

PHYSICAL THERAPY LLC

# **Patient Information Sheet**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zipcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Telephone(home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(work/cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Name & Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Is this Worker’s Comp?\_\_\_\_\_If yes, contact person\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_

# Are you being represented by an attorney? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of Onset/Accident\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person in case of emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Hands-On Physical Therapy. **I understand that it is ultimately MY responsibility to know what my physical therapy benefits are as provided by my insurance company**.

I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 2% per month. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred due to any collections on this account.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative/Legal Guardian, if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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### PROVIDER 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.

**Uses and Disclosures:**  We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

**Your rights:** In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

**Our legal duty:** We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

**Complaints:** If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Privacy Officers : David or Angela Carter

Address: 1940 Sandy Hook Rd.

Suite F

Goochland, VA 23063

Phone: (804) 556-7181

Acknowledgement of receipt of Notice of Privacy Practices:

Please sign your name and print your name and date on this acknowledgement form.

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative/Legal Guardian, if applicable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# PHYSICAL THERAPY LLC

# Medical Appointment Cancellation Policy

Dear Patient,

Hands-On Physical Therapy strives to provide excellent physical therapy care to you and to all of our patients. To that end, we use an appointment system that sets aside one-on-one time with you and your physical therapist. If you do not show up for your appointment, or notify us of your inability to keep your appointment at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. Accordingly, the following Medical Appointment Cancellation Policy has been put into place:

**Our policy is as follows:**

1. We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. Our scheduling number is 804-556-7181. If you give our office a 24 hour notice, you will not be charged a missed appointment fee.
2. **If you miss an appointment and have not contacted us with at least 24 hours notice, we will consider this to be a missed appointment and you will be charged a $30 fee**.
3. We will waive the $30 missed appointment fee if we are able to re-schedule your missed appointment for later the same day or the following day.
4. We will waive the $30 missed appointment fee for the first missed appointment.
5. If you accumulate a total of three missed appointments, you may not be re-scheduled for future appointments and may be discharged from our care.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

**I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms.**

Signature of responsible party Relationship to patient Date

# Patient Health History

Patient Name Primary Care Physician

Referring Physician Date of next visit

Date of injury/Onset of symptoms

Mechanism of injury (how injury occurred)

Did you have surgery for this injury?

If yes, type of surgery and date

Medications

Allergies

Have you had physical therapy before for this injury/condition?

Have you had tests for this injury/condition? Please circle: x-ray MRI other:

**Do you currently have or do you have a history of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
| Cancer | Y / N | High blood pressure | Y / N |
| Pacemaker | Y / N | Incontinence | Y / N |
| Arthritis | Y / N | Pelvic pain | Y / N |
| Heart Disease | Y / N | Back pain | Y / N |
| Heart surgery | Y / N | Joint problems | Y / N |
| Diabetes | Y / N | Seizures | Y / N |
| Headaches | Y / N | Shingles | Y / N |
| Swelling | Y / N | Circulation issues | Y / N |
| Osteoporosis | Y / N | Infections | Y / N |
| Hernia | Y / N | Multiple sclerosis | Y / N |
| Hearing loss | Y / N | Parkinson’s disease | Y / N |
| Head injury | Y / N | Thyroid problems | Y / N |
| Vision loss | Y / N | Liver problems | Y / N |
| Constipation | Y / N | Kidney problems | Y / N |
| Anxiety | Y / N | Fractures | Y / N |
| Weight loss | Y / N | Weight gain | Y / N |
| Weakness | Y / N | Difficulty sleeping | Y / N |
| Depression | Y / N | Joint replacement | Y / N |
| Tuberculosis | Y / N | Emotional problems | Y / N |
| Cold sensitivity | Y / N | Heat sensitivity | Y / N |
| Numbness | Y / N | Sciatica | Y / N |

Do you have any other medical history which may be relevant to physical therapy treatment for your current condition?

What are your goals for physical therapy?

**Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date \_\_\_\_\_\_\_\_\_\_**