Physical Therapy Plus

Duane A. Lege PT CMDT

Patient Information

Personal Information Date: ____________________

Patient's Full Name: ____

Address: ____ Home Phone #: ________________

City: ___________________ State: _____ Zip: ________ Cell Phone #: ________________________

Date of Birth: ______________ Sex: ☐ Male ☐ Female SSN# ____________________________

E-Mail Address: ____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Minor

Place of Employment: _______________________________ Work #: ________________________

Employer's Address: ____

Street City State Zip

Emergency Contact Information

Name: ____ Phone # ______________________

Relationship: ____________________________________ Alt. Phone #: ___________________

How did you hear about us? ____

Medicare ☐ YES ☐ NO

Are you currently on Home Health Care? ☐ YES ☐ NO

→ Please see insurance information on back…

Insurance Information

******If you are primary insurance holder you can skip this section… If someone else in your family is primary insurance holder please fill out this information**

Primary Insurance

Policy Holder Name: ____DOB: ____________________

Policy Holder SSN #: ____ Relationship: ________________

Policy Holder's Employer: ____ Phone # _________________

Has your deductible been met? ☐ YES ☐ NO If so, How much? _______________________________

Secondary Insurance

Policy Holder Name: ____DOB: ____________________

Policy Holder SSN #: ____ Relationship: ________________

Policy Holder's Employer: ____ Phone # _________________

Has your deductible been met? ☐ YES ☐ NO If so, How much? _______________________________

Workers Comp. or Attorney Case

Name of Insurance: ____ Claim# _____________________

Adjuster Name: ____Phone # ______________________

Attorney Name: ____Phone # ______________________

PT+ Physical Therapy Plus

Patient Questionnaire/Health History

Name: ______________________ Date: ____________

History of Present Condition

1. What are your symptoms/chief complaints?

____

2. Which of the following **best describes** how your injury occurred?

- ☐ Lifting
- ☐ Trauma
- ☐ Work Injury
- ☐ Motor Vehicle Accident
- ☐ During Recreation/Sports
- ☐ A Fall
- ☐ Overuse (cumulative trauma)
- ☐ Unknown
- ☐ Other: ____________

What is the date of injury / MVA? ____________

Have you had surgery for the condition that you are being treated? ☐ YES ☐ NO

Date of Surgery: ____________

3. Have you ever had/been diagnosed with any of the following conditions *(check all that apply)*

- ☐ Pacemaker
- ☐ Diabetes
- ☐ Stroke
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ High blood pressure
- ☐ Cancer (type): ____________
- ☐ Epilepsy/seizures
- ☐ Allergies
- ☐ Infectious diseases
- ☐ Heart problems
- ☐ Nuerological Problems
- ☐ Respiratory problems
- ☐ Blood disorders
- ☐ Broken bone
- ☐ Circulation/vascular problems
- ☐ Other: ____________

4. Please list surgeries you have had in the past.

____

____

Previous Functional Level

5. Exercise Habits ☐ None ☐ Moderate ☐ Daily ☐ Heavy

6 . Have you had any previous treatment for this condition?

- ☐ Physical Therapy
- ☐ Massage Therapy
- ☐ Chiropractic
- ☐ Traction
- ☐ Medication
- ☐ Injection
- ☐ Acupuncture
- ☐ Bed rest
- ☐ Hospitalization
- ☐ Other: ____________

7 . Have you had any of the following tests?

- ☐ None
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Stress X-Ray Test
- ☐ Arthrogram
- ☐ Nerve Conduction Study
- ☐ Bone Scan
- ☐ EMG
- ☐ Other: ____________

8. Are you currently pregnant? ☐ Yes ☐ No

Medication:

9 . Please list any medications you are currently taking (including over the counter medications):

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

10. Are you seeing any health care providers other than the physical therapist for this current condition?

☐ Surgeon ☐ Chiropractor ☐ Other: ____________

Goals for Therapy

____

____

______________________ Patient Signature

______________________ Therapist Signature

Please see back side...

Work History

11. Occupation: ______________________________________

☐ Employed Working ☐ Employed Not Working ☐ Employed Working w/ restrictions

☐ Student ☐ Retired ☐ Unemployed

12. Physical activities at work *(check all that apply)*

☐ Sitting	☐ Repetitive lifting	☐ Heavy equipment operation
☐ Standing	☐ Heavy lifting	☐ Driving
☐ Phone use	☐ Computer use	☐ Other: ____________________

13. If not performing your normal activities at work do you plan to RETURN to your normal activity level? ☐ Yes ☐ No

14. Please indicate the worst your pain has been in the last 24 hours on the scale below:

(0 being no pain at all, 10 being the worst pain imaginable)

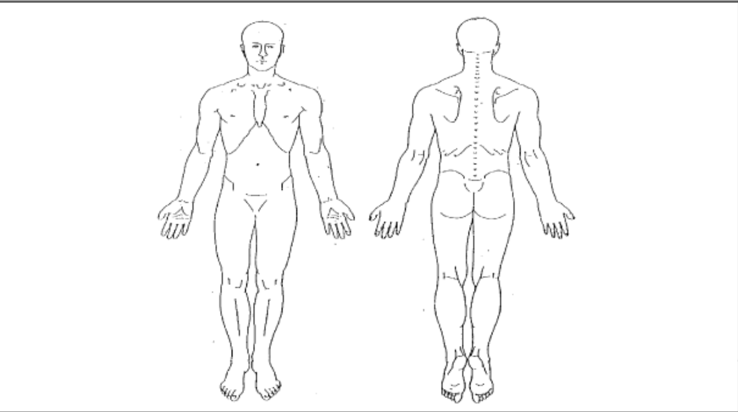
Now: _______	Worst: _______	Best: _______

15. Nature of pain/symptoms *(check all that apply)*

☐ Sharp
☐ Dull
☐ Throbbing
☐ Numbness
☐ Aching
☐ Occasional
☐ Constant
☐ Other: ________________________________

____

Mark areas of **pain** or **abnormal** sensation on the body chart below *(shade in where appropriate)*



Physical Therapy Plus of Vermilion, Inc.

Duane A. Lege PT CMDT

Patient Information Acknowledgement Form

I have read and fully understand **Physical Therapy Plus of Vermilion, Inc.** Notice of Information Practices. I understand that **Physical Therapy Plus of Vermilion, Inc.** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Physical Therapy Plus of Vermilion, Inc.** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Physical Therapy Plus of Vermilion, Inc's.** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at my time.

____

Patient Name

____

Signature

____

Date

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ________________________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

______________	______________	______________
Date	Name	Reason

→ Please see back side…

Physical Therapy Plus of Vermilion, Inc.

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Treatment Authorization & Financial Agreement

Thank you for choosing us as your health care provider. The following is a statement of our financial policy, which will require you to read and sign prior to treatment.

I agree to pay **Physical Therapy Plus of Vermilion** for professional services rendered or to be rendered at the time the service is performed unless other arrangements have been made in advance.

I also understand that insurance benefits assigned to **Physical Therapy Plus of Vermilion** must be paid within 60 days from the date of insurance billing. If the insurance company has not paid within 60 days, I agree to pay **Physical Therapy Plus of Vermilion** the full balance within the credit limits of the office. Any payment received by **Physical Therapy Plus of Vermilion** after my balance if paid will be refunded to me. I understand that **Physical Therapy Plus of Vermilion** cannot be responsible for collecting my insurance claim or negotiating a settlement on a disputed claim. I understand that I am ultimately responsible for this account no matter what my insurance company may or may not pay.

Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under all contractive care and/or other medical information. Should a problem arise, we will work with you to assist in any way possible. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I agree to give at least a 24 hour notice if I need to change my appointment. I agree to pay for the appointment time lost if I fail to keep my appointment without giving notice.

I understand that it is necessary for **Physical Therapy Plus of Vermilion** to retain the services of an attorney to collect my unpaid balance. I will be responsible for all court costs, attorney's fees and any other collection fees which may be incurred as a result of my account being turned over for collection as allowed by the State of Louisiana.

Authorization for Release of Medical Information and Treatment
Authorization is hereby given to release medical information and/or copies of medical records from my doctor for any and all of my related previous medical condition to **Physical Therapy Plus of Vermilion. Physical Therapy Plus of Vermilion** may provide written and/or verbal reports to my insurance company, worker's compensation company and/or my attorney's.

I agree to pay a fee of $25.00 for any check returned N.S.F.

I hereby authorize and consent **Physical Therapy Plus of Vermilion** to provide treatment prescribed by my physician related to my rehabilitation.

I have read and understand the above:

Who is financially responsible for this bill? ____

By signing below I am authorizing Physical Therapy Plus to bill the above mentioned financially responsible party. I understand that I am ultimately responsible for this account no matter what the above mentioned party may or may not pay.

_______________________________ _______________________________
Print Name Social Security Number

_______________________________ _______________________________
Signature of Patient/ Responsible Party Date

_______________________________ _______________________________
Signature of Co-Responsible Party Date