FOCUS PHYSICAL THERAPY

Patient Information Form

Patient Name: _____ Social Security: _____ DOB: _____
Parent/Guardian Name (if patient is minor): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Ok to leave message? ☐ Yes ☐ No Ok to leave message? ☐ Yes ☐ No Ok to leave message? ☐ Yes ☐ No

Email Address:_____ Appointment Reminder Type: ☐ Call ☐ Email ☐ Text ☐ None

Home Address: _____ City: _____ Zip: _____

Employer Name: _____ Occupation: _____
Work Full/Part time: ☐ Yes ☐ No Homemaker: ☐ Yes ☐ No Student: ☐ Yes ☐ No Retired: ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about Focus PT? ☐ Doctor ☐ Internet ☐ Yelp ☐ Friend ☐ Other: _____

Person responsible for payment (other than insurance comp): ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other
Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____ Phone: _____

Referring Physician: _____ Primary Physician (if different): _____

Insurance Information

Primary Insurance
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Policy ID Number: _____
Policy Group Number: _____

Secondary Insurance
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Policy ID Number: _____
Policy Group Number: _____

Worker's Compensation Additional Information
Does your employer consider this a work injury? ☐ Yes ☐ No

Adjuster's Name: _____ Phone: _____ Fax: _____

Automobile Information Are you seeking Physical Therapy due to a car accident? ☐ Yes ☐ No
Car Insurance: _____ Phone: _____ Policy No.: _____

Are you currently on a work restriction from your doctor? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Are you latex sensitive? ☐ Yes ☐ No

For WOMEN: Are you currently pregnant or possibly pregnant? ☐ Yes ☐ No Menopause? ☐ Yes ☐ No

ALLERGIES: ☐ Yes ☐ No List any medication(s) you're allergic to: _____

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History of Current Injury

Age_____ Height_____ Weight_____

Date (roughly) presenting symptoms started?_____

What do you think caused your symptoms? _____

Did you go to the emergency room? ☐ Yes ☐ No If yes, were X-Rays or MRI performed? ☐ Yes ☐ No

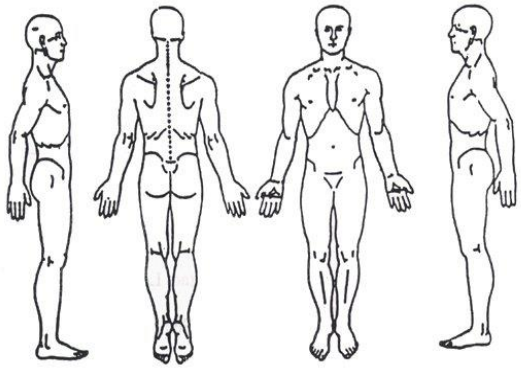
Treatments received so far for this presenting problem (i.e., primary care doctor, orthopedic, chiropractor, injections, etc.) _____

Has this type of injury happened before? ☐ Yes ☐ No If yes, when (dates) _____

Any previoius treatment(s) received? _____ If yes, how long did it take for you to feel better? _____

What are your current goals for physical therapy? _____

Please use the diagram to mark the location of your current symptoms:



My current symptoms are (check all that apply):
☐ Getting Better ☐ Getting Worse ☐ No Change
☐ Constant ☐ Constant, but change with activity ☐ Come and go

My current symptoms are worst:
☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ After exercise

My current symptoms are best:
☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ After exercise

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1._____ 2. _____ 3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1._____ 2. _____ 3. _____

Using the 0 to 10 scale, with 0 being "no pain" and 10 being "worst pain imaginable" please describe:

Current level of pain: _____ Best pain has been in last 24 hours: _____ Worst pain has been in last 24 hours: _____

How are you currently able to sleep due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleeping only with medication

Please list any medications (prescribed or over-the-counter) you are currently taking, INCLUDING pills, injections and/or skin patches):

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical reasons? ☐ Yes ☐ No

Have you ever taken blood thinning or anticoagulant medications for any medical reasons? ☐ Yes ☐ No

Do you have history of smoking? ☐ Yes ☐ No If yes, how many packs per day? _____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1._____ 2. _____ 3. _____

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Have you EVER been diagnosed with any of the following (check all that apply)?

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ fainting
- ☐ pain not relieved with rest
- ☐ cough
- ☐ headaches
- ☐ cancer
- ☐ heart problems
- ☐ chest pain/angina
- ☐ high blood pressure
- ☐ circulation problems
- ☐ blood clots
- ☐ stroke/CVA/TIA
- ☐ anemia
- ☐ bone or joint infection
- ☐ fibromyalgia
- ☐ hepatitis
- ☐ dizziness/lightheadedness
- ☐ shortness of breath
- ☐ heartburn/indigestion
- ☐ difficulty swallowing
- ☐ deep, throbbing or boring pain in abdomen
- ☐ difficulty maintaining balance when walking
- ☐ numbness/tingling
- ☐ muscle weakness
- ☐ depression/anxiety
- ☐ lung problems/tuberculosis
- ☐ head injury/concussion
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ other arthritic condition
- ☐ bladder/urinary tract infection
- ☐ kidney problem/infection
- ☐ pelvic inflammatory disease
- ☐ chemical dependency (i.e., alcoholism)
- ☐ other _____
- ☐ change in appetite, diet
- ☐ any bladder changes
- ☐ any bowel changes
- ☐ pain with intercourse
- ☐ any menstrual change
- ☐ bloody sputum
- ☐ recent infection
- ☐ pneumonia
- ☐ thyroid problems
- ☐ diabetes
- ☐ osteoporosis
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ eye problem/infection
- ☐ ulcers
- ☐ liver problems
- ☐ HIV or AIDS

Functional Assessment

Are you experiencing any difficulty with the following activities and/or tasks:

Eating or Drinking	☐ Yes	☐ No	Balancing on both feet	☐ Yes	☐ No
Dressing: putting on/taking off shoes, socks shirt, jacket and/or pants?	☐ Yes	☐ No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	☐ Yes	☐ No
Lifting	☐ Yes	☐ No	Carrying	☐ Yes	☐ No
Bending, kneeling or squatting	☐ Yes	☐ No	Sitting	☐ Yes	☐ No
Standing	☐ Yes	☐ No	Picking up small objects	☐ Yes	☐ No
Getting in/out of chairs, bed, car, bath/shower	☐ Yes	☐ No	Reaching: overhead, behind back, downward, or forward	☐ Yes	☐ No
Caring for child or adult	☐ Yes	☐ No	Sleeping through the night	☐ Yes	☐ No
Driving a vehicle or ability to use gas/brake pedals	☐ Yes	☐ No	Maintaining position of head bent forward, arms forward arms overhead and/or turning head	☐ Yes	☐ No
Housework and/or yardwork	☐ Yes	☐ No	Recreational activities	☐ Yes	☐ No
Job Related Activities	☐ Yes	☐ No	Gripping or opening jars	☐ Yes	☐ No

Have you fallen more than 1 time in the past year ☐ Yes ☐ No

Have you fallen and hurt yourself in the past year ☐ Yes ☐ No

I attest that the above information is true and correct.

Patient/Guardian Signature _____ Date: _____

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Informed Consent for Physical Therapy

Dear Patient:

Physical Therapy involves the use of many different types of physical evaluation and treatment. At Focus Physical Therapy (FPT), we use a variety of procedures and modalities to help us try and improve your abilities/functioning. As with all forms of medical treatment, there are benefits and risks involved with Physical Therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury or may aggravate previously existing condition(s).

Your Physical Therapist will discuss what type of treatment he/she is planning based on your reported history, diagnosis, symptoms, testing results and initial Physical Therapy evaluation. Discussion with your Therapist will identify what the possible risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session(s).

Therapeutic exercises are an integral part of most Physical Therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions or concerns regarding a type of exercise you are performing and/or any specific risks associated with your exercises, please ask your Therapist; he/she will gladly address them.

Patient Initials: _____

I agree to the following:

1. My participation in Physical Therapy and training is strictly voluntary; I may terminate my treatment at any time; and I may choose not to participate, and/or to limit my participation, in any exercise or activity at any time.
2. I am personally responsible for my own safety while participating in the Physical Therapy program. I will pace myself to maintain a level of participation that is safe and comfortable for me.
3. I will advise my Physical Therapist/Physical Therapy Assistant/Trainer of any changes in my physical or mental health (good or bad) prior to, and during, my participation in each session.
4. My Physical Therapist/Physical Therapy Assistant/Trainer is available to answer any questions or concerns I have regarding my participation, activities, and safety.
5. I will follow my Physical Therapist/Physical Therapy Assistant/Trainer recommendations to avoid any physical activities that may contradict and/or impair my participation and/or treatment.
6. I will seek further direction and/or explanation for anything that I do not fully understand, or that causes me concern.
7. I assume all such risk of services and hereby release Focus Physical Therapy, it's owners, operators, employees and agents from any and all liability, regardless of the nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, damages to property, and the consequences resulting from my active participation or involvement in any Focus Physical Therapy activity, treatment, failure of equipment or defect in the premises.

I will allow Focus Physical Therapy to photograph and/or record video of me for treatment purposes: ☐ Yes ☐ No

I acknowledge that my treatment program has been explained by Focus Physical Therapy, and all my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined by me, and I wish to proceed.

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Office Policies and Procedures

Payment for Services

Payment is due at the time of each service, which includes any and all deductibles, co-payments and/or co-insurance if utilizing health insurance. We accept Check, Cash, Debit, Visa, MasterCard, Discover and American Express.

Appointment Attendance & Cancellation Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities/functioning is something everyone at Focus Physical Therapy takes quite seriously. Because we care so much about you, we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments AND to your created treatment plan are vital components of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results:

1. We expect you to keep ALL your appointments. We will provide you with a schedule of your appointment times.
2. We expect you to arrive on time for each scheduled appointment, ready to begin your participation/treatment.
3. We expect you to follow your Home Exercise Program (HEP), and to discuss any questions or concerns you have with your Therapist.
4. Except for serious medical emergencies, it is expected that you will keep all appointments. **In the event you need to reschedule, we require 24-hour notice**. In such a case, please call our office and arrange for a makeup appointment. The makeup appointment needs to be in the same week, preferably the very next day. Please note, due to popularity of our staff we cannot guarantee that we will be able to reschedule you to keep you compliant with your plan of care.
5. In an instance of cancellation with less than 24-hour notice, you will be charged a $30 late cancellation fee. I understand that this late cancellation fee is not covered by any insurance company, and is fully my responsibility.
6. In an instance of a no-show/missed appointment, you will be charged a $50 fee. I understand that this late cancellation fee is not covered by any insurance company, and is fully my responsibility.
7. In instances of repeated noncompliance with your scheduled appointments (3 no-show/missed appointments, 3 late cancellations, and/or 3 consecutive reschedules) we reserve the right to discontinue care and will inform your referring physician of the fact that your services have been discontinued due to noncompliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read the above policies and procedures, and agree to abide:

Patient Name	Patient/Guardian Signature	Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Focus Physical Therapy.

Patient Name	Patient/Guardian Signature	Date

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Financial Responsibility

1. I understand that Focus Physical Therapy will bill by insurance as a courtesy, but my patient portion (i.e., deductible, copayment and/or co-insurance) is fully my responsibility, and is due at the time to each service.
2. If Focus Physical Therapy staff is unable to determine what my responsibility will be at the onset of treatment, I will be billed and my payment is due upon receipt of the first invoice.
3. I hereby understand that if my health insurance company denies payment for any services provided in good faith, I agree to be personally and fully responsible for payment.
4. An interest charge of 1.5% per month or 18% per year may also apply to deliquent account balances. As well, a 30% charge for accounts sent to a collection agency and additional fees for accounts sent to small claims court. $5/monthly minimum late fees. Any returned and/or NSF checks will incur a $35 bank fee.

Assignment of Benefits

Insurance Disclaimer:
"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service."

Insurance Liability for Payment;
Your health insurance company will only pay for serivces that it determines to be "reasonable and necessary" and/or "meets medical necessity." Every effort will be made by Focus Physical Therapy to have all services and procedures pre-authorized by your health insurance company. If your health insurance company determines that a particular services is not "reasonable and necessary," "does not meet medical necessity," and/or is not covered under your plan, your insurer may deny payment for that service. You agree to be fully responsible for all services rendered in good faith to you by Focus Physical Therapy.

Assignment of Benefits ~ All Insurances, except Medicare:
I hereby assign and convey all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services, treatments, therapies and/or equiment rendered or provided by Focus Physical Therapy, regardless of its managed care network participation status. *A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize my insurance company to pay benefits on my behalf directly to Focus Physical Therapy-SCV, Inc. I authorize Focus Physical Therapy-SCV, Inc. to provide my insurance company any information necessary to process claims for services rendered to me.

Patient Name	Patient/Guardian Signature	Date

Medicare Assignment of Benefits:
I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related MediCare claim. I permit a copy of this authorization to be used in place of the original, and I request that payment of medical insurance benefits be made on my behalf to Focus Physical Thearpy-SCV, Inc. This authorization shall apply to the current treatment period.

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