PATIENT HISTORY AND PHYSICAL

NAME: _____ Height: _____ Weight: _____ Age: _____ Today's Date: _____

Medical & Surgical History:

Arthritis: TYPE_____ Broken Bone/Fracture: BONE_____WHEN_____

Cancer: TYPE_____WHEN_____ Circulation/Vascular Problems Depression

Dizziness/Fainting/Vertigo Diabetes: TYPE_____ Gastrointestinal Problems Hearing Problems

Hernia High Blood Pressure Infectious Disease: TYPE_____WHEN_____

Joint Replacement: TYPE_____;WHEN_____ Kidney Problems Lung Problems Memory Problems

Osteopenia Osteoporosis Pacemaker Pregnancy: WHEN_____ Stroke Thyroid Problems

Other Medical Diagnoses: _____

Please list your entire **SURGICAL** history on the lines below, including type & approximate date:

_____ _____

_____ _____

_____ _____

Please list any relevant family medical history: _____

Current Medications: (Prescription, nonprescription and Supplements) *Please include frequency and dosage*

_____

_____

Allergies: Do you have a latex allergy? Yes No

List all other allergies: _____

Clinical Tests/Interventions Performed for this Condition:

Angiogram Bone Scan CT Scan Electrocardiogram MRI NCV (nerve conduction test) Stress Test X-Rays

Injection(s): TYPE_____WHEN_____ (i.e cortisone, epidural, etc)

Personal History:

What are you goals for physical therapy? _____

Current Employment: _____ Average Blood Pressure: _____ Are You: Right handed Left handed

Who do you live with? Alone Spouse Child Other Relative Other _____

Where do you live? Private Housing/Apartment Assisted Living Other _____

Living Space: One level Multi-level Stairs necessary: NUMBER INTO/OUT OF HOUSE_____NUMBER IN HOUSE_____

Do you use: Cane Walker Manual Wheelchair Motorized Wheelchair Other _____

Tobacco Use? Never Past Current; if current type/how much? _____

Alcohol use: Never Past Current; if current type/how much? _____

Do you exercise regularly: Yes No If yes, how often and what types? _____

Rate your health: Excellent Very Good Fair Poor

PLEASE CONTINUE ON BACK TO COMPLETE THE REST OF THE FORM

Current Condition *(reason for today's visit):*

What happened? _____

When did this problem begin? _____

Have you ever had this problem before? Yes No if yes, when? _____

How long did the problem last? _____ Did the problem get better? _____

What makes the problem better? _____

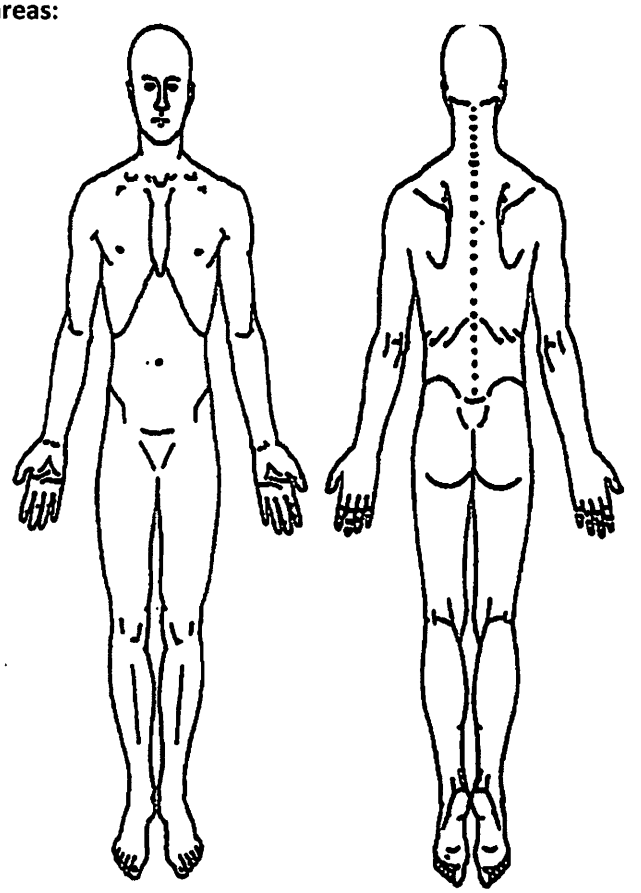
What makes the problem worse? _____

How are you taking care of the problem now? _____

What activities are you not able to do now because of the problem? _____

Are you seeing anyone else for the problem? _____

Using the diagram on the right, please mark your painful areas:



Please rate the level of your pain:

Which of these words describes your pain?

(circle all that apply)

Aching Burning Cramping Dull Numbness

Radiating Sharp Sore Stiff Tight Tingling

Score your pain levels, using the scale below:

(0 = no pain; 10 = emergency room pain)

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

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

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

How frequently are you having pain?

_____Intermittently (<26%)

_____Occasionally (25-50%)

_____Frequently (51-75%)

_____Constantly (>75%)

_____ _____

PATIENT SIGNATURE **DATE**

NORTH FULTON
Physical Therapy & Sports Medicine

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Age: _____ Gender: _____ Male _____ Female Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip Code : _____

Home Phone: _____ Cell Phone: _____ email address: _____

Appointment Reminder Method

Name of Cellular Provider is required for text reminders _____ Text _____ Email _____ or Both

Emergency Contact

Name: _____ Phone Number: _____ Relationship to Patient: _____

Responsible Party

Name : _____ Phone number: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

WE DO NOT FILE SECONDARY ON ANY COMMERICIAL INSURANCE PLANS.

WE ONLY FILE SECONDARY ON TRADITONAL MEDICARE PLANS AND ONLY IF TRADITIONAL MEDICARE PLAN IS THE PRIMARY INSURANCE. WE DO NOT FILE MEDICARE AS SECONDARY AT ANY TIME!

Primary Insurance: _____ Member ID # _____ phone: _____

Secondary Insurance: _____ Member ID # _____ Phone: _____

How did you hear about us: _____ MD ___ Family/Friend _____ Internet Search _____ Insurance Company _____ Other

Whom May we thank for your referral: _____

Case Information

Injury/Surgical Type: _____ Injury/Surgical Date: _____

Referring Physician: _____ Phone Number: _____

Date of Last Appointment: _____ Date of next Appointment: _____

Primary Care Physician (if different) _____ Phone Number: _____

Was this Motor Vehicle Accident: _____ Yes _____ No If Yes, what state did the accident occur in? _____

Is this a Worker's Compensation Case _____ Yes _____ No

If yes, Case Workers Name: _____ Phone: _____ Case Number: _____

Signature: _____ **Date:** _____

NORTH FULTON

Physical Therapy & Sports Medicine

MEDICARE PATIENTS

Have you received ANY physical/speech, Chiropractic care, home health, and/ or Cardiac Rehab this calendar year? Yes _____ NO_____

If yes, when did you have the therapy and how many visits did you have? _____

What type of therapy did you have? _____

Are you currently receiving home health or hospice care at home? Yes _____ No _____
If you are currently receiving home health or hospice care at home, then Medicare will NOT cover your care at our facility until you are discharged from these services.

If you have had physical therapy in the past, what part of the body did you have therapy on? _____

Your annual Medicare benefits allowed for 2022 calendar year is $2150.00 as the first cap, with the maximum benefit of $3000.00 which includes any combination of Physical and Speech Therapy, Cardiac Rehab, Home Health and or Chiropractic care. The Physical Therapist who will be evaluating you today will determine if you are eligible to go over this capitation, if you have already reached the $2150.00 capitation limit and if it is determined that you are NOT eligible for further treatment you will be given the option to continue therapy **AT YOUR EXPENSE or stop treatment.** If you decide to continue with therapy, you will be responsible for payment of each session at the time of service and you will be given an **ABN** (Advance Beneficiary Notice of Non-Coverage) form to sign. Again, if you decide that you wish to continue with your physical therapy, **once you meet $2150.00 you WILL BE REQUIRED to sign and additional ABN form and YOU WILL BE RESPONSIBLE FOR THE FULL BILL OVER THE MAXIMUM ALLOWED OF $2150.00 at the time of the service.**

We will continue to file your claims to Medicare, if you so choose and if Medicare decides they will cover your claim, we will issue you are refund once all your claims have been paid in full by Medicare and your secondary. We are sorry for any inconvenience and wish we had a better way to knowing exactly what they will cover. Unfortunately, NONE of the insurances, including Medicare will guarantee payment over the phone or by computer. **ALL INSURANCE COMPANIES will make their own determination for payment once they have the claim in hand.** Due to all the regulations that we must continue to jump through, for us to bill Medicare claims, it can take several months before your claims maybe paid in full.

If you have any questions or concerns, please feel free to ask us and we will be happy to help you understand or assist you further.

_____ _____

Patients Signature **Date**

NORTH FULTON

Physical Therapy & Sports Medicine

Patient Name: _____ Today's Date: _____

North Fulton Physical Therapy is dedicated to providing the best possible care for you in a warm, comfortable environment. All services are provided by a licensed Physical Therapist.

By signing below, I acknowledge and consent to the following, where applicable:

1. **MEDICAL CONSENT:** I authorize North Fulton Physical Therapy to perform physical therapy assessment and treatment which will be discussed with my therapist.
2. **PAYMENT FOR SERVICES:** I understand that payment is expected at the time of service and I am fully responsible for all fees that are not covered by my insurance except those prohibited by the insurance carrier. Insurance will be filed for services rendered as directed by me. Co-pays and co-insurance are expected at the time of service.
3. **MEDICAL INSURANCE BENEFITS:** North Fulton Physical Therapy will verify my insurance coverage prior to service and filing claims. Based on this information, North Fulton Physical Therapy will estimate the portion of charges for which I should be responsible, taking into consideration coordination of benefits should I have coverage under multiple insurance policies. North Fulton Physical Therapy will only file secondary insurance if primary insurance is a traditional Medicare policy.
4. **MEDICARE AUTHORIZATION:** I certify that the information given in applying for payment under TITLE XVII of the Social Security Act is correct and requests payment of authorized benefits to be made on my behalf. I authorize North Fulton Physical Therapy to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information needed for Medicare claims. Including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished.
5. **SELF PAY DISCOUNT:** A discount is available to those who pay in full at the time of service and do not require North Fulton Physical Therapy to file claims with health insurance. If I choose for North Fulton Physical Therapy not to file claims or take any insurance information, I may file with my health insurance on my own. In this case North Fulton Physical Therapy will provide proper receipts and documentation to be submitted.
6. **MEDICAL RECORDS RELEASE:** I authorize North Fulton Physical Therapy to release my medical records (including any information furnished to North Fulton Physical Therapy or obtained by North Fulton Physical Therapy in connection with my treatment) to any referring physician, insurance company health care facility or government agency requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer. I authorize the release of any medical information to the following person(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PLEASE CONTINUE READING THE BACK PAGE AND SIGN WHERE INDICATED

7. **SCHEDULING POLICY:** North Fulton Physical Therapy does not offer standing schedule appointments each appointment is to be scheduled with the front office staff. North Fulton Physical Therapy tries to run on time with our appointments, if you are late more than 15 minutes for your appointment North Fulton Physical Therapy reserves the right to reschedule that appointment.
8. **CANCELLATION POLICY:** North Fulton Physical Therapy requires that I give **24 Hour prior notice for canceling** or rescheduling of appointments. There is a **$30.00** NO SHOW OR LATE CANCELLATION FEE, insurance does not cover this fee.
9. **SELF-REFERRED/DIRECT ACCESS:** I understand that a physical therapist diagnosis is not a medical diagnosis by a Self-Referred/Direct Access allows for treatment for **21 days** or **8 visits** from the initiation of a physical Therapy plan of intervention.
   I understand that as a self-referred patient I am unable to receive dry needling without my Physical Therapist consulting with my Physician.
10. **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE:** I acknowledge that I have been given or offered a copy of the Notice of Privacy Practices and am providing consent for the use of my protected health information in the manner described in the Notice of Privacy Practices.
11. **VISIT LIMITATION POLICY**
    North Fulton Physical Therapy will review your insurance limitations. Most policies have a visit limitation for outpatient physical therapy. We will try to ascertain if any of your visits have been used previous to your appointment at North Fulton Physical Therapy. You are responsible in keeping up with your visit count as insurance companies cannot always give an accurate account of visits used. Chiropractic care is also sometimes applied towards Physical Therapy limitations. If you have you have used any visits prior to coming to North Fulton Physical Therapy we will need this visit count.

    Have you had any Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehab or any Chiropractic care this year.

    Yes _____ or No _____ If yes, how many visits have been used? _____

Patient Name:_____ **Date of Birth:** _____

Signature: _____ **Today Date:** _____

If patient is a minor, or uncappable to sign for one's self then this form should be signed by Parent or Guardian

Printed Name of Parent or Guardian: _____