Physical Therapy Specialist
1625 Highway 88, Suite 302
Minden, NV 89423
www.physicaltherapyspecialist.com
Phone: 775-782-4422
Fax: 775-782-4232

Dear New Patient,

The attached paperwork is relating to your upcoming physical therapy appointment with Bill Wall, PT, DPT.

Please complete the following documents: New Patient Form, Notice of Privacy and Practices (HIPAA), Cancellation and No Show Policy, Medical History Forms, and the Questionnaire particular to your current injury (if included).

Along with your completed paperwork, please bring your prescription or referral from the doctor and your insurance card(s) so that we may have a copy for our records. Please bring or wear shorts, sweats, tank top/T-shirt, and tennis shoes to your visit.

Our office is located in Minden, across from Douglas High School on the first floor of the Hickey Building at 1625 Highway 88, Suite 302.

If you have any questions or need to reschedule your appointment, please feel free to call us at 775-782-4422.

Thank you,

Physical Therapy Specialist

NEW PATIENT FORM

(PLEASE PRINT CLEARLY**)** **Date:**_____

Patient Name: (Last)_____ **(First)**_____ **(M.I.)**_____

Date of Birth:_____ **Social Security:**_____ **Sex:** Male / Female

Mailing Address:_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Status: Married / Single / Divorced / Separated / Widowed **Email address:** _____

Employment: Full / Part-Time / Not Working / Retired /Student **Employer:**_____

Emergency Contact:_____ **Relation:**_____ **Phone:**_____

Referring Physician:_____ **Phone:**_____

Injury Type: Work / Auto / Home / Other _____ **Attorney Involved:** Yes / No

Attorney Name:_____**Phone:**_____

Who may we thank for your referral other than your Doctor: _____

Please initial the following that apply:

_____**Consent for Treatment of a Minor:** As a parent and/or legal guardian, I authorize Physical Therapy Specialist to treat the minor patient named above while I am not present.

_____**Consent for Care & Treatment:** I the undersigned do hereby agree and give my consent for Physical Therapy Specialist to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

_____**Assignment of Insurance Benefits and Financial Policy:** I hereby authorize Physical Therapy Specialist to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered. We bill your medical insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If you insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company request a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Patient Signature (Parent or Guardian Signature) Date

Contact Information: Please Read Carefully

1. Which method would you prefer that we use to notify you of your next appointment? (Please check all that apply)

☐ Cell Phone
☐ Work Phone
☐ Home Phone
☐ Email

2. May we leave you detailed messages? YES/NO (circle one)

If yes, where may we leave messages? (Please check all that apply)

☐ Cell Phone
☐ Work Phone
☐ Home Phone
☐ Email

3. If we try to reach you and someone other than you answers the phone, with whom may we leave *appointment information?* We will not discuss any medical information with anyone other than the patient, unless otherwise specified to the staff directly. (Please check and fill out the name of any/all options that applies)

☐ Spouse: _____
☐ Roommate: _____
☐ Child/Children: _____
☐ Other /Relation:_____

Disclosure Agreement

I, the patient, understand that Physical Therapy Specialist cannot be liable for the failure of technology used for communication. I acknowledge that though Physical Therapy Specialist will do everything in its power to make sure that communication reaches me in a secure manner; email communication is not always secure. I also realize that though Physical Therapy Specialist will make every attempt to reach me directly, the office staff will leave voice messages if necessary or leave messages with a representative that I have delegated above. I have the right to revoke or alter the choices I've checked above at any time, and if I wish to do so, I will communicate that with the front office staff immediately.

Patient Signature_____ Date: ____/____/_____

Physical Therapy Specialist
CANCELLATION AND NO-SHOW POLICY

We take treatment cancellations seriously at **Physical Therapy Specialist** because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor has prescribed a set frequency of treatment. Showing up as scheduled for these visit is your most important job. Working together we can help you achieve your goals in treatment.

We require 24 hours of notice in the event of a cancellation: It is your responsibility when you call in to have an alternative time in mind to insure that you will receive your full prescribed number of treatments that week. Cancellations may make it necessary for you to receive treatment by one of our therapists other than with the one you originally scheduled.

There is a $25.00 charge for cancellation without proper notification (meaning a 24 hour notice). This charge will not be covered by insurance, but will have to be paid by you personally.

Please understand that your pain will probably vary during your course of treatment. Some conditions can seem to be a reason not to come in: whether you're feeling better or worse. It is important to come in and work with the therapist to re-assess and treat you, and possibly progress your program.

When a patient doesn't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or physical therapist; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will do our best to have you back to full function swiftly. We're looking forward to working with you.

I have read this document and fully understand my responsibilities.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Workers Compensation:** We may release medical information about you for worker's compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if we are asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so that they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect and Copy: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use to disclose about you for treatment, payment, or health care operations. ***(We are not required to agree to your request.)*** **Your Right to Request Confidential communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the law that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my Signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature **Date**

Name: _____ **SSN:** _____ **Date:** _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**
Do you smoke? Yes No **Do you have a pacemaker? Yes No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

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

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflamunatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications 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 conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

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

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

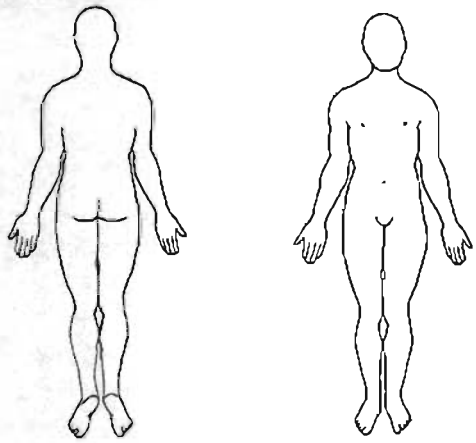
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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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. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____