



Physical Therapy Plus

Patient Information

Personal Information

Date: _____

Patient's Full Name: _____

Address: _____ Home Phone #: _____

City: _____ State: _____ Zip: _____ Cell Phone #: _____

Date of Birth: _____ Sex: Male Female SSN# _____

E-Mail Address: _____

Marital Status: Single Married Widowed Divorced Separated Minor

Place of Employment: _____ Work #: _____

Employer's Address: _____
Street City State Zip

Emergency Contact Information

Name: _____ Phone # _____

Relationship: _____ Alt. Phone #: _____

How did you hear about us? _____

Medicare YES NO

Are you currently on Home Health Care? YES NO

→ Please see insurance information on back...

Insurance Information

****If you are primary insurance holder you can skip this section... If someone else in your family is primary insurance holder please fill out this information

Primary Insurance

Policy Holder Name: _____ DOB: _____

Policy Holder SSN #: _____ Relationship: _____

Policy Holder's Employer: _____ Phone # _____

Has your deductible been met? YES NO If so, How much? _____

Secondary Insurance

Policy Holder Name: _____ DOB: _____

Policy Holder SSN #: _____ Relationship: _____

Policy Holder's Employer: _____ Phone # _____

Has your deductible been met? YES NO If so, How much? _____

Workers Comp. or Attorney Case

Name of Insurance: _____ Claim# _____

Adjuster Name: _____ Phone # _____

Attorney Name: _____ Phone # _____

Name: _____ Date: _____

History of Present Condition

1. What are your symptoms/chief complaints?

2. Which of the following **best describes** how your injury occurred?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> During Recreation/Sports | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> A Fall | _____ |
| <input type="checkbox"/> Work Injury | <input type="checkbox"/> Overuse (cumulative trauma) | _____ |
| <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Unknown | |

What is the date of injury / MVA? _____

Have you had surgery for the condition that you are being treated? YES NO

Date of Surgery: _____

3. Have you ever had/been diagnosed with any of the following conditions (*check all that apply*)

- | | | |
|---|--|--|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Broken bone |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation/vascular problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Infectious diseases | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems | |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Nuerological Problems | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Respiratory problems | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood disorders | |
| <input type="checkbox"/> Cancer (type): _____ | | |

4. Please list surgeries you have had in the past.

Previous Functional Level

5. Exercise Habits None Moderate Daily Heavy

6. Have you had any previous treatment for this condition?

- | | | | |
|---|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Traction | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Medication | <input type="checkbox"/> Bed rest | |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Injection | <input type="checkbox"/> Hospitalization | |

7. Have you had any of the following tests?

- | | | |
|----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Stress X-Ray Test | <input type="checkbox"/> EMG |
| <input type="checkbox"/> X-Rays | <input type="checkbox"/> Arthrogram | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Nerve Conduction Study | _____ |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Bone Scan | |

8. Are you currently pregnant? Yes No

Medication:

9. Please list any medications you are currently taking (including over the counter medications):

_____	_____
_____	_____
_____	_____

10. Are you seeing any health care providers other than the physical therapist for this current condition?

- | | | |
|----------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Surgeon | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Other: _____ |
|----------------------------------|---------------------------------------|---------------------------------------|

Goals for Therapy

Patient Signature

Therapist Signature

Work History

11. Occupation: _____

- Employed Working
 Employed Not Working
 Employed Working w/ restrictions
 Student
 Retired
 Unemployed

12. Physical activities at work (check all that apply)

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Repetitive lifting | <input type="checkbox"/> Heavy equipment operation |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Heavy lifting | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Phone use | <input type="checkbox"/> Computer use | <input type="checkbox"/> Other: _____ |

13. If not performing your normal activities at work do you plan to RETURN to your normal activity level? Yes No

14. Please indicate the worst your pain has been in the last 24 hours on the scale below:

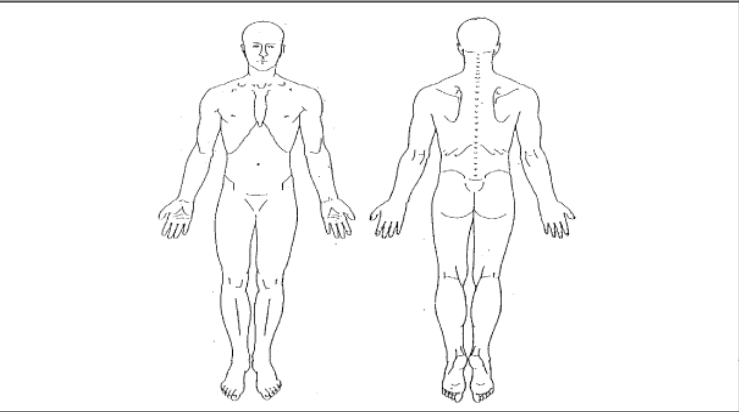
Mark areas of **pain** or **abnormal** sensation on the body chart below (shade in where appropriate)

(0 being no pain at all, 10 being the worst pain imaginable)

Now: _____ Worst: _____ Best: _____

15. Nature of pain/symptoms (check all that apply)

- Sharp
 Dull
 Throbbing
 Numbness
 Aching
 Occasional
 Constant
 Other: _____



Physical Therapy Plus of Vermilion, Inc.
Patient Information Acknowledgement Form

I have read and fully understand **Physical Therapy Plus of Vermilion, Inc.** Notice of Information Practices. I understand that **Physical Therapy Plus of Vermilion, Inc.** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Physical Therapy Plus of Vermilion, Inc.** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Physical Therapy Plus of Vermilion, Inc's**. Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at my time.

Patient Name

Signature

Date

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

_____ Date	_____ Name	_____ Reason
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→ Please see back side...

Physical Therapy Plus of Vermilion, Inc.

Treatment Authorization & Financial Agreement

Thank you for choosing us as your health care provider. The following is a statement of our financial policy, which will require you to read and sign prior to treatment.

I agree to pay **Physical Therapy Plus of Vermilion** for professional services rendered or to be rendered at the time the service is performed unless other arrangements have been made in advance.

I also understand that insurance benefits assigned to **Physical Therapy Plus of Vermilion** must be paid within 60 days from the date of insurance billing. If the insurance company has not paid within 60 days, I agree to pay **Physical Therapy Plus of Vermilion** the full balance within the credit limits of the office. Any payment received by **Physical Therapy Plus of Vermilion** after my balance is paid will be refunded to me. I understand that **Physical Therapy Plus of Vermilion** cannot be responsible for collecting my insurance claim or negotiating a settlement on a disputed claim. I understand that I am ultimately responsible for this account no matter what my insurance company may or may not pay.

Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under all contractive care and/or other medical information. Should a problem arise, we will work with you to assist in any way possible. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I agree to give at least a 24 hour notice if I need to change my appointment. I agree to pay for the appointment time lost if I fail to keep my appointment without giving notice.

I understand that it is necessary for **Physical Therapy Plus of Vermilion** to retain the services of an attorney to collect my unpaid balance. I will be responsible for all court costs, attorney's fees and any other collection fees which may be incurred as a result of my account being turned over for collection as allowed by the State of Louisiana.

Authorization for Release of Medical Information and Treatment

Authorization is hereby given to release medical information and/or copies of medical records from my doctor for any and all of my related previous medical condition to **Physical Therapy Plus of Vermilion**. **Physical Therapy Plus of Vermilion** may provide written and/or verbal reports to my insurance company, worker's compensation company and/or my attorney's.

I agree to pay a fee of \$25.00 for any check returned N.S.F.

I hereby authorize and consent **Physical Therapy Plus of Vermilion** to provide treatment prescribed by my physician related to my rehabilitation.

I have read and understand the above:

Who is financially responsible for this bill? _____

By signing below I am authorizing Physical Therapy Plus to bill the above mentioned financially responsible party. I understand that I am ultimately responsible for this account no matter what the above mentioned party may or may not pay.

Print Name

Social Security Number

Signature of Patient/ Responsible Party

Date

Signature of Co-Responsible Party

Date