# GIVE US STRENGTH PHYSICAL THERAPY

Thank you for choosing Give Us Strength Physical Therapy for your rehabilitation needs.

**PATIENT INFORMATION:**

Name (Last, First, Middle Initial): _____ DOB:_____

Social Security Number: _____ Sex: ____Male ____Female

Marital Status: ____ Single ____Married Email:_____

Mailing Address:_____ City_____ State_____ Zip_____

Home phone: _____ Cell Phone_____

Employer: _____ Occupation:_____

Employer Phone: _____ Employer Address: _____

Emergency Contact: _____ Relation to you? _____ Phone: _____

Preferred Method of Appointment Reminders: _____ Text _____Email

How did you hear about us? ____ Doctor ____ Friend/Family _____Internet _____Other (Describe):_____

**RESPONSIBLE PARTY** (If different from Patient):

Name: _____ (Parent/Guardian)

Address: _____ Phone: _____

**PHYSICIAN INFORMATION:**

Referring Physician: _____ Primary Physician: _____

**INJURY INFORMATION:** Type: ____ Work ____ Auto ____Sport ____Other

Name of Auto Insurance (If Auto Accident): _____

Date of injury: _____ Claim # _____ Place of Injury _____

Brief description of Injury: _____

*If Workers Comp: Case Workers Name: _____

**INSURANCE INFORMATION**

Primary Ins: _____ Subscriber Name: _____

Date of Birth: _____ Policy #:_____ Group #: _____

**For Military/TRICARE patients: Sponsor's Social Security #: _____ Sponsor DOB:_____**

Secondary Ins: _____ Subscriber Name: _____

Date of Birth: _____ Policy #: _____ Group # _____

**_____ No Insurance: Pay at time of service unless prior arrangements have been made.**

# Consent for Treatment, Billing Agreement and Privacy Policies

## Information for patients without insurance:

If you do not have insurance coverage, you will be expected to pay for your bill, in full at the time of service, or make payment arrangements with one of our administrative staff members. For your convenience we accept cash, checks, major credit cards and debit cards.

## Information for patients with insurance:

Insurance coverage is a contract between you, your insurance company, and in many instances your employer. As a courtesy to you, we will file your medical claim with your insurance company in a timely manner. In most instances, we will accept payment directly from your insurance company in accordance with your policy's terms and apply the payment to your account. Contractual discounts will be applied at that time.

**You are responsible for any co-payment, co-insurance, or deductible.** Co-pays are expected at the time of service. Even though we provide you with the most up to date information about your benefits, ultimately, you are expected to know your co-pay and deductible amounts.

You will receive periodic statements indicating that we have billed your insurance company on your behalf. However, **you are ultimately responsible for payment of your physical therapy services.** If your insurance company fails to pay your claim in a timely manner, or rejects your claim in part or in full, you are personally responsible for, and will be billed directly for the services you received. If that happens you may want to contact your insurance company directly or your insurance plan administrator at your place of employment to discuss the reason for the denial of benefits.

**We accept cash, personal checks, Visa, Mastercard and discover**

**There is a returned check processing fee of $25 per occurrence**

## MISSED APPOINTMENT POLICY:

Our priority is quality patient care. We are very dedicated to you, and are determined to help as much as we can. In order for us to better assist you in achieving your desired results, compliance to your scheduled appointment times are strongly encouraged. Our time is also very valuable to assisting other patients. We understand there may be times when you miss an appointment due to illness, obligations to work or family and emergency situations. However, we urge you to call **24-hours** prior to cancelling your appointment. Not following this policy or if there is a no-show to a scheduled appointment a **$75.00 cancellation fee** will be assessed.

Please understand that if you no-show for 2 consecutive appointments, no show for 3 appointments, or cancel for a total of 3 appointments, you may be discharged from care. We will notify you in writing, via mail, if you are discharged from care.

## HIPAA/PRIVACY POLICY:

We are required by law to maintain the privacy of your health information and provide you with a copy of our Privacy Policy. Specifically HIPAA and Give Us Strength's Privacy Policy individually identify you and relate to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare. Under no circumstances is your private healthcare information given to anyone unless your consent is given. If you wish for someone to be authorized to assist you with your care at Give Us Strength Physical Therapy, written consent will be needed. We may use health information about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care. If you have further questions about our HIPPA or Privacy Policy we have a copy at the front desk.

*I have read and agree to the terms of this statement.

*I consent to receive Physical Therapy care at Give Us Strength Physical Therapy.

_____

Signature of Patient/Guardian  Printed Name of Patient  Date

# GIVE US STRENGTH
# PHYSICAL THERAPY

| | | | |
|---|---|---|---|
| **PATIENT'S NAME** | | **CHIEF CONCERN** | |
| **DATE OF BIRTH** | | **DATE OF INJURY** | |
| | | **LAST DOCTOR'S VISIT** | |

| **USING THE 0-10 SCALE WITH 0 BEING "NO PAIN" AND 10 BEING "THE WORST PAIN IMAGINABLE" PLEASE DESCRIBE THE FOLLOWING:** | |
|---|---|
| **CURRENT LEVEL OF PAIN:** | **/10** |
| **THE BEST YOUR PAIN HAS BEEN IN THE LAST 2 DAYS:** | **/10** |
| **THE WORST YOUR PAIN HAS BEEN IN THE LAST 2 DAYS:** | **/10** |

**CURRENT MEDICATIONS**

Drug allergies: No Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

| **Name of drug** | **Dose (include strength & number of pills per day)** | **How long have you been taking this?** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

**Please List Any Surgeries or other conditions for which you have been hospitalized:**

1.

2.

3.

**Please indicate if you have received any of the following for the current injury:**

| | | |
|---|---|---|
| ☐ General Practitioner | ☐ Physiatrist (Pain Doctor) | ☐ Massage Therapy |
| ☐ Orthopedic Surgeon | ☐ Chiropractor | ☐ X-Ray |
| ☐ Neurosurgeon | ☐ Physical Therapy | ☐ CT Scan |
| ☐ Neurologist | ☐ Occupational Therapy | ☐ MRI |
| ☐ Myelogram | ☐ EMG / NCV (Nerve Testing) | ☐ Emergency Room |

## MEDICAL HISTORY: SYSTEMS REVIEW

**Please indicate if you have been treated for or experienced any of the following:**

**GENERAL**

- ☐ Fatigue
- ☐ Recent Weight Change; How much _____ lbs.
- ☐ Night Sweats/Fevers

**CARDIOVASULAR**

- ☐ High Blood Pressure
- ☐ Chest Pain/Angina
- ☐ Coronary Heart Disease
- ☐ Heart Surgery/Pacemaker

**MUSCULOSKELETAL**

- ☐ Muscle Pain/Cramps
- ☐ Stiffness
- ☐ Joint Pain or Swelling
- ☐ Osteoporosis

**RESPIRATORY**

- ☐ Shortness of Breath
- ☐ Excessive Coughing/Sputnum
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

**NEUROLOGICAL**

- ☐ Severe or Frequent Headaches
- ☐ Epilepsy/Seizures
- ☐ Numbness or Tingling
- ☐ Dizziness or Fainting
- ☐ Weakness
- ☐ CVA (Stroke)/TIA (Mini Stroke)
- ☐ Huntington's
- ☐ Traumatic Brain Injury
- ☐ Muscular Dystrophy
- ☐ Fibromyalgia

**GASTROINTESTINAL/URINARY**

- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Rectal Bleeding
- ☐ Blood in Urine
- ☐ Kidney Stones

**ENDOCRINE**

- ☐ Excessive Thirst/Urination
- ☐ Thyroid Dysfunction/Goiter
- ☐ Hormone Problem(s)
- ☐ Diabetes

**HEMATOLOGICAL/LYMPHATIC**

- ☐ Bruise Easily
- ☐ Slow to Heal
- ☐ Enlarged Glands

**OPHTHALMOLOGICALY**

- ☐ Glasses/Contacts
- ☐ Blurred/Double Vision
- ☐ Eye Disease/Injury
- ☐ Glaucoma

**EAR-NOSE-THROAT**

- ☐ Hearing Loss or Ringing
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Voice Change

**ALLERGIES**

- ☐ Food and Medical Allergies

**OTHER**

- ☐ Pregnant
- ☐ Breast Pain/Discharge
- ☐ Menstrual Changes
- ☐ Blood Clot/Emboli
- ☐ Confusion/Memory Loss
- ☐ Tobacco
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Cancer/Chemotherapy/Radiation
- ☐ Depression
- ☐ Unexplained Weight or Energy Loss
- ☐ Other (Explain):_____

GIVE US STRENGTH
PHYSICAL THERAPY

# Acknowledgement of Receipt of Notice of Privacy Practices

1. I have received/been offered a copy of Give Us Strength Physical Therapy's Notice of Privacy Practices. Initial _____
2. I agree to the open treatment area used by Give Us Strength Physical Therapy and understand that a private treatment may not be available. Initial _____
3. I agree and understand that other patients will be completing treatment plans during my visit and may overhear information regarding my plan of care. Initial _____
4. I agree that I must sign in at each visit. Initial _____
5. I agree that a Physical Therapist/Physical Therapist Assistant student may assist in my care. Initial _____
6. I agree that Give Us Strength Physical Therapy employees may call my home in regard to my health. Initial _____
7. I agree that Give Us Strength Physical Therapy may use my email address to send receipts, home exercise programs, and appointment reminders. Initial _____

Patient/Responsible Printed Name: _____ Date:_____

Patient/Responsible Signature: _____

**This Section is for Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

Individual refused to sign

Communication barrier

An emergency prohibited obtaining the acknowledgement

Other (specify): _____

Employee Name: _____ Employee Signature: _____

Date: _____