ProActive Physical Therapy

Patient Information (Please Print Clearly)					
Patient Name:			Date of Birth:	Gender: M F	Marital Status:
Address:		City:		State:	Zip:
Home Phone:	Cell Phone:		Work Phone:	Employer:	
Referring Doctor:		Emergency Contact:	Relationship:	Phone:	
Social Security Number:	Email:			Work or Auto Injury: Yes No	Date of Injury:

NOTICE OF PRIVACY PRACTICES 2013 — Patient Signed Acknowledgment

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to ProActive Physical Therapy and its entities. All the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: You have the right to revoke the authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: Doctors and other professionals involved in your care will use information in your medical record and information you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you.

Individuals Involved in Your Care: With your written agreement, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement for you or paying for your care.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organization, such as auditing, accreditations, legal services, etc.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or alternative locations.

RIGHTS THAT YOU MAY HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION

Access to Your Personal Health Information: You have the right to copy and/or inspect much of the personal health information that we retain on your behalf.

Amendments to Your Personal Health Information: You have the right to request to amend your written medical information. We will consider amending any patient's PHI.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive an accounting of certain disclosures of your medical information that we have made in the last six years prior to the date of the request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or healthcare operations.

PATIENT (or reponsible party) SIGNATURE _____ DATE _____ PRINT NAME _____

ProActive Physical Therapy

Consent to Treatment & Therapeutic Procedures

* I voluntarily consent to outpatient therapy treatment and services deemed necessary by my therapist. I am aware that the practice of Physical Therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the services provided at ProActive Physical Therapy.

* It is the clinic's sincere intent to educate me on every process, from billing to treatment, and eventually discharge from our services. Therefore, if evaluation techniques, manual therapy techniques or prescribed exercise techniques are not fully understood, it is my responsibility to obtain a clearer understanding of what the therapist's objective outcomes are, and how he/she is trying to achieve them.

* I further understand that as a part of therapy instruction or required manual treatments, the clinical staff may place their hands on various parts of my body, such as the head, neck, breastbone, ribcage, pelvis, or buttock.

Initial _____

Cancellation Policy

* 24- Hour notice is required to cancel a therapy appointment. A cancellation fee of $50.00 may be charged to the responsible party if sufficient notice is not provided.

Initial _____

Assignments and Authorization to Pay Insurance Benefits

* I hereby assign and authorize payment directly to the facility, herein specified and otherwise payable directly to me. I understand I am responsible to the facility for charges not covered or paid by my insurance.

Initial _____

Financial Responsibility Policy

* I hereby guarantee payment of therapy services to ProActive Physical Therapy. I understand that I am responsible for payment of my account and the facility does not accept responsibility for negotiating a settlement on a disputed claim.

* As a courtesy, the facility will bill my insurance. I understand that co-payments are due when services are rendered. Any balances, after initial insurance payment has been received, is due and payable upon receipt. Interest of 1.5% monthly (18% per annum) will be added to all accounts 30 days past due.

* In the event this account is placed with an attorney or collection agency for collection, I agree to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

Initial _____

Payment Policy

* Payment is due at the time of service for copays, deductible, services deemed non-covered by insurance and any other items addressed herein.

* Budget payments are available with a minimum of $150.00 monthly payment. Responsible party's credit/debit card information and signature is kept on file to process budget payments.

Initial _____

I certify that I have read, understand, and agree to the above information.

PATIENT (or reponsible party) SIGNATURE	DATE	PRINT NAME

PATIENT SUBJECTIVE QUESTIONNAIRE

Name _____ D.O.B. _____ Date _____

1. ***Reason for visit*** (low back pain, headaches, etc.): _____

2. ***Please indicate how your pain started:***
   - ☐ Trauma
   - ☐ Work Accident
   - ☐ Surgery
   - ☐ Motor Vehicle Accident
   - ☐ Pregnancy Related
   - ☐ Chronic Pain (unsure of cause)
   - ☐ Progressive
   - ☐ Sports Injury
   - ☐ Other (briefly explain)_____

3. Have you had Physical Therapy or Chiropractic treatments previously? ☐ NO ☐ YES

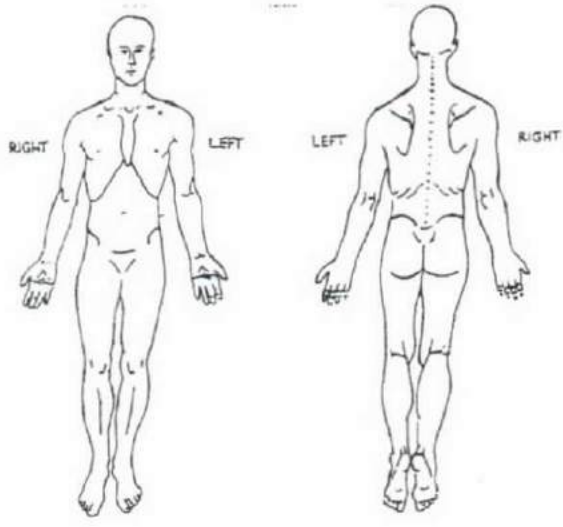
4. Have you had any of the following ***diagnostic studies***?

	NO	YES	Date (year)	Where
Diagnostic X-Rays	☐	☐	_____	_____
CT Scan (computed tomography)	☐	☐	_____	_____
MRI (magnetic resonance image)	☐	☐	_____	_____
Other: _____	☐	☐	_____	_____

5. On the body diagrams, mark and label your primary areas of concern:

On the line below, please indicate (with an "X") the Maximum amount of pain you feel on a daily basis:

No Pain----------Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10



What activities make your pain worse?
(Please check (x) all that apply to you)

- ☐ Lying on back
- ☐ Exercise (during)
- ☐ Bending forward
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Bending backwards
- ☐ Coughing / Sneezing
- ☐ Standing
- ☐ Twisting
- ☐ Early Morning
- ☐ End of Day
- ☐ Walking
- ☐ None
- ☐ Other_____

6. How do you feel in the morning? ☐ Stiff ☐ Sore ☐ Fine
   On you move about, does it: ☐ Worsen ☐ Ease

7. Can you sleep comfortably at night? ☐ NO ☐ YES Is your mattress: ☐ Firm ☐ Medium ☐ Soft
   Number of sleep interruptions caused by pain:_____
8. Have you had any major dental work done? ☐ NO ☐ YES
   If yes, briefly explain:_____

9. Do you: ☐ Clench ☐ Grind Teeth ☐ Snore ☐ Wake up thirsty
   Do you wear a day or night mouth splint? ☐ NO ☐ YES

WORK STATUS

10. Are you: ☐ Currently working ☐ Unemployed If yes, ☐ Full Duty or
☐ Disabled ☐ Retired ☐ Light Duty
☐ Employed but not working

11. What is your occupation? _____

12. Type of work: ☐ Sedentary ☐ Light ☐ Heavy Lifting <50 lbs ☐ Very Heavy Lifting > 50 lbs

13. Do you do a lot of standing, bending or twisting at work? ☐ NO ☐ YES
14. Are you having difficulties at work because of your pain? ☐ NO ☐ YES

15. Were you injured at work? ☐ NO ☐ YES
Explain _____

PAST MEDICAL HISTORY

16. *Past Medical History*: (i.e. Diabetes, High Blood Pressure, Arthritis, etc.)
1. _____ 3. _____
2. _____ 4. _____

17. *Past Surgical History*: (i.e. Tonsillectomy, Back Surgery, Appendix, etc.)
1. _____ 2. _____

18. Social History:
Do you smoke, chew ? _____ Y _____ N If yes, how much: _____
Do you drink alcohol ? _____ Y _____ N If yes, how much: _____

19. *Current Medications*: (i.e. pain, heart, arthritis, psych meds, vitamins, etc.)
1. _____ 3. _____
2. _____ 4. _____

20. Briefly list any other pertinent information that may be beneficial for your therapist to know:
_____
_____
_____

PATIENTS WITH NECK PAIN ☐ N/A

21. Do you get headaches? ☐ NO ☐ YES If yes, how often? _____

22. Do you get facial numbness? ☐ NO ☐ YES

23. Has your grip strength weakened? ☐ NO ☐ YES
Have you noticed a loss of muscle in your hand(s)? ☐ NO ☐ YES