PHYSICAL THERAPY

PATIENT INFORMATION

Social Security #:	Title:	Last Name:	First Name:	MI:

Mailing Address:	Apartment #/ Second Address:

City:	State:	Zip Code:	Home Phone: ( ) -	Mobile Phone: ( ) -

Date of Birth: / /	Age:	Sex: M ☐ F ☐	E-mail Address:

Referring Physician:	Primary Doctor:	Last time seen by physician:

Marital Status:
☐ Married ☐ Widowed
☐ Single ☐ Divorced

Employment:
☐ Retired ☐ Part-time ☐ None
☐ Full time ☐ Student

(IF EMPLOYED) Employer:	Employer Address:

City:	State:	Zip Code:	Business Phone:

Relationship to insured:
☐ Self ☐ Spouse (if so, ⟹)
☐ Child ☐ Other

Only complete if coverage is in spouse's name
Spouse's Social Security #: _____

Last Name:_____ First Name: _____MI:_____

Date of Birth : / /

Complete the following if accident-related:

☐ Work Accident ☐ Auto Accident ☐ Other Accident

Accident / Injury Date: / /

Details of accident: _____

I give LAVA Physical Therapy consent to provide evaluation and treatment and to use or share my protected health information to obtain payment for my bills or to conduct its healthcare operations and business. I authorize payment to be made directly to LAVA Physical Therapy, including Medicare, Medicaid, or other benefits payable from any source, for all services rendered. I understand that I am ultimately responsible for payment of my account, and accept full responsibility for the cost of all services. I realize that I have the right to refuse any procedure after having the risks and benefits explained to me. The LAVA Physical Therapy Summary Note of Privacy Practices was given to me. LAVA Physical Therapy is hereby released from all legal liabilities.

Signed Date

PHYSICAL THERAPY

Name_____ **Age**_____ **Height**_____**Weight**_____

Occupation_____**Injury onset**_____**Activities**_____

Restrictions_____**How did injury occur**_____

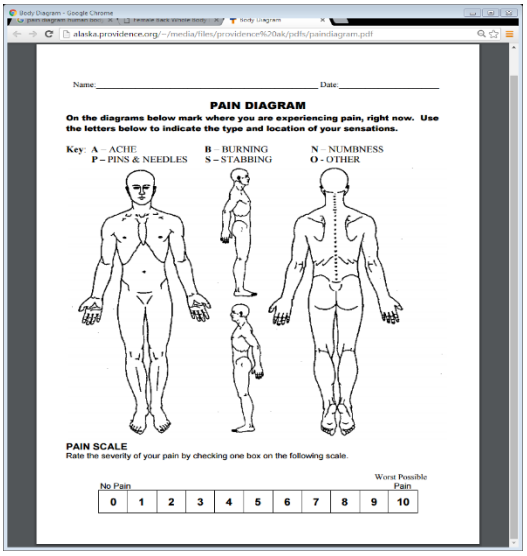
Your complaints_____

What makes it feel better_____

What makes it feel worse_____

Does pain change throughout the day_____

Radiating symptoms (pins & needles), odd sensations Y N
Sleep disruptions (times per night)_____
Headaches, dizziness or other changes Y N
Bowel or bladder changes Y N
Xrays/MRI/CT or any other diagnostic tests Y N
Dates_____



MARK YOUR PAIN (X)

MEDICAL HISTORY NO YES-Explain

. Arthritis_____
. Cancer_____
. Diabetes_____
. Heart problems_____
Medications_____
. High blood pressure_____
. Vascular condition_____
. Lung problems_____
. Allergies_____
. Birth control medications_____
. Pregnant or possibly_____
Surgeries_____
. Pacemaker_____
. Exercise regularly_____
. Congenital disorder_____
. Smoker_____
. Alcohol_____

Current Problems:

. Neck Pain . Hip/knee
. Upper/mid back pain . Foot
. Low back pain . Other
. Shoulder/wrist/hand
. Headache

On the scale please mark where your pain is today 0 1 2 3 4 5 6 7 8 9 10
On the scale please mark where your pain has been since the injury 0 1 2 3 4 5 6 7 8 9 10
Have you been to physical therapy for this injury in the past Y N

PHYSICAL THERAPY

OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and or legal guardian, I authorize **LAVA Physical Therapy** to treat the minor patients named in the attached forms while I am not present.

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned do hereby agree and give my consent for **LAVA Physical Therapy** to furnish physical therapy care and treatment consented necessary and proper in evaluation or treating my physical condition.

ASSIGNMENT OF ISURANCE BENEFTIS: I hereby authorize **LAVA Physical Therapy** to furnish information to insurance carries considering this treatment and I hereby assign all payment for services rendered. If my account is not paid in full by my insurance company within 90 day, I am immediately responsible for the remaining balance.

MEDICARE CARDHOLDERS: Have you had any Physical Therapy or Speech Therapy this year (2018)? If so, how many visits? _____ Are you currently receiving any Rehabilitative care (chiropractic, home health, etc.)? If yes, have you been discharged from Home Health Care?_____. If Medicare **DOES NOT** forward to your secondary insurance, you are responsible for this amount. _____ **(initial)**

WORKERS COMPENSATION CLAIMS: If you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

MOTOR VEHICLE ACCIDENT PATIENTS: If you are a personal-injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment after six (6) months, the charges for the services rendered will be your responsibility. All bills will be sent directly to you. It is your responsibility to forward them to your attorney if you wish. Financial responsibility ALWAYS rests with the patient.

CANCELLATION & NO SHOW POLICY: We require 24 hours' notice in the event of a cancellation. The charge for cancellation without proper notice is $25.00 for a physical therapy visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

Financial Responsible Party: _____

Print Name: _____Date:_____

ACKNOWLEDGEMENT OF RECIEPT

OF

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Lava Physical Therapy. I recognize that outside of Purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Lava Physical Therapy to release any of my protected healthcare information.

_____ _____

Patient's or Authorized Representative's Printed Name **Relationship to patient**

_____ _____

Patient's or Authorized Representative's Signature **Date**

<u>Please include all personnel in which you give permission to obtain your personal health information:</u>

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

By signing below, I hereby give permission to personnel listed above to obtain medical health information:

_____ _____

Patient's or Authorized Representative's Printed Name Patient's or Authorized Representative's Signature & Date