



PATIENT INFORMATION FORM

Social Security #	First Name	MI	Last Name	Sex M/F	DOB / /
Home Telephone # ()	Best Contact Telephone # ()	E-mail Address		Marital Status	
Address (Street)		PO Box	City	State	Zip Code
Emergency Contact Name	Emergency Contact Phone # ()	Relationship to Patient			
Current Employer	Employer Telephone # ()	Employer Address			
Policy Holder's Name	Policy Holder's DOB / /	Policy Holder's Employer			
Have you received services from a home health agency within the last 30 days? YES NO	Have you received any outpatient physical therapy this year? YES NO	Current Work Status (Circle One) Full Part Student Retired			

PAYMENT AND INSURANCE FILING

Payment Policy

Payment is requested at the time of service unless other arrangements are made prior to treatment. Payment may include a co-pay or estimated patient balance depending on your insurance type. Payment can be made by cash, check, Master Card, Visa, Discover, American Express .

Insurance Filing

Pace Physical Therapy (PPT) will file your primary and secondary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance and you are responsible for the payment of that balance.

Our participation in an insurance program is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance has responded to our claim. If your insurance does not pay, you should contact your insurance company. PPT will NOT negotiate the settlement of a disputed insurance claim.

Legal Cases

PPT cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered unless prior arrangements for payment have been made.

CONSENT FOR TREATMENT AND AUTHORIZATION

I do hereby consent for treatment at Pace Physical Therapy. I authorize PPT to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to PPT when indicated on claim. I understand I am financially responsible for the services I received.

Signed: _____ Date: _____

Relationship to Patient: _____ Witnessed by: _____



CANCELLATION & PRIVACY POLICIES

CANCELLATION POLICY

Your appointment time is important to you, your physical therapist and the others who are in need of our services. The following policy is in place to ensure everyone receives timely uninterrupted care.

- For cancellations please call us at least **24 hours** prior to your appointment time.
- There is a **\$25.00 Fee** charged if you do not attend your appointment and do not call to cancel at least 24 hours prior to your appointment.
 - Future appointments will not be made until the fee is paid.
 - This fee is your personal responsibility and will not be billed to or paid by your insurance company
- If you are **more than 10 minutes late** for your appointment and there is not sufficient time left to complete your treatment, you may be asked to reschedule.

By signing below, you acknowledge that you have read and understood this cancellation policy and agree to comply with it as written.

Communication Release

1. I hereby give permission to the Pace PT office to notify me for: (Check all that apply)

Appointment reminders by email

Appointment reminders by text Appointment reminders by voice call

2. The individual(s) listed below is/are authorized to receive the above information on my behalf:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY

By signing below, I confirm that I have received and reviewed a copy of the Notice of Privacy Practices from Pace Physical Therapy and understand the information as outlined.

By signing below, I agree to the above statements and verify that the above information is accurate to the best of my knowledge.

Signed: _____ Date: _____

Relationship to Patient : _____ Witnessed by : _____



1617 HIGHWAY 20 WEST • MCDONOUGH, GA 30253
PHONE 770.898.9993 • FAX 770.898.9983

Pace PT Family,

We wanted to inform you on how we are working to keep you safe during the current COVID-19 pandemic. We feel a responsibility to sustain a clean and safe environment for our patients during their care. We are currently following recommendations from the CDC for employers and those working with the public including:

- **Actively encouraging sick employees and patients to stay at home.**
- **Emphasizing Respiratory Etiquette and Hand Hygiene for all patients and employees. We have hand sanitizer and tissue in our waiting room as well as in our treatment areas.**
- **Performance of routine environmental cleaning between patients and at end of day.**
- **Taking temperatures of all patients upon entrance to treatment area.**
- **We are utilizing a neutral disinfectant cleanser in our facility that is used in hospitals, nursing homes, and other facilities. This provides broad spectrum kill of micro-organisms including HBV, HIV-1, MRSA, GRSA, Influenza Type A2, Adenovirus, Rotavirus and many more.**

Governor Kemp has recently signed **Senate Bill 359: Georgia COVID-19 Pandemic Business Safety Act**. This Act states any person entering the premises waives all civil liability against this premises owner and operator for any injuries caused by the inherent risk associated with contracting COVID-19 at public gatherings, except for gross negligence, willful and wanton misconduct, reckless infliction of harm, by the individual or entity of the premises.

By my signature below, I acknowledge I have been made aware of Georgia Senate Bill 359 and I agree that if I discover that I have been exposed to, experience symptoms of, or have otherwise tested positive for COVID-19, I must immediately notify Pace Physical Therapy.

Patient Signature _____ Date _____

Thank you for placing your trust in us to provide your Physical Therapy care!

Name: _____

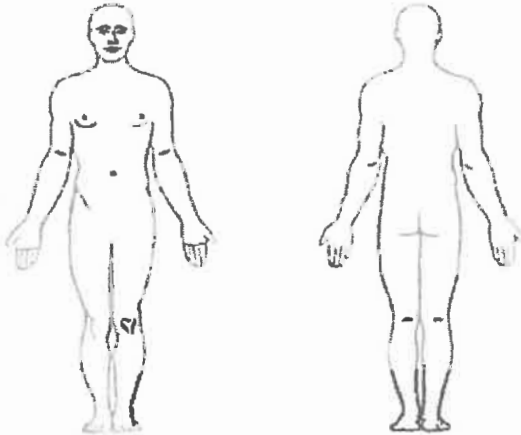
Date of Birth: _____

CURRENT COMPLAINTS

1. Please indicate the body part(s) to be treated today.
 Left Right

- Neck Shoulder Elbow Wrist/Hand
 Back Hip Knee Ankle/Foot
 Other: _____

2. On the diagram below please indicate where you are currently having pain:



3. When did the problem begin (date of injury)?

4. How did it happen?

- a. Injury? Yes No Unknown
 b. How did the injury occur?
 Accident Fall In competition
 Other: _____
 c. Where did the injury occur? Work Home
 Other: _____
 d. Surgery Performed? Yes No
 Date of surgery: _____

5. Have you had this problem(s) before? Yes No

a. What did you do for the problem(s)?

- Physical Therapy Medication Physician
 Chiropractor Other: _____

b. Did the problem(s) get better? Yes No

c. How long did the problem(s) last? _____

6. Have you had any of the following tests for your current problem?

- X-rays CT Scan MRI
 Bone Scan Nerve Conduction Study

7. Do you currently use any of the following?

- Cane Glasses Crutches
 Hearing Aid Walker Brace
 Pacemaker Wheelchair (Motor/Manual)
 Other: _____

8. Are you seeing anyone else for the problem(s)?

- Acupuncturist Orthopedist
 Cardiologist Osteopath
 Chiropractor Podiatrist
 Family Practitioner Psychologist/Counselor
 Internist Psychiatrist
 Massage Therapist Rheumatologist
 Neurologist Other: _____
 Ob/Gyn

9. Please list three activities that are difficult for you because of this current injury:

1. _____
 2. _____
 3. _____

10. PLEASE USE THE PAIN SCALE TO ANSWER THE FOLLOWING QUESTIONS (Circle one number for each):

- a. What is your pain level NOW? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
 b. Pain at its WORST in the last week? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
 c. Pain at its BEST in the last week? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICAL THERAPIST SIGNATURE: _____ LICENSE #: _____ DATE: _____

Name: _____ Date: _____

MEDICAL/SOCIAL HISTORY FORM

Please complete the following form to the best of your knowledge. If you are a returning patient you will be asked to complete this form once every six months to keep our records current.

MEDICAL HISTORY

1. Do you have any allergies? Yes No
 a. If yes, please list: _____

2. Please check if you have ever had any of the following:
- | | |
|--|--|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney problems |
| Type: _____ | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Cancer | Type: _____ |
| Type: _____ | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Diabetes/High blood sugar | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Type I Diabetes | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Head Injury | Type: _____ |
| Type: _____ | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tuberculosis |
| Type: _____ | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other: _____ |

3. Have you recently had any of the following symptoms?
- | | |
|--|---|
| <input type="checkbox"/> Bowel/bladder problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Dizziness/Lightheadedness | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Unexplained weakness |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Unexplained weight loss/gain |

4. Are you currently pregnant or think you might be pregnant? Yes No

CLINICAL TESTS

1. Within the past year, have you had any of the following tests? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> Mammogram |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Bone Density Scan | <input type="checkbox"/> Myelogram |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Nerve Conduction Test |
| <input type="checkbox"/> Doppler Ultrasound | <input type="checkbox"/> Pulmonary Function Test |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Stress Test |
| <input type="checkbox"/> EKG (electrocardiogram) | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> EMG (electromyogram) | <input type="checkbox"/> Other: _____ |

SURGERY / HOSPITALIZATIONS

1. Have you ever had surgery? Yes No
2. Please list approximate dates and reasons for any surgery or other conditions (including childbirth) that required hospitalization: (a separate list may be provided)

Date	Reason for hospital stay
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use						
HEIGHT: _____	WEIGHT: _____	BP: _____	HR: _____	FALLS? <input type="checkbox"/> YES <input type="checkbox"/> NO	_____	



SOCIAL HISTORY

Work Status

1. Employment / Work (Job / School / Play)

- Working full-time Working part-time
- Regular duty Light duty

2. Occupation: _____

- Student Retired Unemployed Disabled

Cultural / Religious

1. Are there any customs or religious beliefs or wishes that might affect your care? No Yes

a. Please explain: _____

Social/Health Habits

1. Smoking

a. Do you currently use tobacco products? Yes No

If yes: Cigarettes Cigars/Pipes Smokeless
How many packs/day: _____

If no: Have you used tobacco in the past?

- Yes No

Year Quit: _____

2. Alcohol

a. How many days per week do you drink beer, wine or other alcoholic beverages? _____

b. If 1 beer, 1 glass of wine or 1 cocktail equals 1 drink, how many drinks do you have in average week? _____

3. Caffeine

a. How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

4. Exercise

a. Do you exercise regularly?

- Yes Type: _____
- No

b. On average, how many days per week do you exercise? _____

c. For how many minutes, on an average day? _____

5. In the past month have you been feeling down, depressed or hopeless? Yes No

6. In the past month have you lost interest or pleasure in doing things you used to enjoy? Yes No

7. General Health Status. Please rate your health:

- Excellent Good Fair Poor

Living Environment

1. With whom do you live?

- Alone Spouse only
- Spouse and others Child (not spouse)
- Other relative(s) Group Setting
- Personal Care Attendant
- Other: _____

Other

1. Primary Language:

- English Other: _____

Do you need an interpreter Yes No

2. Learning Barriers

- None Vision
- Hearing Unable to read
- Unable to understand what is read
- Other _____

Patient/Guardian Signature: _____ Date: _____

Physical Therapist Signature: _____ License #: _____ Date: _____



Current Prescription Medications

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
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			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	

Current over the Counter (Non-Prescription) Medications

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
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			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	

Current Vitamins and Supplements

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
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			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	

for office use