SCOTT COUNTY PHYSICAL THERAPY

Patient Demographics Form

Patient Name: _____ DOB: ____/____/____
First M Last

Address: _____
Street or P.O. Box City State Zip Code

Home Phone #: (____)_____ Cell Phone #: (____)_____ Would you like to receive text message reminders for your appointments? Y / N

Marital Status: S / M / D / W SS#: ____-____-____ Primary Care Physician: _____
(Required)

Additional Patient Information

Are you a Student? ☐Full-Time ☐ Part-Time ☐ No Are you Retired? ☐ Yes ☐ No

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone #: _____

Guarantor Information

If the patient is under 18 years old, please fill out the section below with the information of the person signing for financial responsibility.

Parent/Guardian Name: _____ DOB: _____ Relationship: _____

SS#: ____-____-____ Phone #: _____ Place of Employment: _____

Guarantor's Address: _____
Street or P.O. Box City State Zip Code

Patient Insurance Information

Primary Insurance: _____
Policy Holder's Name: _____
DOB: _____ Relationship: _____
Employer: _____

Secondary Insurance: _____
Policy Holder's Name: _____
DOB: _____ Relationship: _____
Employer: _____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's workplace instead of the individual's home.

I wish to be contacted in the following manner (please check all that apply):

- ○ Home/Cell Phone
- ○ Work Phone
- ○ O.K. to leave voicemail message with detailed info
- ○ Written Communication
- ○ O.K. to mail to my home address
- ○ O.K. to mail to my work address

X _____ _____
Signature **Date**

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Medical History

How would you classify your general health? ☐ Good ☐ Fair ☐ Poor

Do you have a history of? (Please mark **ALL** that apply)

○ High Blood Pressure	○ Cough for >2 weeks	○ Diabetes
○ Pacemaker	○ Fever for >2 weeks	○ Dizziness
○ Exposure/Tx of TB	○ Unexplained weight loss	○ Falls
○ Heart Condition	○ Stroke	○ Night Sweats
○ Seizures	○ Cancer	

Do you smoke? Y / N

Do you drink alcohol? Y / N

Female Patients: Are you pregnant now or is there a chance you may be pregnant? Y / N

In the last year, have you been admitted to a hospital? Y / N
If yes, please specify: _____

_____

In the last year, have you undergone any surgical procedures? Y / N
If yes, please list: _____

Please list all medications, with dosage, that you are currently taking (including over-the-counter, prescriptions, herbals and vitamins/minerals): _____

_____

_____

If you have a list of these medications and would like us to make a copy, we would be happy to do so.

ATTENTION: *Uses and disclosures for treatment, payment and operations (TPO) may be permitted without prior consent in the event of an emergency.*

By signing below, I agree that the information I have given above is correct to the best of my knowledge. If anything changes, I agree to notify Scott County Physical Therapy, LLC and update this form.

X _____ _____

Signature of Patient/Guarantor Date

SCOTT COUNTY PHYSICAL THERAPY

Subjective History Form

Patient Name: _____ **Date of Evaluation:** _____

Have you been treated in our office previously? Y / N

Subjective History

****Is your injury due to one of the following accidents?:*** WORK / AUTO / SCHOOL / SOCIAL EVENT / HOME / OTHER / NONE

What are you here to be treated for? Symptoms? _____

_____

_____

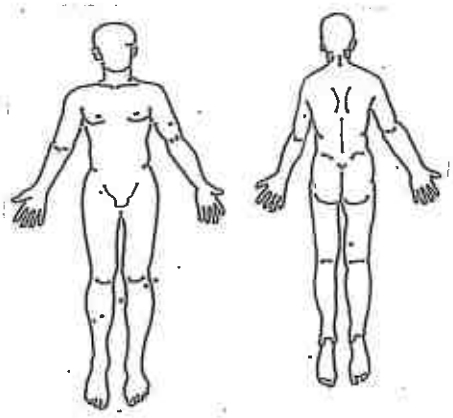
Date of injury/onset date? _____ Date of surgery (if applicable): _____

Physician that referred you to physical therapy (if applicable): _____

Have you received any special tests related to your injury/condition (ex: x-ray, MRI, CT scan, EMG)? Please specify (if applicable): _____

What is your ***dominant*** side? ☐ Right ☐ Left What is your ***affected/injured*** side (if applicable)? ☐ Right ☐ Left

Please mark the location(s) of your pain on the diagram to the right with an "X":



On a pain scale of 0-10 (0= No pain, 10= Severe/Extreme Pain), please circle the number in which your pain is the **WORST:**

0 1 2 3 4 5 6 7 8 9 10

On a pain scale of 0-10 (0= No pain, 10= Severe/Extreme Pain), please circle the number in which your pain is **CURRENTLY:**

0 1 2 3 4 5 6 7 8 9 10

Have you received any type of therapy treatment THIS calendar year (PT, OT, Speech, Chiropractic, Home Health)? Y / N
If yes, for what condition? _____ Where? _____ Number of Visits? _____

What is the heaviest object you lift daily? _____
What is the weight? _____ How many times during the day do you lift this object? _____
What types of exercise activities are you currently performing (if applicable)? _____
Have you been unable to work? Y / N If yes, last date worked? _____

X_____ _____
Signature Patient /Guarantor Date

SCOTT COUNTY PHYSICAL THERAPY

Notice of Privacy Practices & Consent of Treatment

Please read ***each*** statement then sign & date the bottom of the page that you agree & understand the statements listed below.

If you have any questions, please feel free to address them with our front office.

- ***Consent for Treatment***
  I hereby authorize Scott County Physical Therapy, LLC and any of their representatives to provide therapy to **myself** or to any minor (under the age of 18) that I represent. I understand that by signing this form I am consenting to treatment. I understand that I may refuse treatment at any time, although it may affect the outcome of my overall condition.

- ***Consent to the Release of Medical Information***
  I hereby authorize Scott County Physical Therapy, LLC to ***release and receive*** any and all pertinent information regarding my physical therapy treatment ***to and from*** my physician, insurance carrier and the below listed parties should they ask about my care or in case of an emergency:

  Name: _____ Relationship: _____ Phone #: _____
  Name: _____ Relationship: _____ Phone #: _____
  Name: _____ Relationship: _____ Phone #: _____

  (Please be advised that if a party (including family members) that is not listed above contacts us for information regarding your care with Scott County Physical Therapy, Inc., we are NOT authorized to release ANY of your information and will NOT do so. This can be changed at any time in writing.)

- ***Consent for Assignment of Benefits***
  As a courtesy to our patients, we are happy to bill your private Insurance company, Auto, and/or Workers Compensation carrier on your behalf. However due to changes in the health care industry, insurance carriers do not always pay for all care. Please be aware that YOUR insurance coverage is a contract between YOU and the insurance provider. WE ARE NOT A PARTY TO THAT CONTRACT. I hereby instruct and direct my insurance company to pay Scott County Physical Therapy. This assignment will remain in effect until all insurance monies have been applied to my account and paid in full. I understand that insurance pre-authorization and billing is done as a courtesy to me as a patient, but I am ultimately responsible for keeping track of these said benefits.

- ***Consent for Responsibility of Payment***
  I understand that I, as the patient or Guarantor of the patient, ultimately am responsible for any and all payments due for services rendered by Scott County Physical Therapy, LLC. I understand that ALL co-insurance payments, co-pays and billing statements are due at time of service or upon receipt. I acknowledge I am responsible for a 35% fee if involved in a collections process.

- ***Payment Policy Regarding Children & Separated or Divorced Parents***
  We cannot mediate financial disputes between two parents. When children visit our office, we hold the parent who signs the Financial Agreement page responsible for any payments required. Any disputes about reimbursement for medical expenses need to be settled between the parents privately.

****Would you like a copy of this medical practice's Notice of Privacy Practices? Yes / No**

I certify that I understand all the above statements and agree to policies stated for me:

X _____ _____ _____
Signature Relationship to Patient Date