PATIENT REGISTRATION INFORMATION

FIRST CHOICE PHYSICAL THERAPY

NAME: _____
FIRST MI LAST

MAILING ADDRESS: _____
STREET ADDRESS OR PO BOX

_____ _____ _____
CITY STATE ZIP

SPONSOR'S SOCIAL SECURITY NUMBER (For TRICARE for LIFE & VA): _____

PHONE: _____ _____
HOME CELL

BIRTHDATE: _____ MALE OR FEMALE: _____

****Appointment reminders are texted the day before your appointment. Is it ok to text your cell #? YES or NO**

MARITAL STATUS (Please circle one): SINGLE MARRIED WIDOWED OTHER_____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

We are very glad that you are choosing First Choice Physical Therapy for your therapy needs. Please notify our staff of any changes in address, phone number, or insurance coverage as soon as changes are made. Your insurance information will be collected by presenting your insurance card(s) at your first visit. Your card(s) will be scanned into your chart on our computer system. **If your visits are authorized by the VA, the sponsor/veteran's social security number is required. Failure to provide us with this social security number, leaves you responsible for payment of your visits.** For all other insurance companies, a social security number is optional; however, providing us with it will help us in communicating with your insurance company should problems arise. Your information is entered into your chart on our computer, and this form is then shredded. If you feel more comfortable verbally providing us with your number, please let us know. Coverage of outpatient physical therapy by medical insurance companies varies with each company and each policy.

It is the patient's responsibility to be aware of their insurance coverage (for example: if prior authorization is needed for physical therapy treatment) and maintain knowledge of that coverage. In the event that a problem should arise with your insurance, it is more beneficial that you check with your insurance company. As a courtesy to you, we can contact your insurance company in addition to your contact with them.

I acknowledge, by my initials, that I have read the above paragraph: _____

OCCUPATION: _____ EMPLOYER: _____

IF EMPLOYED, WORK PHONE (Only used to contact you if other numbers fail): _____

EMERGENCY CONTACT: _____
NAME PHONE # RELATIONSHIP

AUTHORIZATION AND RELEASES

FIRST CHOICE PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

We will use and disclose your personal health information to assist in your treatment, to receive payment for the services we provide, and for routine healthcare operations. We have prepared a detailed "Notice of Privacy Practices" to help you understand our policies regarding your personal health information and your rights on how your medical information may be used and disclosed. A copy of this Notice is available to you or may be read on our website at www.firstchoiceptminot.com.

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby authorize and consent to the rendering of such physical therapy or occupational therapy treatment considered to be necessary or advisable. Further, I realize that among those who attend to patients at First Choice Physical Therapy, Inc there are personnel in training who, unless requested otherwise, may be present during patient care as a part of their education.

FINANCIAL RESPONSIBILITY

I hereby authorize payment of any insurance benefits arising from policies insuring the patient, or any party liable to the patient, directly to First Choice Physical Therapy, Inc and the treating providers. I understand that I am financially responsible for any charges not covered by this assignment.

I hereby acknowledge that I have read each of the above statements and have received a satisfactory explanation of each item. As the patient (or authorized representative), I do agree and accept these terms.

_____

Patient (or authorized representative) signature

_____

Date

_____

If authorized representative is signing, relationship to patient

MEDICARE SECONDARY PAYER QUESTIONNAIRE

FIRST CHOICE PHYSICAL THERAPY

Patient Name: _____

Today's Date: _____

1. Are you currently on Medicare based on (please check all that apply):
   ___Age
   ___Disability
   ___End-Stage Renal Disease (Transplant Date: _____ Dialysis Date: _____)
2. Are you receiving Black Lung Benefits? ___Yes ___ No
   If YES, Date benefits began _____
3. Are the services to be paid by a government research program? ___Yes ___ No
4. Has the Department of Veterans Affairs authorized and agreed to pay for your care at our facility? ___Yes ___ No
5. Was the illness or injury due to a **work-related** accident? ___Yes ___ No
6. Was the illness or injury due to a **non-work related** accident or other liability accident? ___Yes ___ No
7. Are you or your spouse currently employed? ___Yes ___ No
8. Other health plan coverage besides Medicare & your supplement? ___Yes ___ No

I understand that federal law requires completion of this form for all Medicare patients as there may be situations where Medicare is not the primary payer or Medicare coverage varies. I certify that all the information provided herein is true and correct.

Signature of Patient/Representative _____

ONLY complete this section for OTHER insurance BESIDES Medicare & your supplement.

Type of Insurance:
___Workers Comp Insurance ___No-fault, Auto or Liability Insurance ___Group Health Plan (GHP)
If GHP, approximate number of employees: ___1-19 ___20-99 ___100 or more

Name of Policy Holder _____ Relationship to Patient _____

Insurance Name_____

Street Address _____ City, State, Zip _____

Phone Number _____ Policy/Group Number _____

Name of Employer (if applicable) _____

Date of accident (if applicable) _____

MEDICATION LOG SHEET

NAME: _____ DATE:_____

Be sure to include ALL prescription drugs, over-the-counter medications, vitamins, and herbal supplements.

	MEDICINE, VITAMIN, OR SUPPLEMENT	FORM (pill, injection, liquid, patch, etc)	DOSAGE	HOW MUCH & WHEN	USE (regularly or occasionally)	START/STOP DATE (1/15/17-3/5/17 or 1/5/17-ongoing)	NOTES, SPECIAL DIRECTIONS OR REASONS FOR USE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							

FIRST CHOICE PHYSICAL THERAPY

NAME: _____ DATE: _____

DESCRIBE YOUR CURRENT INJURY/ILLNESS THAT BRINGS YOU HERE TODAY:

_____

_____

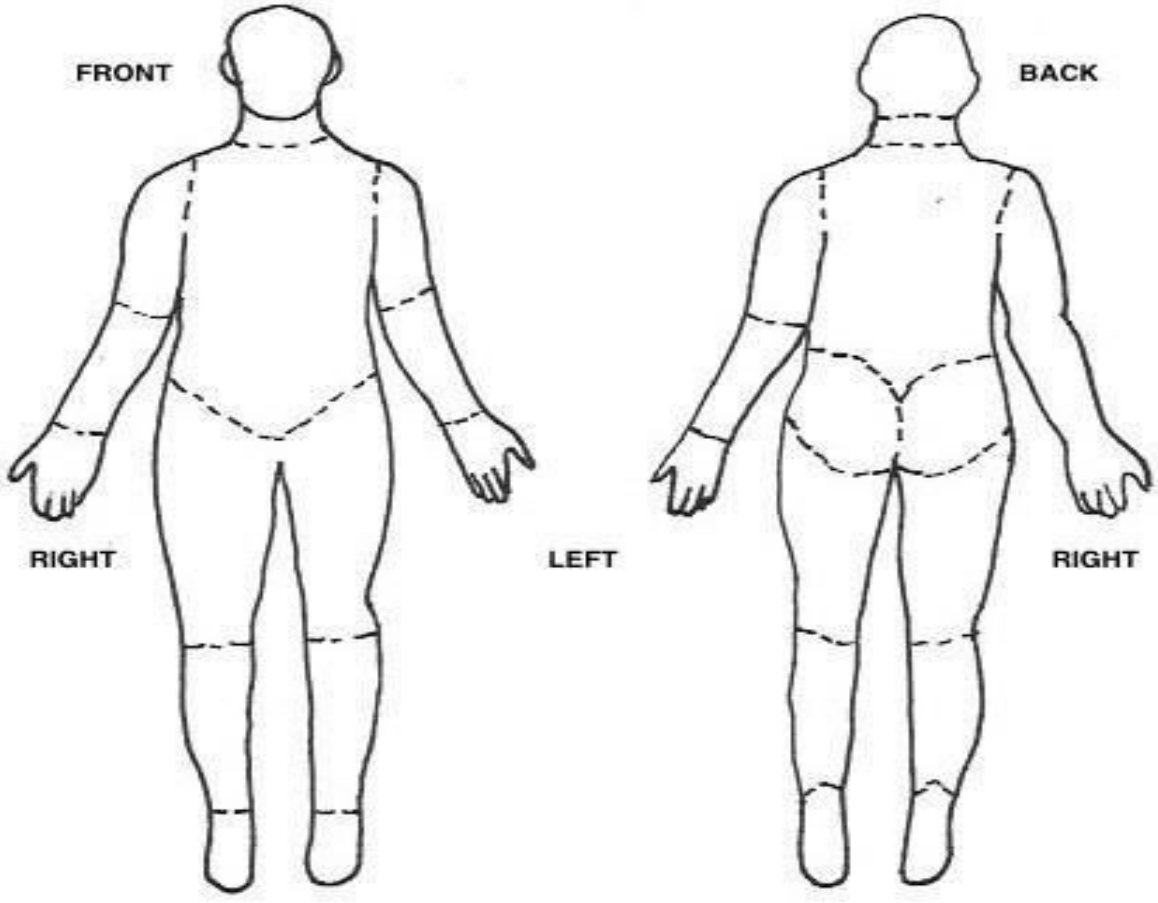
PAIN RATING: CIRCLE THE NUMBER THAT CORRESPONDS TO YOUR CURRENT PAIN

<-----0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10----->

NO PAIN

WORST PAIN IMAGINABLE

ON THE PICTURE BELOW, DIAGRAM THE LOCATION AND TYPE OF YOUR CURRENT PAIN SYMPTOMS USING THE FOLLOWING SYMBOLS:



//// SHARP/STABBING === DULL ACHE xxxx BURNING .... PINS & NEEDLES/TINGLING oooo NUMBNESS

SINCE THE PROBLEM STARTED ARE YOU? ____BETTER ____WORSE ____SAME

(PLEASE FLIP TO SIDE 2 FOR MORE ON YOUR CURRENT CONDITION & BRIEF MEDICAL HISTORY)

HAVE YOU RECEIVED ANY TREATMENT FOR YOUR CURRENT PROBLEM? __YES __NO IF YES, DESCRIBE TREATMENT RECEIVED: _____

_____

WHAT ACTIVITIES DOES YOUR PROBLEM PREVENT YOU FROM DOING?

_____

WHAT ACTIVITIES OR POSITIONS MAKE YOU FEEL BETTER?

_____

IN THE PAST 12 MONTHS, HAVE YOU FALLEN? __NO __YES, HOW MANY TIMES?_____

WHAT IS YOUR GOAL FROM THERAPY? _____

_____

_____

MEDICAL HISTORY

LIST ANY MEDICAL CONDITIONS: _____

_____

LIST ALL PREVIOUS MAJOR SURGERIES: _____

_____

_____

ALLERGIC TO LATEX? ___YES __NO ALLERGIC TO ANY METALS? ___YES __NO

ANY MEDICATION ALLERGIES? _____

ANY OTHER ALLERGIES NOT LISTED? _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (IF NOT SURE OF NAME, LIST WHAT YOU ARE TAKING THEM FOR): _____

_____

_____

_____

CURRENT HEIGHT? _____ CURRENT WEIGHT?_____

Patient Name: _____

Today's Date: _____

FUNCTIONAL ASSESSMENT OF DIFFICULTY WITH ACTIVITIES (OPTIMAL INSTRUMENT)

Instructions: Please circle the level of confidence you have for each activity today

ACTIVITY	Able to do WITHOUT ANY DIFFICULTY	Able to do WITH LITTLE DIFFICULTY	Able to do WITH MODERATE DIFFICULTY	Able to do WITH MUCH DIFFICULTY	UNABLE TO DO	DOES NOT APPLY TO ME
Lying Flat	1	2	3	4	5	0
Rolling over	1	2	3	4	5	0
Moving-lying to sitting	1	2	3	4	5	0
Sitting	1	2	3	4	5	0
Squatting	1	2	3	4	5	0
Bending	1	2	3	4	5	0
Stooping	1	2	3	4	5	0
Balancing	1	2	3	4	5	0
Kneeling	1	2	3	4	5	0
Standing	1	2	3	4	5	0
Climbing stairs	1	2	3	4	5	0
Walking-short distance	1	2	3	4	5	0
Walking-long distance	1	2	3	4	5	0
Walking-outdoors	1	2	3	4	5	0
Hopping	1	2	3	4	5	0
Jumping	1	2	3	4	5	0
Running	1	2	3	4	5	0
Pushing	1	2	3	4	5	0
Pulling	1	2	3	4	5	0
Reaching	1	2	3	4	5	0
Grasping	1	2	3	4	5	0
Lifting	1	2	3	4	5	0
Carrying	1	2	3	4	5	0

These assessments have been put together by First Choice Physical Therapy per the Medicare guidelines to help us better serve our patients. Thank you for your time!

PATIENT HEALTH QUESTIONNAIRE

Please circle 0, 1, 2, or 3 in response to your answer.

Over the last 2 weeks, how often have you been bothered by any of these problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed OR being so fidgety/restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts of hurting yourself or that you would be better off dead	0	1	2	3

First Choice Physical Therapy · 2900 10th Street SW, Suite A • Minot, ND 58701 • Phone 701.839.4102 • Fax 701.838.9603

NAME: _____ DATE: _____

ELDER ABUSE SUSPICION INDEX © (EASI)

EASI Questions Q.1-Q.5 asked of patient; Q.6 answered by doctor (Within the last 12 months)			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	DID NOT ANSWER
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	DID NOT ANSWER
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	DID NOT ANSWER
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	DID NOT ANSWER
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	DID NOT ANSWER
6) **Doctor**: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	DID NOT ANSWER

FIRST CHOICE PHYSICAL THERAPY

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