Nephew Physical Therapy
12723 N. Bellwood Dr. Suite 10 Holland, MI 49424

PATIENT INFORMATION FORMS
Please complete and sign

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□ Cauda Equina Syndrome
YES □ NO□ Cerebral Vascular Accident
YES □ NO□ Current Infection
YES □ NO□ Diabetes Mellitus Type I
YES □ NO□ Diabetes Mellitus Type 2
YES □ NO□ Fibromyalgia
YES □ NO□ Fracture or Suspected Fracture
YES □ NO□ High Blood Pressure
YES □ NO□ Other
YES □ NO□ History of Cancer
YES □ NO□ Huntington's
YES □ NO□ Immunosuppression
YES □ NO□ Lupus
YES □ NO□ Muscular Dystrophy
YES □ NO□ Osteoarthritis
YES □ NO□ Parkinson's
YES □ NO□ Rheumatoid Arthritis
YES □ NO□ Smoking
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 _____

Name _____

MEDICAL CARE

Main Reason for Today's Visit _____
When did your symptoms start? _____
Date of Surgery (if applicable) _____
Date of Last Doctor's Appointment _____
Date of Next Doctor's Appointment _____

MEDICATIONS

Please list all current medications and reason for use:

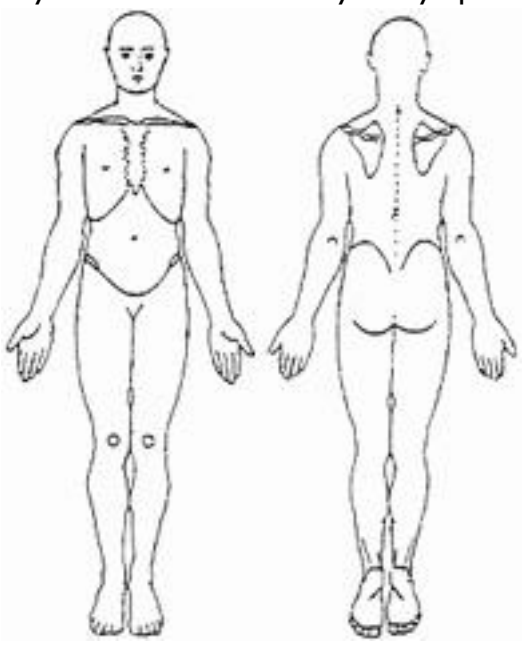
_____
_____
_____
_____

TESTINGS and Dates:

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

CURRENT SYMPTOMS

Identify the **LOCATION** of your symptoms on the chart below.



Check all that describes your symptoms and the location of those symptoms.

☐ Stabbing _____
☐ Shooting _____
☐ Throbbing _____
☐ Aching _____
☐ Burning _____
☐ Numbness _____
☐ Tingling _____
☐ Other _____

RATE YOUR SYMPTOMS

On a scale of 0-10, 0 being no pain and 10 being the worst pain, circle the RANGE of your pain:

0 1 2 3 4 5 6 7 8 9 10

What activities, movements or position makes you feel worse? _____

_____

_____

What makes you feel better? _____

_____

_____

Is your pain present all of the time or some of the time? Constant / Intermittent

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.

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.

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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

Nephew Physical Therapy