendered. I am fully aware that I am ultimately responsible for deductibles, co-pays, co-insurance and non-covered services. I authorize PTMS 3.0, LLC. to release any information acquired in the course of my treatment necessary to process insurance claims or to discuss my treatment with other practitioners.

By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys, and other information relating to your therapy services via the communication channels you provided above.

My signature below also acknowledges receipt of PTMS 3.0, LLC. Notice of Privacy Practices (effective 01/01/2018).

Patient/Guardian Signature: _____ **Date:** _____

If you do not have personal health insurance OR you do not want PTMS 3.0, LLC to file claims to your personal health insurance, please read and sign below:

I have asked PTMS 3.0, LLC. to **NOT** file claims to my personal health insurance carrier. If I decide at a later date to have PTMS 3.0, LLC. send claims to my personal health insurance carrier, I understand PTMS 3.0, LLC. will only do so at its discretion because possible contract obligations, per-certifications, per-authorizations, etc., may not have been performed, which would prohibit the likelihood of benefit coverage of my services. I understand and accept responsibility for full payment of any unpaid claims.

Patient/Guardian Signature: _____ **Date:** _____

MEDICARE SECONDARY PAYER (MSP) FORM

Patient Name: _____

Account #: _____ **Medicare Number:** _____

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1. Do you receive Veteran's benefits? Yes ☐ No ☐
2. Are you receiving benefits under the Black Lung Program? Yes ☐ No ☐

   If yes, date benefits began _____
   If yes, are the services you will be receiving related to a non-black lung condition? Yes ☐ No ☐

3. Was this injury/illness due to a work related accident/condition? Yes ☐ No ☐

   If yes, date of injury/illness _____

4. Was the injury/illness related to an automobile accident? Yes☐ No☐

   If yes, date of accident _____

5. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending?

   Yes ☐ No ☐

   If yes, please provide: Attorney's name: _____

   Address: _____

   Phone number: _____

6. Are you entitled to Medicare based on: ☐ Age (65 & over)—go to question 7

   ☐ Disability—go to question 7

   ☐ End Stage Renal Disease
   Do you have group health plan coverage? Yes ☐ No ☐
   Are you within the 30 month coordination period? Yes ☐ No ☐

7. Are you currently employed? Yes ☐ No ☐ Date of retirement _____
   a. Is your spouse employed? Yes ☐ No ☐ Date of retirement _____
   b. Do you have a group health plan as primary coverage based on your own or a spouse's current (or former) employment? Yes ☐ No ☐
   c. Does the employer that sponsors your group health employ 20 or more employees? Yes ☐ No ☐

If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Insurance Co:_____

Address: _____

Policy/Cert #: _____

Group name and number: _____

_____

Signature of Patient/Representative **Date**

_____

Relationship to patient

REV: 04/03/19

ACCIDENTAL INJURY QUESTIONNAIRE

Is this physical therapy care the result of an accidental injury? Y ☐ N ☐

Please indicate if your injury is the result of an: _____ Auto Accident _____ Third Party _____ Employment

Date of Accident: _____ Location of Accident: _____

Attorney's Name: _____ Phone #: _____

If you do not have an attorney at this time but do retain an attorney at a later date, you must notify our office immediately.

PATIENT'S AUTOMOBILE INSURANCE

Policyholder Name:e:_____ Policy #:#:_____

Insurance Name:: _____ Phone #:: _____

Address of Insurance:_____

_____

Claim #:_____

Do you carry Personal Injury Protection and/or MedPay? ☐ Y ☐ N Limit $ _____

Do you carry Uninsured Motorist? ☐ Y ☐ N Limit $ _____

If your condition is the result of a Third Party claim, you must furnish the following information:

Name of 3rd Party Insurance Carrier: _____

Address of Insurance Carrier: _____

_____

Adjuster Name:_____ Phone #: _____

Claim #: _____

If your condition is the result of a work related injury, you must furnish the following information:

Name of your Employer: _____ Phone #:_____

Address of Employer:_____

_____

Employer's WC Carrier: _____ Phone #:_____

Address:_____

_____

Worker's Compensation Claim or Case #: _____

Nurse Case Manager Name:_____ Phone #:_____

Adjustor Name:_____ Phone #:_____

If you are filing your claims with your group health plan, it may have a reimbursement provision for claims resulting from an act or omission of a third party. The term "third party" can be a person, a business, or other entity. In most cases, the third party has insurance to cover your claims. The medical expenses that your group health plan pays, which are also paid by the third party's insurance, may need to be reimbursed to your group health plan.

I hereby authorize any third party or insurer to reimburse my group health plan for benefit payments made on my behalf as a result of this accident involving myself and/or my dependents. The above answers are true and completed to the best of my knowledge. I understand that I am fully responsible for any balance for services rendered. I also understand that if payment is denied by the above mentioned parties I will be personally responsible for the full amount charged for all services rendered.

I understand it is the policy of PTMS 3.0, LLC. to file medical liens on all Motor Vehicle and Personal Injury claims.

Patient/Guardian Signature: _____ **Date:** _____

PHOTO/VIDEO AUTHORIZATION RELEASE

I grant to Physical Therapy Central and its affiliated entities, and its representatives and employees (collectively the “Company”) the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation, therefore I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization. **AGREE** ☐ **DECLINE** ☐

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICE

(Patient/Representative Initials) _____ I acknowledge that I have received the practice/clinic’s Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact Tina Lehman, the Confluent Health Compliance and Privacy Officer, on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider’s business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/ clinic’s Notice of Privacy Practice/clinics.

Patient Signature: _____ **Date:**_____

Parent/Guardian Signature: _____ **Date:** _____

For questions or complaints, please contact:

Compliance Department

Toll free: 888-937-4479

Patient Name:_____

PATIENT HEALTH QUESTIONNAIRE

Occupation: _____ Leisure Activities: _____

Height: _____ Weight: _____ Age: _____

Have you recently traveled from an area with widespread or ongoing community spread of coronavirus? □ Yes □ No

Have you had direct prolonged contact with someone with confirmed case of coronavirus? □ Yes □ No

Are you currently experiencing or do you have any of the following:

Allergies	□Yes	□No	Seizures	□Yes	□No
Anemia	□Yes	□No	Speech Problems	□Yes	□No
Anxiety or Panic Disorders	□Yes	□No	Stroke/TIA	□Yes	□No
Asthma	□Yes	□No	Thyroid Disease	□Yes	□No
Cancer	□Yes	□No	Tuberculosis	□Yes	□No
Site:_____			Vision Problems	□Yes	□No
Cardiac Conditions	□Yes	□No	Pacemaker	□Yes	□No
Chemical Dependency	□Yes	□No	Spinal Cord Stimulator	□Yes	□No
Cardiac Pacemaker	□Yes	□No	Lung Disease	□Yes	□No
Currently Pregnant	□Yes	□No	Blood Clots	□Yes	□No
Depression	□Yes	□No	Autoimmune Disease	□Yes	□No
Diabetes	□Yes	□No	Type:_____		
Dizzy Spells	□Yes	□No	Stomach Ulcers	□Yes	□No
Emphysema/Bronchitis	□Yes	□No	HIV	□Yes	□No
Fractures	□Yes	□No	Recent **fever**, chills, sweats	□Yes	□No
Gall Bladder Problems	□Yes	□No	Ringing in ears	□Yes	□No
Gastro Intestinal Disease	□Yes	□No	Hearing Loss	□Yes	□No
Heart Attack	□Yes	□No	Nausea Vomiting	□Yes	□No
Hepatitis	□Yes	□No	Headaches	□Yes	□No
Type:_____			Difficulty Swallowing	□Yes	□No
High Blood Pressure	□Yes	□No	Unexplained Weight Changes	□Yes	□No
Incontinence	□Yes	□No	Pain wakes me at night	□Yes	□No
Kidney Disease/Problems	□Yes	□No	Chest Pains - Angina	□Yes	□No
Metal Implants	□Yes	□No	**Cough**	□Yes	□No
Multiple Sclerosis	□Yes	□No	**Shortness of Breath**	□Yes	□No
Osteoporosis	□Yes	□No	Bowel or Bladder Disorder	□Yes	□No
Osteoarthritis	□Yes	□No			
Parkinson's	□Yes	□No	**Social History/ Wellness**		
Peripheral Vascular Disease	□Yes	□No	Do you drink alcoholic beverages?	□Yes	□No
Prosthesis/ Implants	□Yes	□No	Do you use tobacco?	□Yes	□No
Rheumatoid Arthritis	□Yes	□No	Do you exercise regularly?	□Yes	□No

List current medications (including prescription, over-the-counter, and herbal):

	Name	Dosage	Frequency	Administration
1.	_____	_____	_____	Oral, Patch, Topical, Other
2.	_____	_____	_____	Oral, Patch, Topical, Other
3.	_____	_____	_____	Oral, Patch, Topical, Other
4.	_____	_____	_____	Oral, Patch, Topical, Other

Surgery / Hospitalization: Include date and reason

1. _____ 2. _____

3. _____ 4. _____

Patient Name:_____

1. List any known allergies (include medications, latex, etc): _____

2. List the dates and results of any X-rays: _____
   MRI: _____
   Bone Density test: _____
   Nerve Conduction test: _____
   Other: _____

3. Please rate your **current** pain on the line below:
   0……5……10

4. On a scale from 0-10 (0 = no pain; 10 = worst pain imaginable), what is the **worst** your pain has been in the past several days? _____/10. What is the **best** your pain has been? _____/10

5. Do you have any numbness, tingling, or burning? □Yes □No Constant or Intermittent

6. When did this problem first begin? _____/_____/_____ (Approximate date)

7. How did this problem begin? _____

_____

8. Have you ever had this problem before? □Yes □ No How many times? _____

9. Are your symptoms worse in? □ Morning □ Afternoon □ Evening □ Night □ Same all day

10. How are you able to sleep at night?
    □ Fine □ Moderate difficulty □ Only with medication □ Change positions all night

11. My pain/problem is slowly getting: □ worse □ better □ staying the same

12. My symptoms bother me: □ constantly 100% □ most of the time 75% □ occasionally 50% □ once in a while 25% or less

13. How often have you completed a least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? □ At least 3 times per week □ 1-2 times a week □ Seldom or Never

14. During the past month, have you often been bothered by feeling down, depressed, or hopeless? □Yes □No

15. During the past month, have you often been bothered by little interest or pleasure in doing things? □Yes □No

16. How many times have you fallen in the past 12 months? _____ Did it result in an injury? □Yes □No

17. This is a statement other patients have made. "***I should not do physical activities which (might) make my pain worse***." Please rate your level of agreement with this statement below. (Circle number)

0	1	2	3	4	5	6
Completely Disagree			Unsure			Completely Agree

Please provide your email so we can send your home exercise program: _____

Please keep in mind that communication via email over the Internet is not a secure form of communication.

PATIENT'S SIGNATURE: _____ DATE: _____/_____/_____

Patient Name:_____

Please indicate your current symptoms on the diagram below:

Deep Ache = ZZZZ
Sharp/Stabbing = ////
Pins and needles = 0000
Burning = XXXX
Throbbing = ++++
Cleared = ✓