_____ Authorization Required

PHYSICAL THERAPY etc. Patient Information

First: **MI:** **Last:**

Date of Birth: Age: Gender at birth: ☐ Male ☐ Female

Mailing Address: _____

_____

_____

Physical Address: _____

_____

_____

OK To Call **Phone:** **Best Time To Call**

☐ Home:

☐ Work:

☐ Cell:

Social Security Number:

Height: **Weight:**

Race:

☐ **American Indian / Alaska Native** ☐ **Asian** ☐ **Black or African American**

☐ **Native Hawaiian / Other Pacific Islander** ☐ **White** ☐ **Chose not to respond**

Ethnicity:

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Chose not to respond**

Preferred language:

Interpreter required?

☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Unknown**

Student Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **None**

Patient Name: _____

EMPLOYMENT STATUS
Employment Status: ☐ **Active Military** ☐ **Full-Time** ☐ **None** ☐ **Part-Time** ☐ **Retired** ☐ **Self Employed**
Employer: Occupation:
Address:
Phone:
INSURANCE INFORMATION
Primary Insurance:
Policy Holder's Name: Holder's Birth Date:
Policy or Certificate #: Group #:
Policy Holder's Employer:
Secondary Insurance:
Policy Holder's Name: Holder's Birth Date:
Policy or Certificate #: Group #:
Policy Holder's Employer:

Is this a Worker's Compensation Case? ____ Is this an Auto Accident? ____ If yes, Claim # _____

Insurance Company Name: _____

Date of Injury: _____ Claims Adjuster:_____

If this is a Worker's Compensation Case, we must have:

Employer at time of injury: _____ Phone: _____

Address: _____

Patient Name: _____

Note: Please provide us with the most updated information down below.

EMERGENCY CONTACTS

Name	Phone	Work	Cell	Fax	Relationship

ALLERGIES

Date	Status	Type	Allergen	Severity	Reaction	Source

MEDICATIONS

Medication	Dose	Dose Unit	Frequency	Admin

Patient Name: _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other: _____

HAVE YOU RECEIVED ANY OTHER THERAPY THIS YEAR? ____Yes ____ No

IF YES, PLEASE LET US KNOW WHAT TYPE AND THE NUMBER OF TREATMENTS:

____Physical Therapy ____ Occupational Therapy ____ Speech Therapy

____Chiropractic Treatments ____ In-Home Therapy (# of treatments ____)

COMMUNICATION PREFERENCES

Please tell us how you would like us to communicate with you by filling out the check boxes below:

Appointment Reminder: ☐ Text ☐ Email

Interactive text messages with office: ☐ Text

You acknowledge that text alerts will be sent to the mobile phone number you provided. Such alerts may include limited personal information and whoever has access to the mobile phone or carrier account will also be able to see this information. Once you enroll, the frequency of text alerts we send to you will vary. You will typically receive text alerts when we have information for you about your appointments or other healthcare information. We do not impose a separate charge for text alerts; however, your mobile carrier's message and data rates may apply depending on the terms and conditions of your mobile phone contract. You are solely responsible for all message and data charges that you incur. Please contact your mobile service provider about such charges.

You may opt out of text alerts at any time. To stop receiving text alerts, reply STOP. After you submit a request to unsubscribe, you will receive one final text alert from our clinic confirming that you will no longer receive text alerts. No additional text alerts will be sent unless you re-activate your enrollment.

☐ I agree with the communication preferences indicated above.

☐ I do not want to receive any correspondence via text or email.

_____ _____

Signature Date

Patient Authorization Record

Initial boxes below

	Authorization for Treatment ➢ I hereby give authorization to Physical Therapy etc. to provide such procedures/treatments/equipment to me (or to a person for whom I am legally responsible) as permitted by Pennsylvania Statutes under the appropriate scope of practice are, in accordance with my doctor's referral and/or the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Physical Therapy etc. may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Physical Therapy etc. for services rendered. ➢ I agree that Physical Therapy etc. may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I authorize the following person(s) or class of persons to receive information: ( ) Spouse _____ ( ) Child _____ ( ) Attorney _____ ( ) Other_____
	Authorization for Release of Payment/ Patient Financial Obligation ➢ I authorize Physical Therapy etc. to bill my primary and/or secondary insurance and I request payment be made on my behalf to Physical Therapy etc. ➢ I agree to pay Physical Therapy etc. charges for services rendered to me during my course of treatment. ➢ I understand that it is my responsibility to understand the limitations of my insurance coverage and to monitor the use of my benefits. ➢ Unless laws or a contract with my insurance company states otherwise, I acknowledge that I am responsible for and agree to pay ALL charges, including deductibles, co-pays, co-insurance, non-covered services or services in excess of limits set by my insurance company. If I do not pay for charges that are my responsibility, I agree to pay Physical Therapy etc. collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Physical Therapy etc. in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Physical Therapy etc. may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to Physical Therapy etc. in applying for benefits under Workers Compensation is complete and accurate. I agree that Physical Therapy etc. may give intermediary information necessary to process claims.

_____

Patient signature Date

_____

Printed patient name Witness Signature Date

_____

Signature of Legal Representative/POA Date

PHYSICAL THERAPY etc. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Physical Therapy Associates of Chambersburg, Inc. (dba Physical Therapy etc.) (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy or have been offered a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 142 Franklin Farm Lane, Chambersburg, PA 17202, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THE STATEMENTS ABOVE AND HAVE BEEN OFFERED A COPY OF THE PRACTICE'S POLICY NOTICE. I AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Patient or Representative | Date

_____ _____

Patient's Name | Date of Birth

_____ _____

Name of Personal Representative (if applicable) | Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

( ) Accepted ( ) Denied ( )Not Applicable ( ) Other (explain) _____

_____ _____

Signature of Authorized Practice Representative | Date

PHYSICAL THERAPY etc.
PHYSICAL, OCCUPATIONAL, SPEECH

Cancellation / No-Show Policy

All of us at Physical Therapy etc. want to make your therapy as effective as possible. We believe that part of that goal is to schedule your appointments on days and at times that are convenient to you. We try very hard to do that.

WE NEED YOUR HELP.

If you are late for a scheduled appointment, your treatment time may need to be shortened or, depending on our schedule, we may not be able to treat you at all.

If you need to reschedule or cancel an appointment, please let us know as soon as possible. We would appreciate at least 24 hours' notice. We may be able to fill your appointment time with another patient. You may be billed $25 if you repeatedly miss scheduled appointments or if you do not give us adequate notice. *(This policy does not apply to cancellations due to inclement weather. If our office is closed for inclement weather, our answering machine will indicate that the office is closed.)*

CALL US AT 717-263-5147.

IF WE DO NOT ANSWER, PLEASE LEAVE A MESSAGE.

_____ _____

Patient signature Date

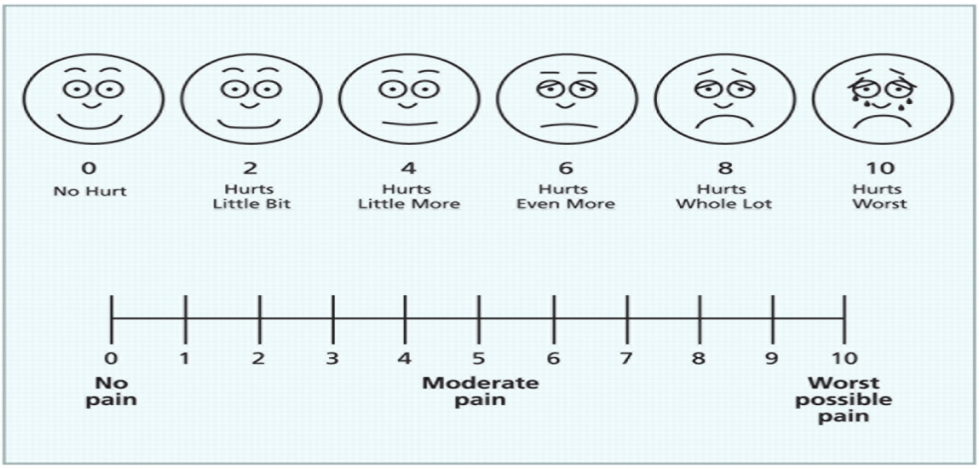
Revised 03-18

PHYSICAL THERAPY etc.
PHYSICAL, OCCUPATIONAL, SPEECH

Patient Questionnaire

Patient Name: _____

1. Do you have a history of pain for greater than 3 months? Yes No
2. Do you currently use tobacco products? Yes No
3. Do you currently use alcohol? Yes No
4. Are you currently taking opioids? Yes No
5. Do you perform moderately intense exercise at least 3x/week? Yes No
6. Are you confident that you can overcome your problem? Yes No
7. Do you have a history of? (circle all that apply)
   Depression Anxiety Diabetes Heart Disease
   Chronic Lung Disease Neurological conditions (brain or spinal cord) Cancer
8. How long have you had this condition? < 1 month 1-3 months >3 months
9. Please circle your pain rating on average over the last two weeks.



_____ _____

Patient Signature Date