Cindi A. Prentiss, P.T., P.C.

Physical Therapy & Beyond

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PATIENT INFORMATION FORM

PLEASE PRINT LEGIBLY Today's Date____________________

First Name____________________ Last Name____________________ Social Security No._____-_____-______

Marital Status: (Circle One) Married/Single/Divorced/Widow/Widowed Spouse's/Partner Name____________________

Birth Date ____________Age_______ Sex: M/F Height___/___ Weight_____ R/L hand dominant_____.

Home Address____ Home Phone_________________

City/State/Zip____ Cell Phone___________________

Work Phone________________ E-mail_________________ What is the best way to contact you? _____________

Employer Name/ Work Address ____

Current Work Status: Full Time Part Time Retired Unemployed On Disability Restricted Work

Student Homemaker Not Working Due to Injury. Occupation: ____________________________

Is this condition due to: ____Auto Accident ____Workers Comp Injury ____Slip and Fall ____Other

If you currently have an attorney working with you, please provide his/her name and address.

____

Have you received **physical therapy**, **occupational therapy**, and/or **speech therapy** since January 1st of this calendar year? Yes/No If yes, which therapy did you have and what were you being treated for?

____

Are you now having homecare services of any kind? Yes/No

Whom may we thank for referring you? ____

Please mark * ***C*** for ***Current*** Conditions or * ***P*** for ***Past*** Conditions

___Fibromyalgia	___Neck Pain	___Knee/Lower Leg Pain	___Heart Disease	___High Blood Pressure	___Hepatitis
___Rheumatoid Arthritis	___Back Pain	___Ankle/Foot Pain	___Angina	___Stroke	___Cancer
___Osteoarthritis	___Sciatica	___Jaw Pain	___Pacemaker	___Lupus	___Tumor
___Osteopenia	___Abnormal Posture	___Hearing Loss	___Diabetes	Difficulty ___Walking	___HIV/Aids
___Osteoporosis	___Headaches	___Kidney Disorder/Stones	___Neuropathies	___Parkinson's Disease	___Asthma
___Broken Bones	___Shoulder Pain	___Prostate Problems	___Peripheral Vascular Disease	___Multiple Sclerosis	___COPD
Joint ___Swelling/Stiffness	___Elbow/Upper Arm pain	___Painful Urination	___General Fatigue	___Muscular Dystrophies	___Cigarette Smoker
___Pregnancy	___Wrist/hand pain	___Bladder Infection	___Lack of Coordination	___Epilepsy	___Drugs/Alcohol Dependence
___Dermatitis/Eczema /Rash	___Hip/Upper leg Pain	___ Pelvic Pain ___Loss of Bladder Control	___Vertigo	___Liver/Gall Bladder Disorder	___Depression

Dates and Descriptions of **Surgeries**: ____

____

List all **prescriptions** (and why you are taking them) and over the counter medications & nutritional/herbal supplements you are taking____

Allergies: ____

Please state the body parts where your problems or injuries are located, and give a brief description of your current problems including difficulties with any functional activities.______________________________________

____

____

Please give a ***date*** (actual or approximate) this problem started.____

Please describe ***how*** your condition or injury started.____

____

Have you ever been treated for this condition before? Yes No

Date and location where you were last treated.____

Are you currently being seen by a chiropractor for the same condition? Yes No

Please check any of the following characteristics that you are feeling:

____Sharp Pain ____Dull Ache ____Throbbing ____Numbness ____Burning ____Pins/Needles

____Constant ____Usually present ____Sometimes present ____Occurs once in a while

Please circle the number that represents the intensity of your pain *when you are at rest*:

(No Pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)

0 1 2 3 4 5 6 7 8 9 10

Please circle the number that represents the intensity of your pain *during any movements*:

(No Pain) (Minimal Pain) (Moderate Pain) (Unbearable Pain)

0 1 2 3 4 5 6 7 8 9 10

Please check all the problems that you currently have:

_____Pain _____Shooting Pain _____Inability to work _____Difficulty walking

_____Weakness _____Loss of Motion _____Numbness _____Muscle tightness

_____Stiffness _____Loss of Function _____Extreme Fatigue _____Loss of Balance

_____Headaches _____Unable to sleep _____Unable to walk stairs

Please state anything that makes your problem ***better***____

____

____

Please state anything that makes your problem ***worse:*** ____

____

____

When is your next appointment with the doctor who is seeing you for this condition? ____________________

What are your ***goals*** you would like therapy to help you with? ______________________________________

____

____

____

____ ____________________

Patient Signature Date

____

FDA INITIALS

Physical Therapy & Beyond

PATIENT INSURANCE AND AUTHORIZATION FORM

Patient Name (print) ______________________________ Phone#____________________________________

Primary Insurance Carrier: ______________________________________ID# ___________________________

Group #____________________________________

Primary Insured: ___________________________________ Date of Birth ___________SS#______-_____-_____

Male/ Female Relationship to patient: SELF SPOUSE CHILD OTHER

Adj/Caseworker:___________________________________ Adj. phone#_________________________________

Secondary Insurance Carrier: ___________________________________ ID# ___________________________

Group #____________________________________ Phone#___________________

Insured: ___________________________________ Date of Birth ___________SS#______-_____-_____

Male/ Female Relationship to patient: SELF SPOUSE CHILD OTHER

Tertiary Insurance Carrier: ____________________________________ ID# ___________________________

Group #____________________________________ Phone#___________________

Insured: ___________________________________ Date of Birth ___________SS#______-_____-_____

Male/ Female Relationship to patient: SELF SPOUSE CHILD

INSURANCE AUTHORIZATION SECTION

Physical Therapy& Beyond strongly believes that patients should not pay for any services their insurance companies are obligated to cover. As a courtesy to our patients, we will bill your insurance company in an attempt to recovery any payments due fully for the services provided. Any uncollected fees are billed to the patient only after all options to get paid for services have been exhausted by our Accounting Department.

I understand that I am fully responsible for notifying Physical Therapy & Beyond of any changes regarding my medical coverage during ongoing treatment. The changes in medical coverage may include an auto accident, a work-related injury, termination of insurance, a change of insurance company and/or policies. ***If I do NOT comply with this policy, I understand and am fully aware I will be liable for any and all outstanding bills.***

I further understand that I am responsible for paying the balance of charges in the event my insurance does not fully cover for all services provided, including deductible, co-pay, co-insurance or percentage authorized or limited by law.

Additionally, I hereby authorize and assign insurance benefits to Physical Therapy & Beyond and the release of any and all medical records as requested by any insurance company so that my bills can be processed and paid.

____ ________________________________

Patient Signature (Parent Signature if under 18) Date

Acknowledgement of Notice of Privacy Practices

I, ____, have been offered a copy of the Notice of Privacy Practices from Physical Therapy& Beyond. Patient Signature_________________________________ Date___________

In lieu of patient signature, I, ___________________________, a staff member of Physical Therapy& Beyond, state that ___________________________________ has been offered our current Notice of Privacy Practices.

____

FDA INITIALS

Cindi A. Prentiss, P.T., P.C.,
dba: ***Physical Therapy & Beyond***

Patient Release Form

1. I authorize Cindi A. Prentiss, P.T., P.C., and /or staff to release information to the following physician (s):

List the Physician writing your prescription so that we may send all your medical reports.

physicans name

address

city, state, zip

phone number

type of doctor

Carbon Copy PT Reports to:

List other Physicians you would like us to send a copy of your physical therapy reports to.

physicians name	**physicians name**
address	address
city, state, zip	city, state, zip
phone number	phone number
type of doctor	type of doctor

Patient Signature **Date**

2. I authorize Cindi A.Prentiss, P.T., P.C., and /or staff to discuss my healthcare with the following person(s)

List the people in your personal life you are allowing us to share your info. with.

name	name
address	address
city, state, zip	city, state, zip
phone number	phone number
relationship to you	relationship to you

Patient Signature **Date**

3. I hereby authorize Cindi A.Prentiss, P.T., P.C. and/or staff to evaluate and treat my Son/ Daughter

______________________________ for Physical Therapy.
Print Minor's Name

Parent or legal Guardian please sign here for minor Child.

Parent Signature **Date**

Witness Signature **Date**

Cindi A. Prentiss, P.T., P.C.,
dba: ***Physical Therapy & Beyond***

To Our Patient Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and or/your Physical Therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your Physical Therapist's instructions and we will be able to help you achieve your goals in treatment.

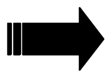
- We require 24 hour notice in the event of a cancellation. When you call in, it is your responsibility to have an alternative date and time in mind. This will ensure that you get the full prescribed number of treatments for that week whenever possible.
- There is a charge of $25 for a cancellation without proper notice. This charge will not be covered by insurance and must be paid by you personally.
- Worker's Compensation and Personal Injury patients are hereby informed that documentation of any missed appointments is forwarded to the Case Manager and Primary Physician and could jeopardize your claim.
- When rescheduling a missed appointment, you may need to see a therapist who you have not seen before. Be assured that all of our therapists are experienced professionals, who will study your patient chart, so you will be in good hands. You will return to your usual therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. The following may seem to be a reason not to come for your treatment.
  A) You're feeling worse and think the treatment is not working or B) You're feeling better and it's a great day for wind surfing. Neither of these conditions is legitimate as a reason not to come in. A) If you are in pain, come in and get it fixed, B) If you are out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself.

To Our Patient Regarding Cancellations and No-Shows

When you don't show for a scheduled appointment, **three** people are hurt.

1. **You**, because you don't get the treatment you need as prescribed by the doctor and or the Physical Therapists.
2. **Your Physical Therapist**, who now has an open space in their schedule that was reserved for you personally.
3. **A Patient who is in pain** who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard by signing the agreement below. We're looking forward to working with you.



___________________________________ Date_________________
Patient Signature (Parent Guardian for Minor)

___________________________________ Date__________________
Interviewer Signature