

# 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, 3<sup>rd</sup> 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: \_\_\_\_\_

**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: \_\_\_\_\_ 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 3<sup>rd</sup> 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                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Speech Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety or Panic Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/TIA                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Site: _____                 |  | Vision Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Conditions          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spinal Cord Stimulator               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently Pregnant          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Clots                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Autoimmune Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____                          |  |
| Dizzy Spells                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema/Bronchitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent <b>fever</b> , chills, sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gall Bladder Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringing in ears                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gastro Intestinal Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Loss                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea Vomiting                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type: _____                 |  | Difficulty Swallowing                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unexplained Weight Changes           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Incontinence                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain wakes me at night               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease/Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains - Angina                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Metal Implants              | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Cough</b>                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Multiple Sclerosis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Shortness of Breath</b>           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel or Bladder Disorder            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoarthritis              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                      |  |
| Parkinson's                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Social History/ Wellness</b>      |  |
| Peripheral Vascular Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you drink alcoholic beverages?    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prosthesis/ Implants        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use tobacco?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatoid Arthritis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you exercise regularly?           | <input type="checkbox"/> Yes <input type="checkbox"/> 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 Unsure Completely  
Disagree 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 = ✓

