Fallon Physical Therapy

Patient Information:

Last Name _____ First Name _____ M.I. ___
Male____ Female____ Name of Spouse/Guardian _____
Home Address _____
Mailing Address _____
City State Zip
Home Phone (___)_____ Work Phone (___)_____
Cell Phone (___)_____ Email _____
Employer Name _____
Social Security Number _____ D.O.B. _____
(If under 18 Parent or Legal Guardian) **Full Name**_____
Referring Physician _____

Primary Insurance (Worker Comp/Auto)

Company Name _____
Insured's ID Number_____ Insured's Employer _____
Name of Insured _____ DOB_____ Relation to Patient _____
Date of Injury _____ Group Number _____

Secondary Insurance

Company Name _____
Insurance Phone (___)_____ Insured's Employer _____
Name of Insured _____ DOB_____ Relation to Patient _____
Insured's ID Number_____ Group Number _____

Name and Phone Number of person to contact in the case of an emergency

_____

I hereby authorize payment of medical benefits billed to my insurance to FPT. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered. In the event this account is assigned to an outside agency for collections, we agree to pay all attorney's fees, court costs, and charges of commission up to 50% with or without suit, which may be assessed by a collection agency retained to pursue the matter.

_____ _____
Signature of patient or legal representative Date

This patient understands that:

- ♦Protected health information may be disclosed or used for treatment, payment or health care operations.
- ♦The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- ♦The Practice reserves the right to change the Notice of Privacy Policies.
- ♦The Patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- ♦The patient may revoke this Consent in writing at any time and all future disclosures will the cease.
- ♦The Practice may condition treatment upon the execution of this Consent.

Patient Signature:_____Date:_____

Authorization for Release of Patient Information

To Family Members or the Office of Fallon Physical Therapy

Patient Name:_____

For my benefit and convenience, I hereby authorize the PT clinic named above, or members of the staff, to release to the following member(s) of my family and medical and/or billing information regarding my care. The release of information may be in person or over the phone.

Authorized Family

Member(s):_____

_____

I understand that the physical therapist or his staff will make a good faith effort to assure themselves that they are releasing such information to individual(s) named above, and I release the physical therapist and his staff from any claim of negligence or HIPPA violation for doing so.

Patient Signature:_____

Date:_____

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected

health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior to Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This patient understands that:

♦Protected health information may be disclosed or used for treatment, payment or health care operations.

♦The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

♦The Practice reserves the right to change the Notice of Privacy Policies.

♦The Patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.

♦The patient may revoke this Consent in writing at any time and all future disclosures will the cease.

♦The Practice may condition treatment upon the execution of this Consent.

Patient Name:_____

Patient Signature:_____Date:_____

Witness:_____

Patient Questionnaire

Patient Name:_____Date:_____Age:_____
Job Title:_____

How did you get injured?:_____

_____

When did you get injured?_____

Did you require surgery? Yes/No
If so, when did you have surgery? _____

What is your current height and weight?_____

Activities affected due to your condition:

_____

_____

_____

Medications you are taking:

_____

_____

Goals and expectations of your treatment:

_____

_____

Check any of the following that apply to you:

_____Diabetes
_____Cancer
_____High Blood Pressure
_____Arthritis
_____Headaches

_____Fainting or dizziness
_____Pregnant/Possibly pregnant
_____Heart disease or chest pain
_____Stroke/Head Injuries
_____Blood disease (anemia, AIDS, etc.)

_____Breathing Problems (asthma, emphysema, etc.)
_____Circulation problems (varicose veins, phlebitis)
_____Previous surgeries (please list)

_____Previous fractured bones (please list)

_____

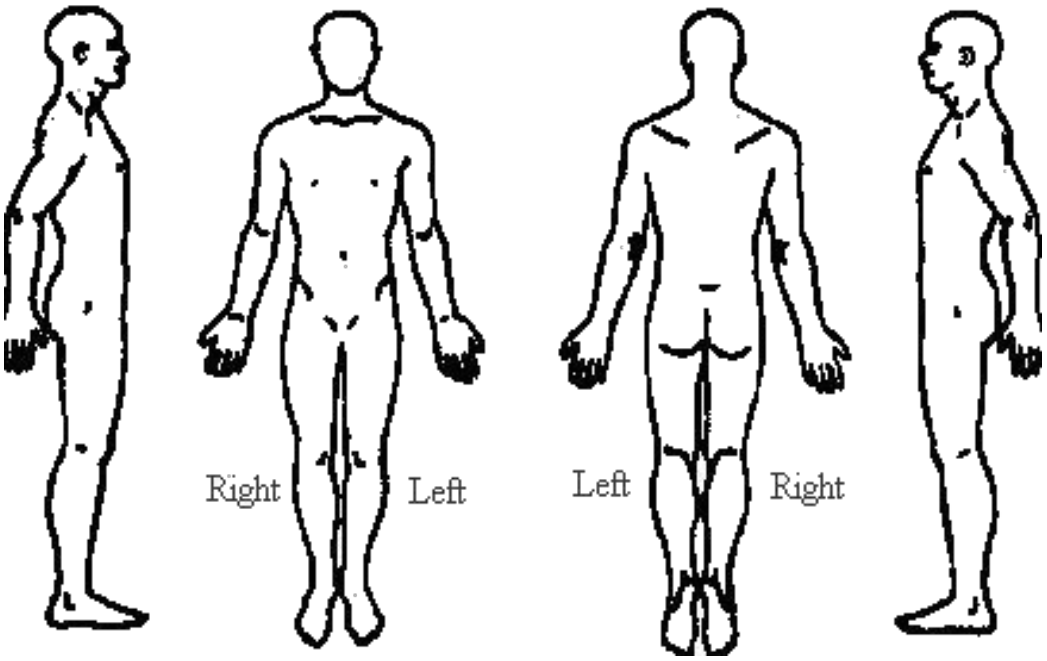
_____

_____

0 **1-2** **3-4** **5-6** **7-8** **9-10**

Please mark an "X" on the number that best describes pain during *activities*.
Please *circle* the number that best describes pain at *rest*.

Pain/Discomfort Description



Pain: Please place X's where you experience pain.
Numbness: Please shade in areas you experience numbness.

Pain Frequency
__Constant
__Comes and goes at regular times
__Happens once in a while

Relationship to sleep
__Wakes from sleep
__Prevents Sleep
__Better after sleep