

## Physical Therapy of Dyersburg, P.C.

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ M Initial \_\_\_\_\_

What do you prefer to be called by? \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Physical Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Your employer: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Position \_\_\_\_\_ How long have you been employed with this company? \_\_\_\_\_

Spouse Last Name \_\_\_\_\_ First \_\_\_\_\_

Spouse employer \_\_\_\_\_ Phone # \_\_\_\_\_ Ext. \_\_\_\_\_

Spouse Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary Care Physician \_\_\_\_\_ Last date of PCP office visit \_\_\_\_\_

Referring Physician \_\_\_\_\_ Last date of Referring Physician office visit \_\_\_\_\_

**Are you now or have you been receiving Home Health? \_\_\_\_\_ Discharge Date \_\_\_\_\_**

**Attn: If you are a Medicare patient receiving Home Health, Medicare will not allow you to receive Physical Therapy! Please let the receptionist know.**

Nearest relative not living with you \_\_\_\_\_ Phone # \_\_\_\_\_

Whom may we contact in case of an emergency? \_\_\_\_\_ Phone# \_\_\_\_\_

### **Telephone Permission:**

Where do you prefer to receive calls?

- Home phone # \_\_\_\_\_  Mobile phone # \_\_\_\_\_  Work phone # \_\_\_\_\_

### **Messages:**

I \_\_\_\_\_ (initial) agree to allow Ed Presley P.T., / or a member of his staff to leave a message.

**Please check all that are acceptable**

- By text message  With \_\_\_\_\_  Exclusively with me  
(specify name and relationship)
- On my answering machine/voicemail

Regarding:

- An appointment  Billing information

# Patient Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please describe your Current Complaint or Limitation: \_\_\_\_\_

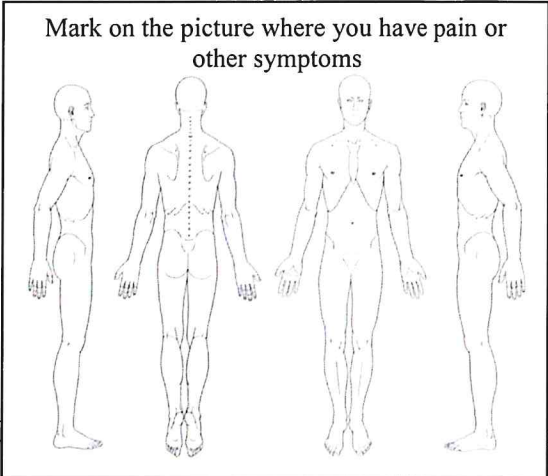
Please describe how your problem began: \_\_\_\_\_

Please tell us when your condition started: \_\_\_\_\_

Did you have surgery?  Yes  No Date: \_\_\_\_\_

**Have you ever received Physical Therapy for this condition before today?** \_\_\_\_\_

- Please describe the nature of your pain:
- Sharp Pain
  - Dull Ache
  - Throbbing
  - Numbness
  - Shooting
  - Burning
  - Tingling
  - Constant (76-100%)
  - Frequent (51-75%)
  - Occasional (26-50%)
  - Intermittent (25% or less)



Indicate the intensity of your pain:  
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Has your work status changed because of this condition?

Do you have any of the following medical conditions?

- Angina
- Arthritis
- Asthma
- Cancer
- Diabetes
- Drug or Alcohol Dependence
- Epilepsy
- Heart Attack
- Hepatitis
- High Blood Pressure
- HIV/ AIDS
- Incontinence
- Pregnancy
- Rheumatoid Arthritis
- Stroke
- Systemic Lupus
- Tobacco Packs per day \_\_\_\_\_
- Tumor
- Other \_\_\_\_\_

Hospitalization/ Surgical Procedures:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**LIFETIME AUTHORIZATION TO FILE MEDICARE**

I request the payment of Medicare benefits be made to Physical Therapy of Dyersburg, PC, for any services furnished to me by that provider. I authorize any holder of medical information about me released to Physical Therapy of Dyersburg and its agencies and information need to determine these benefits or the benefits payable for related services.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**CONSENT FOR CARE**

I hereby give my consent for treatment to Physical Therapy of Dyersburg, PC, including treatment or services which may include but not limited to examination, medical treatment, or procedures rendered for me under the general and specific instruction of the patient's Physical Therapist and physician.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS**

I authorize Physical Therapy of Dyersburg, PC, or any person designated by them to obtain/release copies of my medical records to any physician or institution for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I authorize payment to Physical Therapy of Dyersburg for services rendered to me. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and / or collection cost and legal fees incurred in any attempt to collect said balance. There will be a \$30 charge for returned checks and a \$50 charge for appointments (except in case of emergencies or illness) not cancelled 24 hours prior to appointment time and is payable prior to future visits.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, outlining my rights regarding my health information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Cancellation Policy

We believe your time is as valuable as ours. We do not overbook patients except in cases of emergency. We will do our best to stay on schedule to avoid any delays; however, uncontrollable circumstances do occur. In these rare cases, your patience is greatly appreciated. Please assist us in our efforts to stay on time in the following ways:

1. **Please arrive on time for your scheduled appointment.** If you are more than 15 minutes late, we will try in every way to accommodate you but it still may be necessary to reschedule you for a later time. If you see in advance that you will be late, please notify our office as soon as possible.
2. **Please try to keep up with your scheduled appointment times.** Our methods of scheduling are designed for efficiency of the clinic and the comfort of our patients.
3. **If you need to cancel an appointment, please give us 24 hours notice so we may schedule another patient in that spot. Since we do not make reminder calls for appointments, please be aware of your schedule. If you do not cancel your appointment 24 hours in advance or do not show up for a scheduled appointment, a \$50 fee may be charged (except in cases of illness or emergencies) and is payable prior to future visits.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please be aware that we are not  
responsible for lost or stolen  
items.

**We will provide locks for the lockers in exchange  
for your keys.**

If you have any valuable items with you please make  
sure that you have them closed up in your purse  
and/or bag and keep them in your possession if  
possible.

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Patient Signature

## **NOTICE OF PATIENT INFORMATION PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### **Physical Therapy of Dyersburg LEGAL DUTY**

Physical Therapy of Dyersburg uses your personal health information primarily for treatment: obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example: Physical Therapy of Dyersburg may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Physical Therapy of Dyersburg may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Physical Therapy of Dyersburg policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Physical Therapy of Dyersburg may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency situations. Physical Therapy of Dyersburg will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

### **CONCERNS AND COMPLAINTS**

If you are concerned that Physical Therapy of Dyersburg may have violated your privacy rights or if you disagree with any decisions that we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Physical Therapy of Dyersburg's health information practices, or if you have a complaint, please contact the following person:

Ed Presley, P.T., L.M.T., C.O.M.T.  
2265 Parr Ave  
Dyersburg, TN 38024

Date: March 1, 2005