



NEW PATIENT PAPERWORK – MEDICARE

PATIENT INFORMATION	
Name:	Preferred:
Address, City, State, Zip:	
DOB:	Social security #:
Email Address:	

Home Phone:	Appointment Reminder Method Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Text <input type="checkbox"/>
Cell Phone:	
Work Phone:	

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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Partner's Name:	
Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> Other	
Emergency Contact:	
Emergency contact phone:	Relation:

Have you had Physical Therapy treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No # of visits:	
Have you had Chiropractic treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No # of visits:	
Have you had Home Healthcare in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Home Healthcare Provider:	

CONSENT TO TREATMENT	
I hereby authorize and consent to treatment/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 provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the treatment plan that has been recommended.	
Signature Patient/Guardian and relationship to patient:	Date:

INSURANCE INFORMATION	
Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.	
Primary Insurance:	Secondary Insurance:
Policy #:	Policy #:
Group #:	Group #:



MEDICARE SECONDARY PAYER (MSP) FORM

Part I

<p>1. Are you receiving benefits under the Black Lung Program? If Yes, date benefits began: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Was this injury/illness due to a work-related accident/condition? If yes, date of injury/illness: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: <u>Attorney's Name:</u> _____ <u>Address:</u> _____ <u>Phone Number:</u> _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

If you answered NO to all questions, go to Part II.
If you answered YES to any of the questions above, Medicare is the secondary payer. Please provide primary insurance information.

Part II

<p>1. Are you entitled to Medicare based on? <input type="checkbox"/> Age (65 & older) – go to question #2 <input type="checkbox"/> Disability – go to question #2 <input type="checkbox"/> End Stage – if you answer yes to <u>both</u> questions a and b below <u>group health plan is primary.</u> a. Do you have group health plan coverage? b. Are you within the 30-month coordination period?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? If yes, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage, based upon: <input type="checkbox"/> Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u> <input type="checkbox"/> Disability - If you are disabled and your employer, spouse, or family member employer, has 100 or more employees, <u>your GHP is primary.</u></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Insurance Company: _____

Address: _____

Policy/Cert #: _____

Group Name and Number: _____

Signature of Representative: _____ Date: _____

Relationship to Patient: _____



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PAYMENT FOR SERVICES AND INSURANCE

I assign payment for these services directly to PTMS 3.0, LLC. I authorize the filing of claims to my insurance plan and authorize PTMS 3.0, LLC to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I am responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance plan and understand that I am fully responsible for any balance due for services rendered.

Patient/Guardian Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other described and permitted uses or disclosures. I understand that I may contact the Confluent Health Compliance Officer listed on the notice if I have a question or complaint.

Patient/Guardian Signature: _____ Date: _____

For questions, please contact the Compliance Department (Toll free) at 888-937-4479.

PATIENT HEALTH QUESTIONNAIRE

Occupation: _____ Height: _____ Weight: _____ Sex: Male Female

Leisure Activities/Hobbies: _____

Are you? Right-handed Left-handed

Where do you live? Private home Apartment/rented room Assisted living/group home
 Hospice Other

With whom do you live? Alone Spouse only Spouse and others Child
 Other

Does your home have? Stairs, no railing Stairs, railing Ramps Uneven terrain
Please explain: _____

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

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? Yes No

General Health Status, please rate your health. Excellent Good Fair Poor

Please list any known allergies (including medications, latex, etc.) below:

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Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please indicate route			
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other

Surgery / Hospitalization, please include date and reason.

Are you currently experiencing any of the following?

Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Productive/chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain wakes me at night	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent fever, chills, sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing loss/ringing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue or myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight changes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you been diagnosed with any of the following?

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety or Panic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer If yes, Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord Stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Emphysema/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gall Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Type:			

Social History / Wellness	
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No / Comments:
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No / Comments:
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? <input type="checkbox"/> At least 3 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Seldom or Never	

Current Condition
When did this problem(s) first begin?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?
Are your symptoms worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Same all day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Staying the same
My symptoms bother me: <input type="checkbox"/> Constantly (100%) <input type="checkbox"/> Most of the time (75%) <input type="checkbox"/> Occasionally (50%) <input type="checkbox"/> Once in a while (25%)
Do you have any numbness, tingling, or burning? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check one: <input type="checkbox"/> Constantly <input type="checkbox"/> Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Please list the dates and results of any:
X-Rays:
MRI:
Bone Density Test:

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Nerve Conduction Test:
Other:
Are you aware of any physical reason why you should not receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please tell us what it is:
What are your goals for therapy?

Symptom Rating

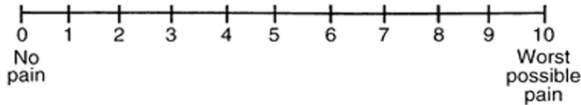
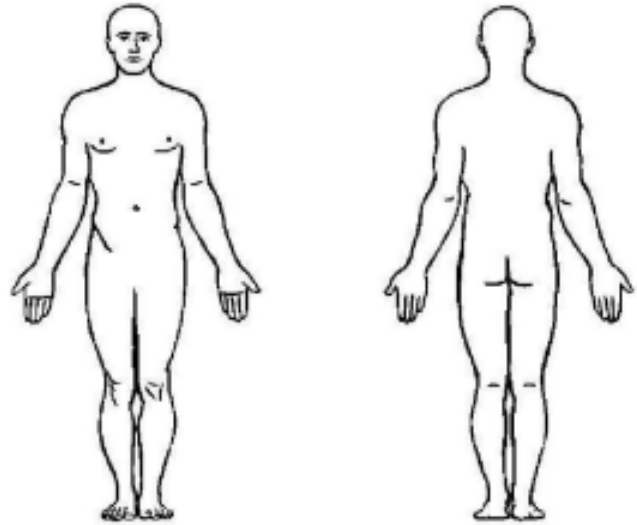
Mark location of symptom(s)

O for pain

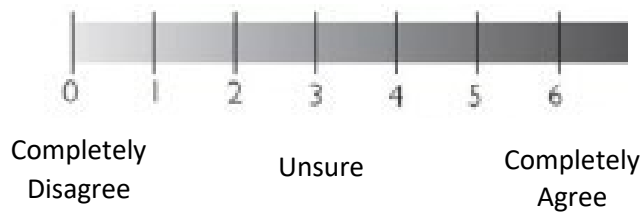
X for numbness/tingling/burning

Please rate your pain - on a scale from 0 – 10
(0 = No Pain; 10 = Worst pain imaginable)

Current: / 10	Best: / 10	Worst: / 10
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“I should not do physical activity which (might) make my pain worse.”
Please rate your level of agreement on the scale below:



Patient/Guardian Signature: _____

Date: _____