PACE
Physical Therapy

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, MasterCard, Visa, Discover, American Express or Care Credit.

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. PPT uses Webpt as their billing company; Therefore, you may be contacted by WebPT regarding your account. 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.

Signature Of Patient/Guarantor_____ Date: _____

Patient Relationship to Guarantor: _____ Witnessed by (Office Staff): _____

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CANCELLATION & PRIVACY POLICES

CANCELLATION POLICY

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

- For cancellation or rescheduling of appointments, please call us at least **24 hours** prior to your appointment time.
- There is a **$50.00 Fee** if you do not attend or 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 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.

Signature of Patient /Guarantor_____ Date:_____

Patient Relationship to Guarantor_____ Witnessed By (Office Staff): _____

PACE Physical Therapy

Name: _____

Date of Birth: _____

CURRENT COMPLAINTS

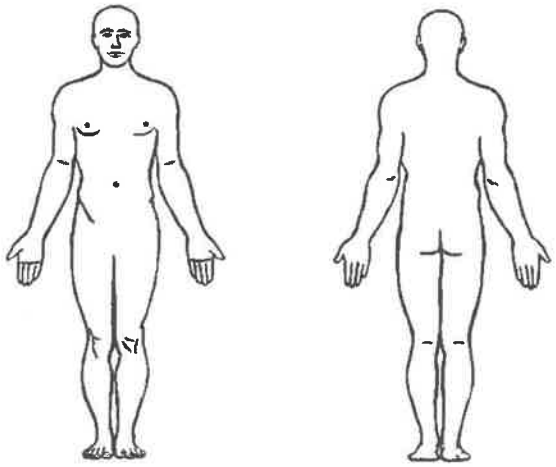
1. Please check the body part(s) to be treated today.
   ☐ Left ☐ Right

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

2. When did the problem begin *(date of injury, surgery or approximate date pain began)*? _____

3. List three (3) activities that are currently difficult for you because of your pain or current complaints.
   A. _____
   B. _____
   C. _____

4. On the diagram mark where you are having pain:



5. Circle **ONLY ONE NUMBER** on the pain scale to describe your pain over the LAST WEEK. Please answer each question using the following guide:

0/10 = No pain at all, 10/10 = excruciating pain that requires an immediate ER visit

A. Pain at its **WORST** in the last week:	0	1	2	3	4	5	6	7	8	9	10
B. What is your pain level **NOW**:	0	1	2	3	4	5	6	7	8	9	10
C. Pain at its **BEST** in the last week:	0	1	2	3	4	5	6	7	8	9	10

6. Current complaint: How did it begin?
   A. Injury? ☐ Yes ☐ No *(Skip to B)*
      1. How did the injury occur?
         ☐ Accident ☐ Fall ☐ Sport
         ☐ Other _____
      2. Where did the injury occur? ☐ Work ☐ Home
         ☐ Other _____
   B. Did you have surgery? ☐ Yes ☐ No *(Skip to C)*
      1. Date of surgery: _____
   C. Age Related Changes? ☐ Yes ☐ No

7. Have you had this problem 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? _____

8. Have you had any of the following tests for your current problem?
   ☐ X-rays ☐ CT Scan ☐ MRI
   ☐ Bone Scan ☐ Nerve Conduction Study

9. Do you currently use any of the following?
   ☐ Cane ☐ Glasses ☐ Crutches
   ☐ Hearing Aid ☐ Walker ☐ Brace
   ☐ Pacemaker ☐ Wheelchair (Motor/Manual)
   ☐ Other: _____

10. Are you seeing anyone else for the problem(s)?
    ☐ Family Practitioner ☐ Internist
    ☐ Orthopedist ☐ Chiropractor
    ☐ Neurologist ☐ Massage Therapist
    ☐ Podiatrist ☐ Psychologist/Counselor
    ☐ Rheumatologist ☐ Acupuncturist
    ☐ Cardiologist ☐ Other _____

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ License #: _____ Date _____

PACE Physical Therapy

Name: _____

Date of Birth: _____

MEDICAL/SOCIAL HISTORY FORM

Please complete the following form to the best of your knowledge. Returning patients 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. Have you ever had any of the following conditions?

- ☐ Alzheimer's disease
- ☐ Arthritis
  - ☐ OA ☐ Rheumatoid
- ☐ Blood disorders
- ☐ Broken bones/fractures
- ☐ Cancer
  Type: _____
- ☐ Chemical dependency
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes/High blood sugar
  - ☐ Type I Diabetes
  - ☐ Type II Diabetes
- ☐ Head Injury
  Type: _____
- ☐ Heart problems
  Type: _____
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Low blood sugar
- ☐ Latex allergy
- ☐ Lung problems
  Type: _____
- ☐ Multiple sclerosis
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's disease
- ☐ Repeated infections
- ☐ Stroke
- ☐ Seizures/epilepsy
- ☐ Skin diseases
  Type: _____
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers/stomach problems
- ☐ Other: _____

3. Have you recently had the following symptoms?

- ☐ Bowel/bladder problems
- ☐ Chest pain
- ☐ Coordination problems
- ☐ Difficulty swallowing
- ☐ Dizziness/Lightheadedness
- ☐ Unexplained weakness
- ☐ Unexplained weight change
- ☐ Loss of appetite
- ☐ Loss of balance
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Fever or Chills

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.)

- ☐ Angiogram
- ☐ Biopsy
- ☐ Bone Density Scan
- ☐ Nerve ConductionTest
- ☐ Pulmonary Function Test
- ☐ Echocardiogram
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ Stress Test
- ☐ X-rays
- ☐ Other: _____

MEDICATION

1. Are you taking any of the following over the counter medications:

- ☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen
- ☐ Antacid ☐ Laxatives ☐ Antihistamines
- ☐ Decongestants
- ☐ Vitamins/Minerals/Supplements
- ☐ Other: _____

2. Please list any prescription medications you are taking and their dosages. A separate list may be provided.

Medication Name	Dosage	Reason for Taking

SURGERY / HOSPITALIZATIONS

1. Have you ever had surgery? ☐ Yes ☐ No
2. Please list approximate dates and reasons for any surgery *(in-patient or out-patient)* and any conditions that required a hospital stay *(including childbirth)*. A separate list may be provided.

Date	Type of surgery/ Reason for hospital stay
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Work Status

1. Employment / Work / School

☐ 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. Do you currently use tobacco/nicotine products?
   ☐ Yes ☐ No *(Skip to C)*
   A. If yes: ☐ Cigarettes ☐ Cigars/Pipes
   ☐ Smokeless ☐ Vape
   B. How many packs/cartridges per day: _____
   C. Have you used tobacco in the past?
   ☐ No ☐ Yes Year Quit: _____

2. How many days per week do you drink beer, wine or other alcoholic beverages? _____
   A. If 1 beer, 1 glass of wine or 1 cocktail equals 1 drink, how many drinks do you have in average week? ____

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

4. Do you exercise regularly?
   ☐ Yes Type: _____
   ☐ No *(Skip to 5)*
   A. On average, how many days per week do you exercise? _____
   B. 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: _____

Other

1. Primary Language:
   ☐ English ☐ Other: _____
   A. 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: _____

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Current Prescription Medications

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	

Current over the Counter (Non-Prescription) Medications

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	

Current Vitamins and Supplements

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	
			○ Oral ○ Topical ○ Other	

for office use

PACE
Physical Therapy

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WWW.MYPTGA.COM •EMAIL: INFO@MYPTGA.COM

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.

Signature Patient/Guarantor: _____ Date: _____

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