

PATIENT HISTORY

Please complete this form thoroughly. It is important to your treatment as it helps differentiate between disease and dysfunction. **(Please print)**

Date: _____ Account #: _____

Patient's Name: _____ D.O.B. _____ Age: _____

Diagnosis: _____ Date of onset/surgery/injury: _____

Physician: _____ Phone Number _____

When is your next appointment with this physician? _____

Have you had this problem before? _____ When? _____ Where? _____

Past Medical History Have you ever had any of the following? (Check appropriate answer)

Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hypoglycemia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hypertension / High Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Angina or Chest Pain	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Shortness of Breath	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Stroke	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Kidney Disease/Stones	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Urinary Tract Infection	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Allergies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Asthma/Hay Fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Rheumatic/Scarlet Fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hepatitis/Jaundice	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cirrhosis/Liver Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Polio	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Chronic Bronchitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Pneumonia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Emphysema	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Migraine Headaches	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Anemia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Ulcers/Stomach Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Arthritis/Gout	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Osteoporosis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Depression	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Latex Allergies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other (please explain)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Incontinence	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Medical Testing

Are you taking any prescription or over the counter medication? Yes No
If yes, **please list**

Have you had any x-rays, sonogram, computed tomography (CT) Scans, bone scans, or magnetic resonance imaging (MRI) related to this condition done recently? Yes No
If yes, **please explain**

Are you a smoker? Yes No

Please list any operations that you have had and the date(s) of surgery:

Surgery

Date

General Health:

Have you noticed any lumps or thickening of skin or muscle anywhere on your body? Yes No

Have you had any unexplained weight loss in the last month? Yes No

Are you on any special diet prescribed by a physician? Yes No

Do you exercise regularly? Yes No

Do you have any difficulty sleeping? Yes No

Do you have difficulty swallowing? Yes No

Do you experience episodes of dizziness? Yes No

Work Environment:

Occupation: _____

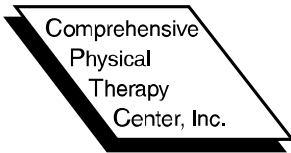
Does your job involve: prolonged sitting prolonged standing prolonged walking

use of large or small equipment lifting, bending twisting, climbing, turning, reaching

other _____

Do you use any special supports: back cushion, neck cushion back brace corset

• other _____



NEW PATIENT REGISTRATION

ASSIGNED TO: _____

Appt. Date _____ / _____ / _____

OT __ PT __

PLEASE PRINT

PATIENT INFORMATION					
LAST NAME	FIRST	MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	SEX
HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ()	
MARITAL STATUS SINGLE () MARRIED () OTHER ()		EMPLOYMENT STATUS EMPLOYED () FULL TIME STUDENT () PART TIME STUDENT () RETIRED ()			
EMPLOYER NAME / SCHOOL NAME			TITLE / POSITION		
WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ()	
E-MAIL ADDRESS					
REFERRING PHYSICIAN INFORMATION (WHERE TO SEND TREATMENT NOTES)					
PHYSICIAN LAST NAME	FIRST	MI	CLINIC NAME		
ADDRESS	CITY	STATE	ZIP CODE	PHONE ()	
REASON FOR TODAY'S VISIT					
IS THIS INJURY / CONDITION RELATED TO YOUR:					
JOB: YES () NO ()	CAR: YES () NO ()	HOME: YES () NO ()		OTHER ACCIDENT: YES () NO ()	
PLEASE INDICATE THE DATE OF ACCIDENT OR INJURY: (MM/DD/YY)			PLEASE INDICATE THE DATE OF ILLNESS (1 ST SYMPTOM) (MM/DD/YY)		
PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT:			TELEPHONE:		
PLEASE DESCRIBE INJURY / ACCIDENT / ILLNESS:					
RESPONSIBLE PARTY STATEMENT					
AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.					
RESPONSIBLE PARTY SIGNATURE				TODAY'S DATE:	
X					

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME:	FIRST NAME:	MI
ADDRESS:	STATE	ZIP CODE
HOME PHONE	WORK PHONE	
RELATIONSHIP: EMERGENCY CONTACT () PARENT () GUARDIAN ()	PARENT OR GUARDIAN E-MAIL ADDRESS	

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER
ADDRESS	CITY	STATE ZIP CODE PHONE
POLICYHOLDER (if other than patient)	SEX	DATE OF BIRTH
SOCIAL SECURITY NUMBER (of policyholder)	PHONE NUMBER (of policyholder)	RELATIONSHIP TO PATIENT
EMPLOYER (of policyholder)		

SECONDARY INSURANCE COMPANY INFORMATION (MEDICARE PATIENTS ONLY)

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER
ADDRESS	CITY	STATE ZIP CODE PHONE
POLICYHOLDER (if other than patient)	SEX	DATE OF BIRTH
SOCIAL SECURITY NUMBER (of policyholder)	PHONE NUMBER (of policyholder)	RELATIONSHIP TO PATIENT
EMPLOYER (of policyholder)		

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO COMPREHENSIVE PHYSICAL THERAPY CENTER, INC. IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER THIRTY DAYS OLD. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF COMPREHENSIVE PHYSICAL THERAPY CENTER, INC. AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE: X	TODAY'S DATE
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COMPREHENSIVE PHYSICAL THERAPY CENTER, INC.

Welcome to Comprehensive Physical Therapy Center, Inc.! We are happy to further extend your services by filing your primary insurance for you. Please select from the following payment choices.

- According to _____ (insurance carrier) you have satisfied \$_____ of your \$_____ (yearly) deductible. The balance of \$_____ is payable at the time of service.
- Co-Payment: \$_____ per visit or _____% per visit.
- Medicare will pay 80% of charges. The remaining 20% will be billed to secondary insurance or become patient responsibility.
- Worker's Compensation: We will bill your worker's compensation carrier for all charges. Please note that you will be financially responsible for all charges if your carrier denies coverage.
- Self-Pay: Balance paid in full at time of service.
- H.M.O. Waiver: I am attesting that I have not enrolled in or disenrolled from Medicare H.M.O. in the past 90 (Ninety) days. I understand that if it should later be discovered that I did enroll/disenroll and this prevents Medicare from making payment, I will be responsible for the full payment of all charges.

WE WILL FILE WITH YOUR INSURANCE COMPANY AS A COURTESY TO YOU. HOWEVER, AFTER 60 DAYS, IF YOUR ACCOUNT HAS NOT BEEN SETTLED, THE RESPONSIBILITY WILL THEN SHIFT TO YOU. IT IS OUR IMPRESSION THAT BILLS SHOULD BE SETTLED WITHIN 60 DAYS AND WILL THEREFORE REQUIRE THAT YOU BECOME ACTIVELY INVOLVED IN SETTLING YOUR ACCOUNT.

PLEASE BE AWARE THAT SECONDARY INSURANCE WILL BE YOUR RESPONSIBILITY TO FILE AND COLLECT.

PLEASE BE AWARE THAT WE REQUIRE PAYMENT FOR ALL COPAYS, DEDUCTIBLES, AND PERCENTAGES THAT YOUR INSURANCE WILL NOT COVER AT THE TIME OF SERVICE.

ALL SUPPLIES ARE PAYABLE AT THE TIME OF SERVICE AND CANNOT BE CHARGED. WE WILL FILE FOR ANY COVERED SUPPLIES ALLOWED BY YOUR INSURANCE CARRIER.

There may be a difference between an **out of network insurance company's** usual and customary charges and our fee schedule. The patient would be responsible for any difference not paid by insurance. This does not apply to current contracted carriers.

If you cannot keep your appointment for any reason, please call 24 hours prior to your appointment. If you do not show or if you cancel without 24-hour notice, a fee of \$20 will be applied. This charge will not be billed nor paid by your insurance.

Please be advised that we are not a credit guarantor. Therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collections.

You will remain financially responsible for the contracted allowable for services rendered, regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the recovery of this debt.

There will be a \$25.00 charge for all returned checks.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for assistance.

Kindly sign and date this form to indicate that you understand and agree to the terms of this payment policy.

Signature: _____

Date: _____

MEDICARE SECONDARY PAYOR SCREENING FORM

NAME: _____

- 1. Are you covered under VA Medicare? yes no
- 2. Are you covered under Black Lung Medicare? yes no
- 3. If Medicare is your primary coverage and you have secondary coverage under another insurance company please complete the following if the secondary insurance is under someone else's name:
 - a. Name of secondary insurance company: _____
 - b. Name of insured other than yourself: _____
 - c. Is that person employed: yes no

If yes, provide name, full address and phone number of their employer:

- 4. If you are retired, give your official retirement date: _____
- 5. If Medicare is your secondary insurance please give the following information:
 - a. Name of primary insured: _____
 - b. Name and address of primary insurance company: _____
 - c. Name and complete address of employer: _____

- 6. Is this condition related to an automobile accident? yes no
- 7. Is this condition related to a work accident? yes no
- 8. Any other type of accident for which another party may be held liable? yes no
- 9. Is this condition related to an accident in your home? yes no
- 10. If none of the above, please explain how this injury / diagnosis occurred?

- 11. If you answered yes to any of the above questions, please supply the following information:
 - d. Date of accident: _____
 - e. Name and address of the responsible party: _____
 - c. Date the other party's insurance was first billed _____
 - f. Name, address and phone number of attorney if one is involved _____
 - e. Give a brief description of the accident: _____

Signature

Date

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Are you taking any prescription or over the counter medication? Yes No

If yes, **please list**

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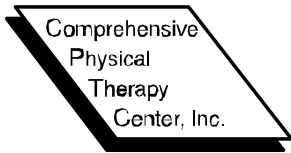
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other _____

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JOB: YES () NO ()	CAR: YES () NO ()	HOME: YES () NO ()	OTHER ACCIDENT: YES () NO ()		
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AUTHORIZED SIGNATURE: X	TODAY'S DATE
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Notice of Patient Information Practices

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

Comprehensive Physical Therapy Center, Inc. LEGAL DUTY

Comprehensive Physical Therapy Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Comprehensive Physical Therapy Center uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Comprehensive Physical Therapy Center, Inc. may use your personal health related information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Comprehensive Physical Therapy Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Comprehensive Physical Therapy Center's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Comprehensive Physical Therapy Center may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our facility. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

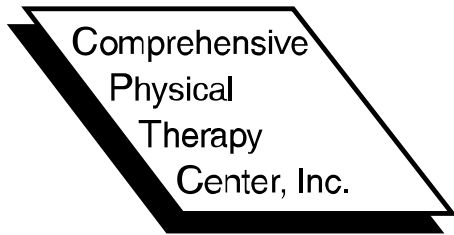
You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances.

Comprehensive Physical Therapy Center will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Comprehensive Physical Therapy Center may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please let the administrative staff know. You may also send a written complaint to the US Department of Health and Human Services.

EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM



PATIENT INFORMATION CONSENT FORM

I have read and fully understand Comprehensive Physical Therapy Center’s Notice of Information Practices. I understand that Comprehensive Physical Therapy Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Company in writing. I also understand that Comprehensive Physical Therapy Center will consider requests for restriction on a case-by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Comprehensive Physical Therapy Center’s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

I authorize Comprehensive Physical Therapy Center to leave messages on my phone regarding my physical therapy.

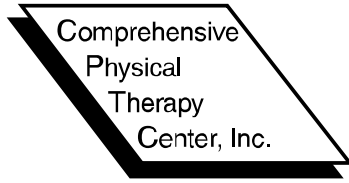
YES NO

Patient Name (please print)

Patient Signature

Date

REQUEST SIGNATURE FROM EVERY PATIENT



DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Name (please print)

Patient Signature

Date

STRESS SURVEY

We are interested in treating the whole you. Please take a minute to complete the following short survey, and give it to your physical therapist in the treatment room.

NAME _____ DATE _____

Instructions: Place a check (✓) in the box to the right of each symptom to indicate how much this type of feeling has been bothering you in the past several days.	0 NOT AT ALL	1 SOMEWHAT	2 MODERATELY	3 A LOT
1. Feeling anxious, nervous, worried, panicky or afraid.				
2. Feeling tense, restless or unable to relax.				
3. Feeling stressed, uptight or on edge.				
4. Frightening thoughts, fantasies or daydreams.				
5. Physical feelings of stress, such as tight, tense muscles, shortness of breath, or a racing heart.				
TOTAL SCORE ON ITEMS #1 - #5				