Keys Physical Therapy, LLC

Patient Information Form (Please Print)

Patient Information

Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Employer / Employer Address				Work Phone
Email Address				Cell Phone

Guardian Information (Responsible Party)

Guarantor / Guardian Name	Sex	Relation	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Guarantor / Guardian Employer	Employer Address			Work Phone

Other Information

Referring Doctor (Name, Location)
Family Doctor (Name, Location)
Emergency Contact /Relation/ Phone

Primary Health Insurance

Primary Carrier	Mailing Address			
ID No.	Group No.		Employer	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Secondary Health Insurance

Secondary Carrier	Mailing Address		
ID No.	Group No.		Employer
Policy Holder	Sex	Relation to Patient	Date of Birth

If applicable:

Workman's Compensation

Carrier Name	Mailing Address	
Claim No.	Date of Accident	Adjuster's Name / Phone No.

Automobile Accident

Carrier Name	Mailing Address	
Claim No.	Date of Accident	Adjuster's Name / Phone No.

I certify that the above information is correct. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment, thereof, when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for services provided. If it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's case, I agree to pay Keys Physical Therapy, LLC for services rendered. I authorize payment for these services be paid directly to Keys Physical Therapy, LLC.

Signature____Date____________

Keys Physical Therapy, LLC

CONSENT FOR CARE AND TREATMENT

I the undersigned, having legal authority to do so, do hereby agree and give consent for *Keys Physical Therapy* to furnish medical care and treatment to ________________________________ as considered necessary and proper in diagnosing or treating my/his/her condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitles to *Keys Physical Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information necessary, including Medical Records, to secure payment.

FINANCIAL POLICY STATEMENT

Keys Physical Therapy bills your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimate portion of the bill be made today. This includes co-payments, co-insurance, and deductibles if required by your health insurance carrier. If you insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you agree to promptly remit the payment to *Keys Physical Therapy*.

The above does not apply for those patients covered by the Workers' Compensation Act. However, a Workers' Compensation patient may be responsible for the charges if the claim in denied.

In the event my balances remain unpaid for any reason, I agree to pay a penalty of 30% of the open balance to cover collections agency fees and/or attorney fees in addition to court costs.

SCHEDULING AND CANCELLATION POLICY

Keys Physical Therapy reserves the right to bill a **$30** no show fee **if we are not notified** that you are unable to attend your scheduled appointment. If you cannot attend your scheduled appointment time, we ask that you notify us **24 hours** prior to your appointment so we may accommodate other patients. Consistency in treatment is important to your rehabilitation outcome and multiple cancellations may result in termination of your treatment or a loss of desired schedule time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of HIPAA Privacy Policies. The Notice of HIPAA Privacy Policies describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Above It All Physical Therapy's health care operations. The Notice of HIPAA Privacy Policies also describes my rights and Above It All Physical Therapy's duties with respect to my protected health information. The Notice of HIPAA Privacy Policies is posted in the reception area.

Above It All Physical Therapy reserves the right to change the privacy policies that are described in the Notice of HIPAA Privacy Policies. I may obtain a revised Notice of HIPAA Privacy Policies by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or through e-mail.

Patient: ____ Date: ______________

Guardian/Responsible Party: ______________________________________ Date: ______________

Relationship to Patient:____

Other Authorized Parties:_______________________________________

Keys Physical Therapy, LLC

Health History (Please Print)

Patient Name (Last, First, MI)	Age:	Height:	Weight:	Today's Date

Do you have a pacemaker? Yes No	Do you smoke? Yes No	Are you latex sensitive? Yes No

ALLERGIES:

MEDICATIONS (include pills, injections and/or skin patches):

Have you ever taken steroid medications for any medical conditions? **Yes** **No**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **Yes** **No**

SURGERIES, INJURIES, AND HOSPITALIZATIONS:

Diagnostic Tests (for example: x-ray, MRI, CT Scan, Bone Scan, blood tests):

Treatment received so far for this injury, pain, or problem:

Occupation, including activities that comprise your work day:

Are you on a work restriction from your doctor? Yes No If yes, explain:

Leisure activities, including exercise:

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? Yes No

Have you RECENTLY experienced any of the following (check all that apply)?

- ❑ Fatigue
- ❑ Fever/chills/sweats
- ❑ Nausea/vomiting
- ❑ Weight loss/gain
- ❑ Difficulty maintaining balance while walking
- ❑ Falls
- ❑ Numbness or tingling
- ❑ Muscle weakness
- ❑ Dizziness/lightheadedness
- ❑ Heartburn/indigestion
- ❑ Difficulty swallowing
- ❑ Changes in bowel or bladder function
- ❑ Constipation
- ❑ Diarrhea
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cough
- ❑ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ AIDS / HIV
- ❑ Cancer
- ❑ Heart problems
- ❑ Chest pain/angina
- ❑ High blood pressure
- ❑ Circulation problems
- ❑ Blood clots
- ❑ Stroke
- ❑ Anemia
- ❑ Bone or joint infection
- ❑ Chemical dependency (i.e., alcoholism, recreational drugs)
- ❑ Depression
- ❑ Lung problems
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Rheumatoid arthritis
- ❑ Other arthritic condition
- ❑ Bladder/urinary tract infection
- ❑ Kidney problem/infection
- ❑ Sexually transmitted disease
- ❑ Pelvic inflammatory disease
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Osteoporosis
- ❑ Multiple sclerosis
- ❑ Epilepsy / Seizures
- ❑ Eye problem/infection
- ❑ Ulcers
- ❑ Liver problems
- ❑ Hepatitis
- ❑ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ Cancer	❑ Diabetes	❑ Tuberculosis
❑ Heart problems	❑ Stroke	❑ Thyroid problems
❑ High blood pressure	❑ Depression	❑ Blood clots

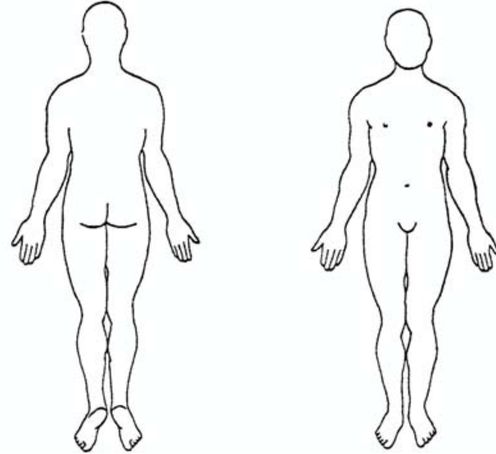
Approximately what date did your symptoms start (include surgery date if applicable)?

What do you think caused your symptoms, injury and/or pain?

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Can you identify positions or activities that make your symptoms worse?

1)

2)

3)

Symptom relieving Factors: Can you identify positions or activities that make your symptoms better?

1)

2)

3)

How are you currently able to sleep at night due to your symptoms?

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst?	❑ Morning	❑ Afternoon	❑ Evening	❑ Night	❑ After exercise
When are your symptoms the best?	❑ Morning	❑ Afternoon	❑ Evening	❑ Night	❑ After exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"emergency room pain"* please describe:
Your current level of pain while completing this survey:__________
The best your pain has been during the past 24 hours: __________
The worst your pain has been during the past 24 hours: __________

Have you ever had this injury before: ❑ Yes ❑ No When__________ Treatment rec'd_____________