



PERSONAL INFORMATION

Name _____ Home Address _____
 Occupation _____ City/State/Zip _____
 Home Phone _____ Cell Phone _____
 Work Phone _____ SSN _____
 Email _____ Date of Birth _____
 Best way to contact: *home cell work email* Gender: *male female*
 You may leave messages about appointments, or health care info at this number: *cell home work*
 I know that a cell phone is not a secure or private line.

IN CASE OF EMERGENCY...

Notify _____ Relationship _____
 Best Phone # _____ Home _____ Cell _____ Work _____

INSURANCE INFO

Personal Insurance Work Comp Claim Auto Insurance Claim
 Name of Insured: _____ Insured's DOB: _____

REFERRALS

How did you hear about Nephew Physical Therapy?
 Physician Employer Family Member Our Website
 Your Insurance Co Valeo Personal Train Friend Other: _____
 Facebook JQ99/1260 Former Patient _____

HEALTH HISTORY

Have you had or have any of the following medical conditions?
 YES NO Cardiovascular Disease YES NO History of Cancer
 YES NO Cauda Equina Syndrome YES NO Huntington's
 YES NO Cerebral Vascular Accident YES NO Immunosuppression
 YES NO Current Infection YES NO Lupus
 YES NO Diabetes Mellitus Type 1 YES NO Muscular Dystrophy
 YES NO Diabetes Mellitus Type 2 YES NO Osteoarthritis
 YES NO Fibromyalgia YES NO Parkinson's
 YES NO Fracture or Suspected Fracture YES NO Rheumatoid Arthritis
 YES NO High Blood Pressure YES NO Smoking
 YES NO Other YES NO Traumatic Brain Injury
 Explain any other medical condition or problems not previously mentioned? _____

YES NO Are you currently receiving **home health care** for Nursing, Physical Therapy, Occupational Therapy and/or Speech Language Pathology?

YES NO Have you received Physical Therapy, Occupational Therapy and/or Speech Therapy at another facility in **the last year**?

YES NO Are you currently exercising? _____ days/week Type of Activity _____



MEDICAL CARE

Date of Last Doctor's Appointment _____

Date of Next Doctor's Appointment _____

MEDICATIONS

Please list all current medications and reason for use: **TESTINGS** and Dates:

- X-ray _____
- MRI _____
- CAT Scan _____
- Other _____

CURRENT SYMPTOMS / CURRENT LEVEL OF FUNCTION

What is your main complaint? _____

When did your symptoms begin? _____

Describe your first episode of dizziness. Was it sudden or gradual? _____

Are your current symptoms better, worse or the same as when they started? _____

Rate the severity of your symptoms from 0-10 at both their best & their worst (10 being worst):

Best _____ Worst _____

What positions, movements or situations make your symptoms worse? _____

How long do your symptoms last when they happen? _____

How frequently do you have symptoms during a single day? _____

Are you experiencing any difficulties with your vision, i.e. double vision, increased difficulty focusing with head movement, etc.? _____

Are you experiencing any ear symptoms, i.e. fullness, ringing, loss of hearing, etc.? _____

Do you have any previous history of dizziness? _____

Have you previously received treatment for dizziness? If so, what kind? _____

What is your current living situation? Do you live alone or with someone? _____

What are you unable to do right now because of your dizziness? _____

Have you had any falls associated with your dizziness? _____

Are you currently driving? _____

Has your dizziness affected your sleeping? _____

Are you currently able to exercise? _____

YOUR GOALS

What is your goal and/or what would you like to accomplish in Physical Therapy?





Name _____

ATTENDANCE POLICY

1. Please arrive on time for every appointment.
2. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.
3. **24-hour notice is required** if you are going to miss, cancel, or reschedule your appointment.
4. If 24-hour notice is not given, an \$80 fee will be charged for missing the initial evaluation (1st) appointment. A **\$40.00** fee will be charged for any additional missed, cancelled, or rescheduled appointments without 24-hour notice.
5. **Three or more** missed appointments may result in discharge from physical therapy.

CONSENT FOR TREATMENT

I agree to have a licensed Physical Therapist perform an evaluation and render appropriate treatment as ordered by my physician. I also authorize the release of any pertinent information regarding my case to any insurance company, physician, adjuster, or attorney involved in the case. I direct the insurer to directly pay without equivocation Nephew Physical Therapy all benefits due them and guarantee payment for services.

FINANCIAL AGREEMENT

I authorize Nephew Physical Therapy to bill my insurance company for payment of services. I understand that I am ultimately responsible for payment in full at this office. If I have no insurance coverage, I understand that the balance is due and payable in full at the time of treatment unless extended payment arrangements have been made between Nephew Physical Therapy and myself. I also understand that if I suspend or terminate my care as determined by my treating doctor and/or Physical Therapist, any fees for professional services will be immediately due and payable, unless both parties have agreed upon other arrangements. All payments are due on the 10th of the month. All balances not paid in full will incur a **\$10 late fee** for each month that there is an outstanding balance. Patient is responsible for any & all legal fees associated with the collection of payment.

STATEMENT OF UNDERSTANDING

I certify that I have read and understand pages 1-4. I understand the above questions are designed to help guide the providers in my current treatment. This information may be used in case of a patient emergency. I have completed this form to the best of my knowledge and find the information to be true and accurate.

PATIENT'S SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE: _____ DATE: _____



PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization.
In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges that I have been given the option to receive of a copy of the currently effective Notice of Privacy Practices (available online) for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** your name

Please **sign** your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

Cell Phone Home Phone Work Phone Email **Any Listed**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** TO BE CONVEYED VIA:

Cell Phone Home Phone Work Phone Email **Any Listed**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

Phone Message Email **Any of the Above** None of the above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____ I could not communicate with the patient _____

The patient refused to sign _____ The patient was unable to sign because _____

Other (please describe) _____

Signature of Privacy Officer