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### NEW PATIENT INFORMATION – adolescent patients

Print, complete, and send all pages below along with prescription from MD and most recent x-rays to our office via U.S. mail, e-mail, or fax. Please e-mail us when documents have been sent.

Scoliosis Physical Therapy  
1101 N 3<sup>rd</sup> St., Monroe, LA 71201  
email: ashley@scoliosisphysicaltherapy.com  
Fax: 318-302 0140 (Attn: Ashley Pittman)  
Tel: 318.366.1663

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Patient Address \_\_\_\_\_ City,State Zip \_\_\_\_\_  
Home telephone \_\_\_\_\_ Cell telephone \_\_\_\_\_  
E-mail \_\_\_\_\_

**Preferred way to contact you?** Circle one: home phone cell phone e-mail

For patients who are minors: (For all information that is same as the patient's, simply write SAME.)

MOTHER Name \_\_\_\_\_  
Address \_\_\_\_\_ City,State Zip \_\_\_\_\_  
Home telephone \_\_\_\_\_ Cell telephone \_\_\_\_\_  
E-mail \_\_\_\_\_

**Preferred way to contact you?** Circle one: home phone cell phone email

FATHER Name \_\_\_\_\_

Address \_\_\_\_\_ City,State Zip \_\_\_\_\_

Home telephone \_\_\_\_\_ Cell telephone \_\_\_\_\_

E-mail \_\_\_\_\_

**Preferred way to contact you?** Circle one: home phone cell phone email

### **Communication with parents**

Circle your preferences.

Which parent to be contacted for appointments and consultation? Mother Father Both

Which parent will be responsible for payment? Mother Father Both

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Mother's signature \_\_\_\_\_ Date \_\_\_\_\_

Father's signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's signature if applicable \_\_\_\_\_ Date \_\_\_\_\_

### **PAYMENT POLICY**

**Scoliosis Physical Therapy is a participating provider with BCBSLA, Vantage Health Plan and Medicare (Jurisdiction H).** If we do not participate with your insurance, we are considered an out of network provider. You may still have benefits for out of network physical therapy services based on your insurance provider and individual plan. If participation in therapy is contingent on insurance payment, please call your insurance provider to check on your out of network benefits prior to scheduling your appoint. We can submit claims on your behalf or provide you with necessary codes for you to do so on your own. Payment will be due at time of visit.

### **Fees for service**

Initial evaluation (1-1.5 hours) \$175

Treatment session (55mins) \$105

**Forms of payment:** Payment may be made by check, cash, Visa, Mastercard, American Express or Discover. (make checks payable to Ashley Pittman or Scoliosis Physical Therapy)

### **Responsibility for payment**

Adult patients assume responsibility for payment of fees.

For patients who are under 18 years of age:

Which parent will be responsible for payment?    Mother    Father    Both

Invoices should be sent to email of which parent?    Mother    Father    Both

Email address where invoices should be sent:

Mother \_\_\_\_\_

Father \_\_\_\_\_

If patient is a minor:

Signature of parent or guardian responsible for payment

\_\_\_\_\_ Date \_\_\_\_\_

Insurance carrier \_\_\_\_\_ Member ID \_\_\_\_\_

Phone # (on back of card) \_\_\_\_\_

Secondary insurance (if applicable) \_\_\_\_\_ Member ID \_\_\_\_\_

**Prescription for physical therapy (to be sent with this paperwork)**

Prescribing physician \_\_\_\_\_

Specialty \_\_\_\_\_

Office telephone \_\_\_\_\_

If prescribing physician is not your primary care doctor, please provide:

Primary care physician (pediatrician or internist) \_\_\_\_\_

Office address (city & state) \_\_\_\_\_

Office telephone \_\_\_\_\_ website, if any \_\_\_\_\_

**SCOLIOSIS AND MEDICAL HISTORY for youth patients**

**HISTORY OF SCOLIOSIS (or other spinal condition)**

Age at initial diagnosis \_\_\_\_\_ Date of initial diagnosis (mm/yy if possible) \_\_\_\_\_

For adolescents, level of physical maturity

Girls: date of first period \_\_\_\_\_ Boys: approx. date of voice change \_\_\_\_\_

**Date of most recent spinal x-rays (to be sent with this paperwork)** \_\_\_\_\_

Family history of spinal problems \_\_\_\_\_

Treatments for patient's scoliosis to date \_\_\_\_\_

Brace history: type of brace, orthotist, dates or patient's age when brace was prescribed and/or discontinued, number of hours/day prescribed \_\_\_\_\_

Circle level of compliance with wearing brace as ordered:

always   90% of the time   more than 50% of the time   50% of the time   less than 50%

**MEDICAL HISTORY:**

Any significant medical episodes or ongoing conditions (if no longer present, give dates or age when present and how resolved) \_\_\_\_\_

Any surgeries (give dates or age) \_\_\_\_\_

Medications currently taken (separate sheet if needed) \_\_\_\_\_

**CURRENT CONDITION**

Pain: where does it hurt? \_\_\_\_\_

When did it start-- date or age? \_\_\_\_\_

How did it start -- was it gradual or sudden? related to a particular event? \_\_\_\_\_

\_\_\_\_\_

Rate the pain on a scale of 0 to 10, 10 being the worst

Typical pain level this past week \_\_\_\_\_ Worst pain this past week \_\_\_\_\_

Is it constant or does it vary with activities? \_\_\_\_\_

Any other symptoms such shortness of breath, numbness, tingling, other (what brings it on?)

\_\_\_\_\_

**Activities and hobbies** (include brief job description, exercise and dance, musical instruments, any physical activity you engage in with some regularity) \_\_\_\_\_

\_\_\_\_\_

**Activities which are difficult or impossible** because of pain or other symptoms or simply it bothers your back \_\_\_\_\_

\_\_\_\_\_

**Do you experience any episodes of urinary incontinence** (i.e. small amount of leakage during coughing, sneezing, jumping on the trampoline, etc) \_\_\_\_\_

\_\_\_\_\_

**GOAL for physical therapy** What do you hope to get from physical therapy?

patient: \_\_\_\_\_

parent: \_\_\_\_\_

\_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

Patient signature \_\_\_\_\_

Person completing this Medical History \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law.

- You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
- You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Scoliosis Physical Therapy provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient (parent or guardian if patient is under age 18) understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Scoliosis Physical Therapy has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Scoliosis Physical Therapy reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Scoliosis Physical Therapy does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Scoliosis Physical Therapy may condition receipt of treatment upon the execution of this consent.
- The patient (parent or guardian if patient is under age 18) acknowledges that he/she has received a copy of our HIPAA Notice of Privacy Practices as available either in person or on our website at [www.scoliosisphysicaltherapy.com](http://www.scoliosisphysicaltherapy.com).

**My signature below indicates my consent.**

This consent is signed by \_\_\_\_\_

Print name here: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if other than patient): \_\_\_\_\_

## Photo/Material Release

At Scoliosis Physical Therapy, we want to make sure every patient understands his or her right to privacy. We also want to share successes and/or experiences for other patients and health care providers to learn. Information gathered at Scoliosis Physical Therapy may be used for education and/or research purposes.

I authorize the use of any photos or material taken and/or given to be used at the therapist's discretion for:

- Marketing purposes
- I can decide later
- No, thank you

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