EXCEL ORTHOPEDIC PHYSICAL THERAPY

PATIENT & MEDICAL HISTORY QUESTIONNAIRE

Name_____ **Referring Physician**_____ **Date**_____

Do you have a follow up appointment with your doctor?|*(Please circle one)* YES NO If so, when? _____

Diagnosis/Body Part_____

Date of Onset_____**Weight**_____ **Height**_____ **Age**_____

Have *you* ever had any of the following conditions? Circle all that apply.

Cancer	Yes…No	Shortness of Breath	Yes…No
High Blood Pressure	Yes…No	Diabetes	Yes…No
Asthma/Bronchitis	Yes…No	Heart Disease	Yes…No
Polio	Yes…No	Angina/Chest pain	Yes…No
Stroke	Yes…No	Arthritis	Yes…No
Anemia	Yes…No	Are you Pregnant	Yes…No

Please list all surgeries, including dates: _____

_____

Have you had any falls in the past year?	**YES**	**NO**	**If so, about how many?** _____
Do you have a history of fractures?	**YES**	**NO**	**Where?** _____
Do you have any metal implants?	**YES**	**NO**	**Where?** _____
Do you have a pacemaker/electrical implant?	**YES**	**NO**	**Please list** _____
Do you exercise regularly?	**YES**	**NO**	**How often?** _____
Do you smoke?	**YES**	**NO**	**How long/how much per day?** _____
Do you have any respiratory diseases?	**YES**	**NO**	**Please list** _____
Do you have any known allergies? (ie latex)	**YES**	**NO**	**Please list** _____

Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking. Include *dosage and frequency*.

_____

Have you recently or do you currently experience any of the following symptoms *<u>in relation to the condition you are coming here for</u>*? Please briefly explain.

Nausea/vomiting	Yes…No	_____
Fever/chills/sweats	Yes…No	_____
Unexplained weight change	Yes…No	_____
Numbness or tingling	Yes…No	_____
Muscular weakness	Yes…No	_____
Dizziness/Fainting spells	Yes…No	_____
Night Pain	Yes…No	_____
Bowel or bladder changes	Yes…No	_____
Headaches	Yes…No	_____

Please check any tests/procedures that have been done for your *<u>current</u>* condition. If known, report the findings.

☐X-rays ☐MRI ☐CT Scan ☐Bone Scan ☐EMG ☐Blood Work ☐Bone Density ☐Other

_____

Briefly describe the history of your current injury:

_____

_____

_____

Primary Complaint(s):

_____

_____

If you are having pain, please rate the severity on a 0-10 scale, where 0 is no pain and 10 is the most severe pain:

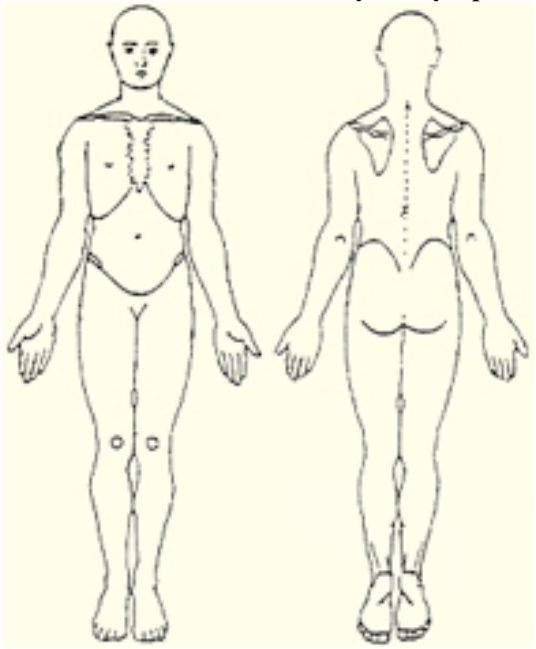
Right now:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At worst:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At best:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Which of the following best describes your pain (circle all that apply):

CONSTANT INTERMITTENT SHARP DULL ACHING LOCALIZED

SHOOTING/RADIATING NUMBNESS/TINGLING BURNING THROBBING

Please indicate the location of your symptoms:



PMH Questionnaire has been read and reviewed by Physical Therapist: Initials/License #: _____

EXCEL
ORTHOPEDIC PHYSICAL THERAPY

Patient name_____ Home phone_____ Cell phone_____

Address_____ Apt#_____ City_____ State_____ Zip _____

Birthdate_____ SSN_____-_____-_____ Email Address: _____

Check appropriate box: ☐Minor ☐Single ☐Married ☐Widowed **Check appropriate box:** ☐Male ☐Female

Occupation _____ Employer/school_____ Work phone_____

Who may we thank for referring you? _____

Person to contact in case of emergency_____ (relationship)_____ Phone_____

Insurance Information

Name of Primary Insurance: _____ Name of Secondary Insurance: _____

Was this injury related to a WORK, AUTO or SCHOOL accident? ☐Yes ☐No **If YES, please check one:** ☐work ☐auto ☐school
If YES, DATE OF INJURY _____ If AUTO related, are you currently being treated by a chiropractor? ☐Yes ☐No

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Financial Agreement and Office Policy

I authorize release of all medical records concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Insurance benefits payable directly to me, are hereby assigned to Excel Orthopedic Rehabilitation for application to the patient's bill. In the event that the patient's insurer denies medical benefits, coverage, or payment in full or at all, consent is hereby authorized to allow Excel Orthopedic Rehabilitation to appeal such decisions on the patient's behalf.

It is my responsibility to provide accurate insurance information. In the event the information provided is incorrect, I accept full financial responsibility.

I understand that a fee of $40 will be charged to me for any returned checks and that I am liable for payment.

Please be advised that unless you have Medicare, we are not in-network with your insurance company, but as a courtesy we will submit your claims for you. If you have Medicaid as a secondary, you understand we do not participate and agree to pay the 20% Medicare does not cover. If you have a second insurance carrier, we will submit to that carrier. Once your primary and secondary companies have processed your bills, you will be responsible for any balance remaining. The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Excel Orthopedic Rehabilitation. I understand that I am responsible for any charges billed to and not covered by any insurance carrier(s), including any deductible, coinsurance, for visits over coverage limitations, for no prescription or MD signed plan of care. Should your account be referred for collections or an attorney, the undersigned agrees to pay costs of collection, including attorney fees, $25.00 administrative fee and 18% interest after 60 days. The undersigned certifies that he/she has read and understands the foregoing, authorizes to execute the above, and accepts the terms.

RESPONSIBLE PARTY (PERSON SOLELY RESPONSIBLE FOR ANY OUTSTANDING BALANCE)

_____ _____
Responsible Party Signature (Patient or guardian if minor) **Date**

_____ **Relationship to patient**_____
Print Name

Birthdate_____ **SSN**_____-_____-_____ **Home phone**_____

Address_____ **Apt#**_____ **City**_____ **State**_____ **Zip** _____

Employer _____**Work phone**_____

Consent for Care

I, the undersigned, do consent to physical therapy treatment as ordered by physician prescription and administered by Excel Orthopedic Rehabilitation (EOR).

Consent for Use and Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information by EOR for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. EOR is not required to agree to the restrictions that I may request. However, if EOR agrees to a restriction that I request, the restriction is binding on EOR. Your request must be in writing and you must state the specific restriction requested and to whom you want the restriction to apply.

I have the right to revoke this consent, in writing, at any time, except to the extent that EOR has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical therapy or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review EOR's Notice of Privacy Practices prior to signing this document. EOR's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care operations of EOR. This Notice of Privacy Practices also describes my rights and EOR's duties with respect to my protected health information.

EOR reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please be advised that EOR practices in an open gym environment. This means that if your treating provider is discussing your private health information with you, someone in close proximity may overhear the conversation. If you are concerned with this, please bring this to the attention of your therapist.

_____

Patient signature (or parent if minor) Date

EXCEL
ORTHOPEDIC PHYSICAL THERAPY

Notice of Privacy Practices and Patient Acknowledgement

To Our Valued Patient:
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do al we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: _____ Signature: _____

If minor, signature of parent or guardian: _____ Date: _____

For Office Use Only

A "good faith effort" was made to get a signature from the patient. Signature was not attained due to the following: _____

Photography Policy

At Excel Orthopedic Rehabilitation, we ask that you refrain from taking any photography or videography while in the physical therapy gym. Please understand that this is to maintain the privacy of all of our patients and within our duty to uphold the laws of the Health Insurance Portability and Accountability Act (HIPAA). If you would like to take a picture or video, please speak with your physical therapist to get consent and to ensure that there are no other patients in the background. Also, if you have any questions, please speak with your physical therapist. By signing this form, you acknowledge this policy and agree to refrain from photography.

Thank you for your cooperation as we strive to maintain a comfortable treatment environment for everyone.

_____ _____

Patient/Guardian Signature Date

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EXCELtherapy.com

YOUR EXPERIENCE WITH US IS PARAMOUNT and want to make sure it is as seamless as possible…

SCHEDULING POLICY

We kindly request you schedule your *following* week appointments on **Monday** or **Tuesday** of each week so you get your desired appointment time each visit.

COPAY POLICY

COPAYS are collected at **EVERY** visit.

Kindly remember to bring ***cash***, ***check***, ***Visa***, ***MasterCard, Discover, or American Express*** in order for us to credit your account efficiently and appropriately.
You also have the option of leaving a credit card on file for your convenience. If you would like to do so please let us know.

By printing your name below you acknowledge you have been fully informed of our scheduling and copay policy.

_____ _____

NAME (PRINT PLEASE) **DATE**