Independence Physical Therapy

Medical History Questionnaire

Patient name: _____

Date of birth: _____ **Age**: _____

Email: _____

Gender: M F **Pregnant:** Yes No N/A

Occupation: _____

Level of sports Participation:

❑ Competitive ❑ Recreational ❑ None

Did a doctor refer you to us? ❑ Yes ❑ No

If yes, please give the name of the doctor.

_____

Current Symptoms:

Where are you currently having symptoms?

_____

When (approximately) did your present symptoms start?

_____

How: Gradually Suddenly Injury Other

_____

The symptoms are currently:

Getting better About the same Getting Worse

_____

Symptoms: (Check all that apply)

❑ Instability/giving way/dislocation

❑ Pain ❑ Weakness

❑ Swelling ❑ Stiffness

❑ Other _____

Please describe your current limitations.

_____

_____

Briefly describe your injury.

_____

_____

_____

Diagnosis (if you have been told.)

_____

Is this a Worker's Comp claim? ❑ Yes ❑ No

Therapist Name/Date: _____

Have you ever had this problem before: Yes No

If so , how was the problem treated: (bracing, injections, medications, surgery, therapy, etc.)

_____

_____

Over the last 48 hours, rate the severity of your pain

(0= none 10 = Worst Pain Imaginable)

Average: 0 1 2 3 4 5 6 7 8 9 10

Best: 0 1 2 3 4 5 6 7 8 9 10

Worst : 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? ❑ Yes ❑ No

Does it wake you from sleep? ❑ Yes ❑ No

What makes your problem better?

_____

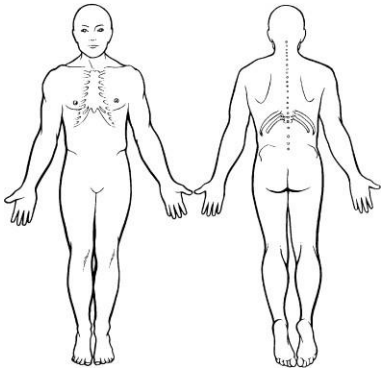
_____

What makes your problem worse?

_____

_____

Body Chart: Please mark the areas where you feel pain on the chart below



For the Therapist:

+/- Saddle Anesth *+/- Bwl/Bladdr chnge*

+/- Tingling/Numb *+/- Cough/ Sneeze*

Patient Initials_____

Have you had :

X-rays ❑ No ❑ Yes: when_____

MRI ❑ No ❑ Yes: when_____

Cat Scan ❑ No ❑ Yes: when_____

Allergies to:

Latex? ❑ No ❑ Yes

Food or Medications? ❑ No ❑ Yes

If yes, please list below.

_____

_____

_____

Medical history (check all that apply):

Do/did you have High Blood Pressure? ❑ Yes ❑ No

Do/did you have high Cholesterol? ❑ Yes ❑ No

Do/did you have any Heart problems? ❑ Yes ❑ No

Do/did you have Angina/Chest Pain? ❑ Yes ❑ No

Do you have a Pacemaker/ Defibrillator? ❑ Yes ❑ No

Do/did you have a Blood Clot/Embolus? ❑ Yes ❑ No

Do you take Aspirin /blood thinners? ❑ Yes ❑ No

Do/did you have a Blood disorder/Anemia? ❑ Yes ❑ No

Do/did you have Kidney disease? ❑ Yes ❑ No

Do/did you have Cancer? ❑ Yes ❑ No

Do/did you Smoke or chew tobacco? ❑ Yes ❑ No

Do/did you have Asthma/Lung Disease? ❑ Yes ❑No

Do/did you have Hepatitis C or HIV? ❑ Yes ❑ No

Do/did you have Gastritis/ Ulcers/Gerd? ❑ Yes ❑ No

Do/did you have Diabetes? ❑ Yes ❑ No

❑ Type I ❑ Type II

Do/did you have Liver disease? ❑ Yes ❑ No

Do/did you have Osteoporosis? ❑ Yes ❑ No

Do/did you take Steroids/Prednisone? ❑ Yes ❑ No

Do/did you have a Stroke? ❑ Yes ❑ No

Do/did you have any Neurological problem? ❑ Yes ❑ No

Do/did you have Arthritis? ❑ Yes ❑ No

Do/did you have Fibromyalgia? ❑ Yes ❑ No

Do/did you have RSD? ❑ Yes ❑ No

Do/did you have Sleep Apnea? ❑ Yes ❑ No

Do/did you have Anxiety/Depression? ❑ Yes ❑ No

HEIGHT_____**WEIGHT**_____

Therapist Initials_____

During the past month, have you often been bothered by: Feeling down, depressed or hopeless? **YES NO**

During the last month, have you often been bothered by: Little interest in doing things? **YES NO**

If Yes to either question: Is this something with which you would like help? **YES YES, but not now NO**

Please List previous surgeries (and Dates)**:**

_____

_____

Please List any other Past Medical History:

_____

_____

Do any Diseases/Illness run in your Family?

_____

_____

Currently I am Experiencing

(circle all that apply):

Unexplained Weight Loss Numbness/Tingling
Headache Dizziness Cough Poor Balance/Falls
Fever/Chills/Sweats Fatigue Difficulty Swallowing
Changes in Appetite Weakness Nausea/Vomiting
Shortness of Breath Increased Pain at Night
Changes in Bowel/Bladder Function

What activities would you like to do if you were not in pain?_____

_____

How did you hear about us? (Check all that apply)

❑ Family/Friend ❑ Doctor
❑ Insurance Co ❑ Q105Radio
❑ Phone Book ❑ School
❑ WELJ Radio 104.7 ❑ Internet
❑ Radio ❑ Website
❑Other_____

What are your Goals for Physical Therapy?

_____

CONSENT: I understand my diagnosis & treatment and that I have a right to question and /or refuse any treatment offered._____

(Patient Signature)

Current Medications

Please list the following:

Prescription Medications Over the Counter Medications Herbals
Vitamin/Mineral/Dietary Nutritional Supplements

Medication	Dosage	Frequency	Route of Administration	Reason

Patient Name: _____ Date: _____

Verified by: _____ Date: _____

CANCELLATIONS AND NO SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

We require 24 hours' notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full prescribed number of treatments that week.(In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)

There is a $25 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.

For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist at your next regularly scheduled appointment.

Please understand that your pain will probably increase and decrease as your course of treatment progresses. Either condition can seem to be a reason not to come in; a) you're feeling worse and think the treatment is not working or, b) you're feeling better and think it would be a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come in; a) if you're in pain, come in anyway, we can modify your exercise program or b) if your out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or physical therapist; the therapist who now has space in their schedule since the time was reserved for you personally; and the other patient who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We are looking forward to working with you. If you have any questions regarding this policy please do not hesitate to forward your concerns to the receptionist or the office manager. Thank you.

Patient Signature Date

Interviewer Signature Date

Independence Physical Therapy

Jeanne Gilbert, P.T.

2440 Gold Star Hwy.
Suite 201
Mystic, CT 06355

Phone: (860) 536-1001
Fax: (860) 536-1527

FINANCIAL POLICY, RELEASE AND AUTHORIZATION

I authorize Independence Physical Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Independence Physical Therapy. _____(initial)

I authorize Independence Physical Therapy to release medical or other information necessary to process these claims. _____(initial)

Although Independence Physical Therapy does verify insurance eligibility for each patient, verification of benefits is not a guarantee of payment from my insurance carrier. I understand that I am ultimately responsible for my physical therapy charges and I agree to pay my deductible, my co-insurance or co-payments, and any charges not reimbursed by my insurance carrier. _____(initial)

I understand that a 1% finance charge will be imposed on each item of my account, which has not been paid within thirty (30) days of the time the item was added to the account. I understand that this finance charge will be computed by applying the periodic rate (1%) per month or an ANNUAL PERCENTAGE RATE of twelve percent (12%). This is applied to the "overdue balance" of my account. The "overdue balance" of my account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to my account during that time. The minimum finance charge is $0.50. I also understand that a $5.00 re-billing fee will be imposed on any balance 60 days past due & beyond. _____(initial)

I understand that there is a $25.00 charge for checks returned by the bank. _____(initial)

I understand that some insurance companies require medical or administrative preauthorization for treatment, or I may have reimbursement limits on physical therapy treatment. _____(initial)

I understand that I am responsible for knowing and meeting the requirements of my insurance plan & that it is my insurance company that makes the final determination of my eligibility. _____(initial)

I understand that CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES WILL BE DUE ON THE DAY OF TREATMENT unless other payment arrangements have been made in advance.

Finance Charge:
A finance charge will be imposed on each item of your account that has not been paid within thirty days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty days ago and subtracting any payments or credits applied to the account during that time.

Monthly Statements:
If you have a balance on your account, we will send you a monthly statement. It will show all remaining balances, including finance charges, if any, applied to your account during the month. Upon request, we will send an account history. This history would include a detail of all charges, payments and adjustments that have occurred on your account.

Transferring and Copying of Records:
You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent upon the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation Cases:
Independence Physical Therapy requires written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury Cases:
If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Past Due Accounts & Collections:
If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all the lawyer's fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Mystic, Connecticut.

Waiver of Confidentiality:
You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce:
In case of divorce or separation, the party responsible for the account prior the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Effective Date:
Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible Party
(If not the patient)_____

Signature:_____ Date:_____
Independence Physical Therapy
Witnessing Party Signature_____ Date:_____

Independence Physical Therapy

Written Acknowledgement of Receipt of Notice of
Privacy Practices

Patient name:_____

Date of birth:_____

I,_____hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints that I may contact: JOHANNAH THOMPSON PRIVACY OFFICER at (860)536-1001.

I also understand that I am entitled to receive updates upon request if Independence Physical Therapy's Notice of Privacy Practices is amended or changed in a material way.

Signature: _____

Relationship to patient _____Date:_____

……

ONLY TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On_____I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient but was unable to because:

( ) Patient declined to sign this Written Acknowledgement
( ) Patient did not understand the request to sign the written acknowledgement
( ) Other (specify)

_____
_____
_____

_____
Name and Title of Employee Date

Independence Physical Therapy

Notice of Privacy Practices

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

1.) Uses and Disclosures: we will use your protected health information (PHI) for the purposes of treatment, payment, and health care operations.

TREATMENT includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

PAYMENT includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was medically necessary.

HEALTH CARE OPERATIONS includes the utilization of your records to monitor to quality of care being given at our facility or for business planning activities.

OTHER SPECIAL USES Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

USES AND DISCLOSURES REQUIRED BY LAW the federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example, by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health and safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for worker's compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2.) Your Privacy Rights

RESTRICTIONS You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

CONFIDENTIAL COMMUNICATIONS You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

ACCESS TO PHI You have to right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

AMENDMENTS You have to right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you we are not required to make any changes. You do have to right to submit a written statement about why you disagree with the statement/s or assessments, to be part of your records. We may not amend parts of your record that we did not create.

ACCOUNTING OF DISCLOSURES after April 14, 2003, you have to the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

3.) Complaints. If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

OUR DUTY TO PROTECT YOUR PRIVACY we are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

PRIVACY CONTACT

Name: Jeanne Gilbert
Title: Owner/Privacy Officer
Address: 2440 Goldstar Highway
Suite 201
Mystic, CT 06355
Phone: 860-536-1001
Effective Date: 01/06/2023

This notice will take effect on January 6, 2023.

Source: American Physical Therapy Association

Reviewed for accuracy and compliance on 01/06/2023