Ph: 253.244.3465
Fax: 318.302.0140
ashley@scoliosisphysicaltherapy.com
www.scoliosisphysicaltherapy.com

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
email: ashley@scoliosisphysicaltherapy.com
Fax: 318-302 0140 (Attn: Ashley Pittman)
Tel: 253 244 3465

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 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 hour) $140

Treatment session (30 mins) $ 40

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.

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: _____