PATIENT INFORMATION FORM

Patient's Name: ______________________________ Date: ______________

Home Ph#: ______________________________ Cell Ph#: ______________________________

Street Address: ______________________________ Work Ph#: ______________________

City, State, Zip: ______________________________ E-mail: ______________________

Mailing Address: ____

Birth Date ____________________ SS# ____________________ [ ] Male [ ] Female

Spouse's Name: ____

HEALTH INFORMATION

Referring Dr: ______________________________ Dr Phone #: ______________________

Family Dr: ______________________________ Dr Phone #: ______________________

Primary Problem: ____

Surgery Date: ____

Work Related: [ ] Yes [ ] No State: _________ Claim #: ______________________

Date of Injury: ______________________ Name of Employer: ______________________

Motor Vehicle Accident: [ ] Yes [ ] No Date of Accident: ______________________

Personal Injury: [ ] Yes [ ] No State: _______ Attorney's Name & phone number: ___________

____

Are you currently receiving Home Health Care? ______________________________

HEALTH INSURANCE INFORMATION

Insurance Company Name: ____

Address: ______________________________ Phone#: ______________________

Policy Holder's Name: ______________________ Policy Holder Birth Date: ________________

Policy Holder's SS#: ______________________ Relationship to Patient: ________________

Policy ID#: ______________________________ Group#: ______________________________

If there is a secondary insurance, complete the following:

Insurance Company Name ____

Address ______________________________ Phone# ______________________

Policy Holder's Name ______________________ Policy Holder Birth Date ________________

Policy Holder's SS# ______________________ Relationship to Patient ________________

Policy ID# ______________________________ Group# ______________________________

PATIENT/GUARDIAN SIGNATURE ____

CONSENT FOR PHYSICAL THERAPY

I, __________________________, am entering Mountaineer Physical Therapy and Sports Medicine, INC, voluntarily for the purpose of physical therapy consultation/treatment. And do hereby consent to such treatment.

1. I hereby authorize Mountaineer Physical Therapy and Sports Medicine to release any information, be it verbal or written, including the diagnosis and record of any treatment or examinations rendered to me, submitted to physician in connection with physical therapy. This authorization is valid unless otherwise revoked, via written from, by myself.
2. I agree that Mountaineer Physical Therapy and Sports Medicine shall not be liable or responsible for the loss or damage to any articles or personal property having a monetary value.
3. I understand that a payment in full for medical treatment is due at the time of consultation. I understand that payment in full for durable medical supplies is due prior to receipt of the equipment.
4. MPT will make every effort to provide adequate privacy. If you feel additional privacy is necessary, please inform our staff.

Signature of Patient, Guardian, or Closest Relative: _____________________________________

** **If patient is a minor, complete the next two questions.**

Patient name above is a minor and is ________ years of age or, patient named above is unable to sign because of ____.

Witness: ___________________________________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone________________
- O.K. to leave message with detailed information
- Leave message with call back number only

Work Telephone_________________
- O.K. to leave message with detailed information
- Leave message with call back number only

Written Communication
- O.K to mail to may home address
- O.K. to mail my work/office address
- O.K. to fax to this number___________ Other___________________________________

I have been offered a copy of the HIPAA privacy rule. If I have any questions regarding this matter I will notify MPT in writing. I am fully aware that my Protected Health Information will not be released unless for: Treatment, Payment, Health Care Operation (or to request other medical notes)

Patient Signature______________________________

Date____

MOUNTAINEER PHYSICAL THERAPY FINANCIAL POLICY

We are committed to provide you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our *Financial Policy* is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

All patients must complete our ***Patient Information, Medical History, and Financial Policy*** forms before being treated.

REGARDING INSURANCE: Insurance is a contract between you and your insurance carrier. **We strongly encourage you to contact your insurance carrier to determine what coverage they provide for physical therapy.** We cannot guarantee what your insurance carrier will pay. We are sometimes given wrong information which is out of our hands. We file insurance claims as a courtesy to our patients. You must provide all necessary information for us to assist you with your billing. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other then to supply factual information as necessary. Some medical equipment and supplies may not be a covered service in your insurance plan; therefore, you are responsible for those charges. You are responsible for the timely payment of your account.

HMO/POS: If you are covered by any of these, your co-payment is due at the time of service.

MEDICARE: We are providers for Medicare, and we will take the responsibility of submitting your claim for you. Medicare pays 80% of the approved charges. Please check your Medicare handbook for details. We will bill your secondary insurance if applicable. However, you are responsible for the deductible if it has not been met at the time of service, and the co-insurance if there is no secondary insurance.

AUTO ACCIDENTS AND PERSONAL INJURY: If you have been injured due to a motor vehicle accident or from personal injury, please inform us upon registration. Arrangements must be made with the billing department regarding your account.

We accept payment by **cash, check, Visa or MasterCard**.

I understand and accept the conditions of this financial policy.

Signature: ________________________________ Date: ___________________________

GENERAL OFFICE INFORMATION

Welcome to Mountaineer Physical Therapy. We look forward to serving your physical therapy needs and wish you a speedy recovery.

Cancellation Policy: Patients are requested to cancel appointments at least 24 hours in advance. Patient cancellations are noted on the billing sheet and noted in the treatment log. Patients are asked for a reason for canceling. Reason for cancellation, if provided by patient, is noted in the patient's chart.

NOTE: Patients who fail to show for appointments are contacted as soon as possible after the scheduled appointment and prior to the next scheduled appointment. The purpose of this is to verify attendance for the next appointment and to educate the patient on the need for proper compliance with treatment program. The referral source is notified if the patient fails to show for appointments or is frequently non-compliant with their appointments. This is done through the regular progress report or through a no show/cancel form completed by the office secretary. These reports are generated on an as needed basis.

We do understand that extenuating circumstances sometimes occur for missing appointments and should be discussed with the front office.

Authorization for Release: I hereby authorize Mountaineer Physical Therapy to release any information concerning my care to the appropriate individuals of insurance companies and physicians. I accept full responsibility for any deductibles and co-insurance, or any amount not covered by my insurance company for service rendered to me by this facility. I authorize payment of medical benefits to Mountaineer Physical Therapy.

Treatment Consent Authorization: I am fully aware of my medical diagnosis and I give my consent to Mountaineer Physical Therapy to provide treatment for my condition.

Medicare Signature on File: I authorize payment of my Medicare Benefits to Mountaineer Physical Therapy for services rendered.

Primary/Secondary Insurance Signature on File: I authorize payments of my medical benefits to Mountaineer Physical Therapy for services rendered.

Notice of Privacy Practices: I have received a copy of Mountaineer Physical Therapy’s Notice of Privacy Practices.

Signature: ______________________________ Date: ____________________

Name: ____ SSN:__________________ Date:_____________

Leisure activities, including exercise routines:____

Occupation, including activities that comprise your workday:____________________________________

Age:_________Height:______________Weight:_____________

Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**

Do you smoke? Yes No If yes, how many packs per day____ **Do you have a pacemaker? Yes No**

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

ALLERGIES: List any medication(s) you are allergic to: ____

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)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ 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
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

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**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. ______________________ 2.__________________________ 3.______________________________

What date (roughly) did your present symptoms start? ____

What do you think caused your symptoms? ____

Are your symptoms due to and injury at work or a motor vehicle accident? __________ **Date:** ___________

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

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) ____________________________

Please list tests performed for this problem (x-ray, MRI, labs, etc) _______________**Date:** ________________

At what hospital or facility were these test completed ____

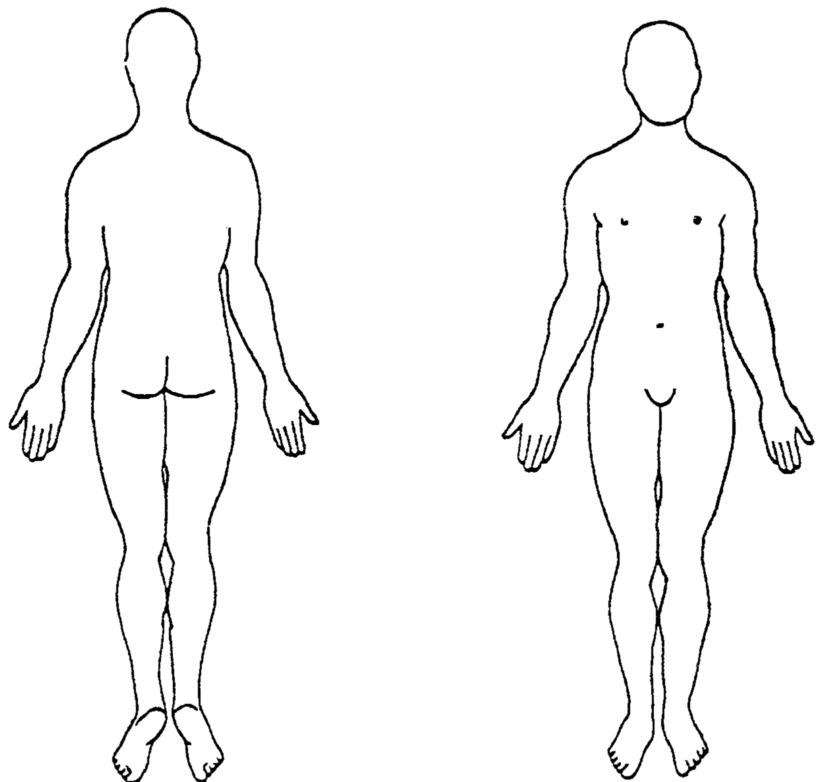
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**__________ **Treatment rec'd**_____________

How long did it take for you to feel better? ____

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

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. ____

2. ____

3. ____

Easing Factors: Identify up to 3 important 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

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* 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: __________

How did you hear about us?

__Friend __Newspaper
__Family __Facebook
__Physician __Website
__Other __Radio (Which station? _________)

I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONAIRE TO THE BEST OF MY KNOWLEDGE: ____
SIGNATURE DATE

Please list the current medications (prescription and over-the-counter):

*****Insurance requires us to have the name, how much, and how many times a day you take the medication. Please fill in all lines.*****

Sorry for the inconvenience!

If you are not on any medications, please write "NONE" on line 1.

	Dosage	**Route** Oral, Sub-lingual, etc.	**Frequency**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
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