Not Just *Different* But *Better*

PATIENT INFORMATION FORM

Name: ______________________________

Address: ____

Home Phone #: ____________ Cell Phone #: ____________ Work Phone #: ____________

Birth Date: ____________________ Age: ___________

Email Address: ____

(For Patients Under 18) Responsible Person's name, address, and phone #: ____________________

____

Employer: ____

Referring Physician: ____________________ Primary Physician: ______________________

Date last seen by Referring Physician or PCP: ________________________________

Marital Status: ____________ Name of Spouse or Emergency Contact: ____________________

Insurance Information:
Primary Insurance Company Name: ____

Secondary Insurance Company Name: ______________________________________
Please Give Receptionist Your Insurance Cards to Copy

ARE YOU THE CARD HOLDER (Primary Subscriber)?: _____ YES _____ NO
IF NO, PLEASE PROVIDE THE FOLLOWING TO HELP US PROCESS YOUR CLAIM:

____
Card Holder's Name   Birth Date   Social Security #   ID# of Card Holder

Is this injury / illness due to a Work-related injury?: _____ YES _____ NO
Is this injury / illness due to a Motor Vehicle Accident?: _____ YES _____ NO
Have you received physical therapy previously in this current year? _____ YES _____ NO

I hereby authorize the Physical Therapist or Assistant to render treatment and procedures in my care, and I certify that answers given herein are true and complete to the best of my knowledge.

____
Patient (or Guardian) Signature   Date

Keystone Orthopedic PT, L.L.C.

Medical History Questionnaire

Name:________________________________ Age:______ Date:__________

Weight:_________ lbs Height:______ (used for quality reporting)

Reason for visit/referral:________________________________ Date symptoms started:__________

How did you hear about us?:____

Have you had any of the following Medical or Rehabilitative Services for this injury?

Acupuncture	Yes	No	
Injection(s)	Yes	No	Type:________________
Chiropractic	Yes	No	
Massage Therapy	Yes	No	
Occupational Therapy	Yes	No	
Physical Therapy	Yes	No	
Emergency Room Care	Yes	No	

Have you had any of the following Diagnostic Tests for this injury?

Bone Scan	Yes	No	Date:________________
CT Scan	Yes	No	Date:________________
EMG or Nerve Conduction Test	Yes	No	Date:________________
MRI	Yes	No	Date:________________
X-rays	Yes	No	Date:________________

Other:______________________________

Do you have an advanced directive?	Yes	No
Do you use an assistive device (cane, walker, wheelchair)?	Yes	No
Do you need to go up/down stairs in your home?	Yes	No
Have you fallen within the last year?	Yes	No

With whom do you live? Alone Spouse/Significant Other/Friend Relative PCA/Nurse

Please list any medications (prescribed and over the counter) OR provide a written list:

____

____

____

Please list any allergies to medications, tapes, or lotions:______________________________

Please list any recent surgeries:____

____

____

Occupation:______________________________ Full-time Part-Time Off-Work

KEYSTONE ORTHOPEDIC
PHYSICAL
THERAPY

Keystone Orthopedic PT, L.L.C.

Medical History Questionnaire

Cancer/Type:____________________	Yes	No	Diabetes/Type____________________	Yes	No
High Blood Pressure	Yes	No	Heart Disease	Yes	No
Angina/Chest Pain	Yes	No	Stroke	Yes	No
Osteoporosis	Yes	No	Tuberculosis	Yes	No
Arthritis	Yes	No	COPD or Emphysema	Yes	No
Epilepsy	Yes	No	Kidney Disease	Yes	No
Hepatitis	Yes	No	Immunosuppressive Disease	Yes	No
Seizure Disorder	Yes	No	Sexually Transmitted Disease	Yes	No
Bleeding Disorder	Yes	No	Lyme Disease	Yes	No
Asthma	Yes	No	Depression	Yes	No
Recent steroid medicine use	Yes	No	Headaches/Migraines	Yes	No

Do you have a pacemaker, stimulator, pain device? Yes No

Are you pregnant? Yes No

In the past 3 months, have you had unexplainable:

Change in health?	Yes	No	Nausea/Vomiting?	Yes	No
Fevers/Chills/Sweats?	Yes	No	Unexplained weight change?	Yes	No
Numbness/Tingling?	Yes	No	Changes in appetite?	Yes	No
Difficulty in swallowing?	Yes	No	Changes in facial sensation?	Yes	No
Change in bowel function?	Yes	No	Change in bladder function?	Yes	No
Shortness of breath?	Yes	No	Dizziness?	Yes	No
Persistent night pain	Yes	No	Unusual lumps or growths?	Yes	No
Swelling without injury?	Yes	No	Constant or pulsating pain?	Yes	No
Fainting/Blackouts?	Yes	No	Changes in vision/hearing/taste/smell?	Yes	No
Abdominal or Chest pain?	Yes	No	Severe headaches?	Yes	No

Other:____

Additional comments/concerns:

The above statements are true to the best of my knowledge.

Patient Signature:____ Date:____________

Medical history reviewed by physical therapist and used in determining individual plan of care.

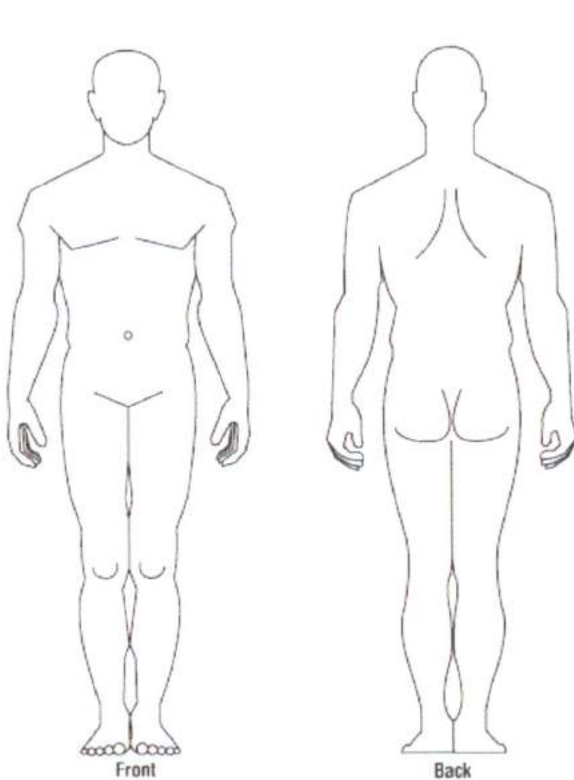
Reviewed By:____ Date:____________

PAIN ASSESSMENT

Name: ______________________________ Date: ______________________

Where is Your Pain?

Please mark, on the drawings below, the areas where you feel pain as related to the reason for visit/referral to physical therapy. Please complete A, B, and C below.



A. Please identify a CURRENT pain level/rating from 0 (none) to 10 (severe, worst pain imaginable):

0 1 2 3 4 5 6 7 8 9 10

Pain level at BEST: 0 1 2 3 4 5 6 7 8 9 10

Pain level at WORST: 0 1 2 3 4 5 6 7 8 9 10

B. Please circle the words that describe your pain or symptoms

(Use all words that apply)

1 - Sharp
2 - Shooting
3 - Burning
4 - Dull
5 - Throbbing
6 - Pulling
7 - Ache
8 - Tingling
9 - Numb
10 - Heavy
11 - Tight
12 - Stabbing

C. Please circle the words that describe the frequency of your pain or symptoms

(Use all words that apply)

A – Never goes away
B – Daily or several times a week
C – Once a week
D – Less than once a week
E – Relieved with position, change or rest

CONSENT to TREAT and PATIENT RESPONSIBILITY FORM

1. Consent to Treatment: I understand that I am being seen for treatment at Keystone Orthopedic PT, L.L.C. (KOPT), an outpatient physical therapy clinic. I authorize the physical therapist or assistant to render treatment and procedures in my care. Though I expect the care received will meet customary standards, I acknowledge that no guarantees have been made as the result of such treatment or examination. If I refuse treatment that is suggested for me, I will not hold KOPT responsible for any consequences resulting from my decision. I certify that answers given related to insurance coverage, medical history, and other patient information is true and complete to the best of my knowledge.

2. Assignment of Insurance Benefits: Medical treatment has or will be provided to the patient named below. As a courtesy to our patients, insurance claims are submitted directly. The insurance benefits that were quoted to us by your carrier are never a guarantee of payment. I understand that I will be responsible for any "patient portion(s)" as related to out-of-pocket expenses which may include a deductible, coinsurance, co-payment, or excluded / non-covered service. I authorize KOPT to furnish medical information to my insurance carrier concerning the illness, injury, or accident, and I assign my insurance benefits to be paid directly to "Keystone". If the insurance benefit is insufficient to pay all of the medical care rendered to the patient named below or the patient has no insurance, I understand that I am fully responsible for the balance due, based upon "Keystone's" charges which I agree are fair and reasonable.

3. Personal Valuables: KOPT will not be liable for loss or damage to money, jewelry, documents or articles of value.

4. Release of Information: I understand and agree that KOPT may disclose all or any part of a patient's record in order to obtain payment or for other reasons in accord with KOPT's Privacy Notice and in accord with State and Federal Law.

5. Cancellation Policy: In order to provide every patient with the most optimal schedule, we have a 24 hour "same day" no show policy. A $25 fee may be billed for failure to show for a scheduled appointment. Also, we kindly request that anyone wishing to cancel an appointment do so before 5 pm on the day prior to a scheduled appointment.

By signing my name below, I verify that I have read, am agreeable to, and understand the information contained in this registration/treatment consent. Additionally, I agree that I have received a copy of or have had the opportunity to review the Notice of Privacy Practices Form, and given the employment of a quality reporting system, as mandated by certain insurance, I understand I will be educated regarding the Body Mass Index and receive guidance/suggestions regarding weight management.

______________________	______________________	______________________
Patient	Patient's Guardian or Representative	Relationship to Patient

______________________	______________________
Date	Witness

DESIGNATION OF INDIVIDUALS INVOLVED IN MY PAYMENT AND TREATMENT DECISIONS

NAME	Last	First	MI
DATE OF BIRTH			
AKA			

In order to comply with the HIPAA Privacy Laws, **KEYSTONE ORTHOPEDIC PHYSICAL THERAPY** may provide limited information about you to individuals who may be involved in your treatment or payment decisions.

In order to assure your privacy while still making information available to those you want to be involved in your care and payment decisions, we request that you list on this form those people you authorize to receive your health information. These persons may include:

Family members or others who accompany you to appointments
Family members or others who call us about your care or payment issues or status
Other medical professionals other than referring source

Please provide us with complete information about these individuals below. You may use multiple forms if needed.

NAME AND ADDRESS OF THE INDIVIDUAL(S) / ENTITY(S) THAT MAY RECEIVE THE INFORMATION:

Name: ______________________________

Address: ______________________________
Street City State Zip

Phone: (____) ____-________ Fax: (____) ____-________

Relationship: ______________________ Involved in: Treatment Payment Both

Name: ______________________________

Address: ______________________________
Street City State Zip

Phone: (____) ____-________ Fax: (____) ____-________

Relationship: ______________________ Involved in: Treatment Payment Both

Name: ______________________________

Address: ______________________________
Street City State Zip

Phone: (____) ____-________ Fax: (____) ____-________

Relationship: ______________________ Involved in: Treatment Payment Both

This information will be presumed valid and the Clinic may rely on it until you have notified us in writing of any changes to this form.

SIGNATURE: ______________________ TODAY'S DATE: ______________

PRINTED NAME: ______________________ RELATIONSHIP: Client/Patient Parent Guardian Representative Conservator Other ________

ADDRESS: ______________________ (____) ____-________
CITY: STATE: ZIP: PHONE:

Distribution: Original - Releaser of Records Copy - Patient's Chart/Medical Record Copy - Patient/Client