Merrimack Valley PHYSICAL THERAPY

Patient Information

Name: _____ Today's Date: _____/_____/_____
First MI Last

( ) Male ( ) Female Date of Birth: ____/_____/_____ Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Occupation: _____ Employment Status: ( ) Employed ( ) Not Employed ( ) Retired

Home Address: _____
Street Address City State Zip Code

Home Phone: (___) _____**O** Work or **O** Cell (____) _____ Email Address: _____

Would you like to receive your appointment reminders via email? ( ) Yes, notify me by email ( ) No, do not email me

Would you like to receive your appointment reminders via text message? ( ) Yes, notify me by text ( ) No, do not text me

Do you give permission to leave a message on your answering machine? Yes ( ) No ( )

Emergency Contact: _____ Ph: (_____) _____-_____
Name Relationship to patient

Physician Information

Referring Physician: _____ Date of Next MD Appt: _____/_____/_____

Primary Care Physician: _____ Date of Current Injury: _____

Consent to Treatment

I, the undersigned, give Merrimack Valley Physical Therapy, LLC my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18): **O** Mother **O** Father **O** Legal Guardian

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the notice. Merrimack Valley Physical Therapy, LLC reserves the right to modify the privacy outlined in this notice.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

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Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Is this Injury related to a Workers Compensation Injury? **O** Yes **O** No Motor Vehicle Accident? **O** Yes **O** No

Do you have an attorney for this injury? **O** Yes **O** No Attorney's Name: _____

Address: _____ Phone: _____ Fax: _____

Financial Policy

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt.

I hereby give authorization for payment of insurance benefits to be made directly to MVPT for services rendered. In the event that my insurance company forwards payment directly to me, instead of MVPT, I will immediately deliver said payment to MVPT.

I understand & agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for MVPT to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance, and in addition attorney fees, court costs and other expenses of litigation.

I agree to release of medical or other information necessary to process my claim

Signature of Person Responsible for Charges: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under the age of 18 years)

Relationship to Patient if patient is under 18 years of age: **O** Mother **O** Father **O** Legal Guardian

Release of Information

I understand that MVPT 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 payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that MVPT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Individual: _____ Relationship:_____

Patient Name:_____ DOB: _____

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under the age of 18 years)

Relationship to Patient <u>if patient is under 18 years of age</u>: **O** Mother **O** Father **O** Legal Guardian

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Patient Commitment & Missed Appointment Policy

Thank you for choosing Merrimack Valley Physical Therapy; our staff will make every effort to ensure your experience here is both positive and productive so that you are able to achieve your functional goals. In order to give you the best possible outcome it is essential that you attend all your therapy appointments, as missing scheduled appointments greatly hinders progress toward your goals and may result in delaying your recovery.

In order to provide optimum outcomes and individualized care, we schedule our patients for one-on-one treatment times. We therefore respectfully require a 24 hour' notice for any appointment cancellation, which allows us the best opportunity to fill your appointment time with another patient who requires treatment.

A 24 hours' notice is required for an appointment to be rescheduled.

In an instance of a cancellation without 24 hours' notice or a no-show to a scheduled appointment, we reserve the right to charge a $50 fee. Exceptions may be made in the case of an emergency, illness, or inclement weather. Please note that this charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

While there may be situations in which you must (with proper notice) cancel your appointment:

- **DO NOT CANCEL** if you are feeling worse or believe the treatment is not working. Please understand that your pain will probably fluctuate as your course of treatment progresses. Keep your appointment and discuss any changes in your symptoms with your therapist.
- **DO NOT CANCEL** if you are feeling better; keep your appointment in order to progress your plan of care and prepare for discharge.

Thank you for your cooperation with this policy.

Signing below indicates that you understand and agree to the terms of this policy.

Patient Name:_____ DOB: _____

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under the age of 18 years)

Relationship to Patient if patient is under 18 years of age: **O** Mother **O** Father **O** Legal Guardian

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Name: _____ DOB: _____/_____/_____

Height: _____ Weight: _____

Medical History

Check all that Apply

O Allergies	**O** Chemical Dependency	**O** Fractures	**O** Osteoporosis
O Anemia	**O** Circulation Problems	**O** Gallbladder Problems	**O** Parkinson's Disease
O Anxiety	**O** Currently Pregnant	**O** Hepatitis	**O** Rheumatoid Arthritis
O Arthritis	**O** Depression	**O** High Blood Pressure	**O** Seizures
O Asthma	**O** Diabetes	**O** Incontinence	**O** Speech Problems
O Cancer (any history of)	**O** Dizzy Spells	**O** Kidney Problems	**O** Strokes
O Cardiac Condition	**O** Emphysema/Bronchitis	**O** Metal Implants	**O** Thyroid Disease
O Cardiac Pacemaker	**O** Fibromyalgia	**O** Multiple Sclerosis	**O** Vision Problems

Describe any other conditions or precautions:

_____

_____

History of Falls

Injured as a result of a fall in the past year? **O** Yes **O** No Date of Fall:_____

Two or more falls in the past year? **O** Yes **O** No Dates of Falls:_____

Surgical History

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____

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Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____

Current Medications: **O** mark if list is attached (Route: oral, topical, inhaler, injection)

Name: _____ Dosage:_____ Frequency:_____ Route:_____

Name: _____ Dosage:_____ Frequency:_____ Route:_____

Name: _____ Dosage:_____ Frequency:_____ Route:_____

Name: _____ Dosage:_____ Frequency:_____ Route:_____

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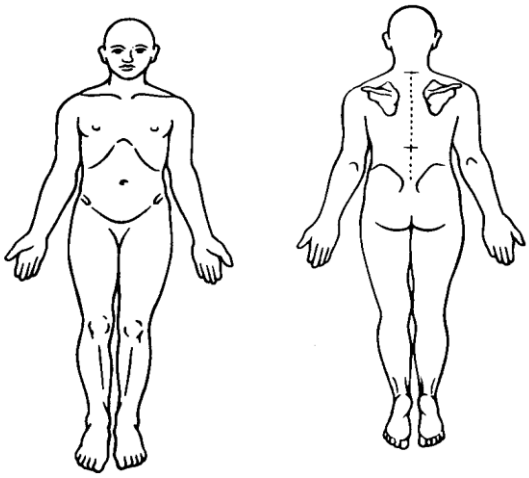
Patient Name: _____ Date of Birth: _____/_____/_____ Date of Injury/Onset: _____

Present Condition

Please localize your **pain** or **abnormal** symptoms /sensations by marking on the body diagram below.



Pain at Rest:
No Pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain

Pain with Movement
No Pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain

Was the onset of this episode gradual or sudden?
O gradual **O** sudden

Which of the following **best describes** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)

O lifting	**O** a car accident
O a fall	**O** an incident at work
O overuse (cumulative trauma)	**O** trauma
O degenerative process	**O** medical condition
O during recreation/sports	**O** unknown

O other_____

Since the onset of your condition, are your symptoms getting: O better **O** worse **O** not changing

Have you experienced similar symptoms in the past?
O yes **O** no **More than one episode? O** yes **O** no

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

O sharp	**O** aching	**O** constant
O dull	**O** throbbing	**O** occasional
O burning	**O** shooting	**O** periodic

O other_____

Your symptoms are worse in the:

O morning	**O** afternoon	**O** night
O increased during the day		**O** same all day

Does the pain wake you at night? O yes **O** no

What aggravates your symptom's? (check all that apply)

O sitting	**O** standing
O going to/rising from sitting	**O** squatting
O lying down	**O** sleeping
O walking	**O** up/down stairs
O reaching overhead	**O** coughing/sneezing
O reaching in front of body	**O** taking a deep breath
O reaching behind back	**O** looking up overhead
O reaching across body	**O** sustained bending
O household activities including_____	**O** recreations or sports including_____
O repetitive activities	**O** stress

O other _____

What eases your symptoms? (check all that apply)

O cold	**O** rest	**O** sitting
O heat	**O** massage	**O** standing
O rest	**O** stretching	**O** lying down
O medication	**O** exercise	**O** nothing

O other_____

How would you rate your general health?
O Excellent **O** Good **O** Average **O** Fair **O** Poor

Living Situation

O live alone	**O** live with caregiver
O live with family members/other	**O** assisted living

Setting

O stairs (railing)	**O** no stairs	**O** elevator
O stairs (no railing)	**O** ramp	**O** uneven ground

The above information is true to the best of my knowledge.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18): **O** Mother **O** Father **O** Legal Guardian