Manual Physical Therapy SPECIALISTS

Phone: (517) 318-6066 **Fax**: (517) 318-6069 **www.manualptspecialists.com**

2740 East Lansing Drive East Lansing, MI 48823

PATIENT INFORMATION

Email:_____

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Date of Birth: / /	Age:	☐ Male ☐ Female	S.S#: - -
Home Phone: ( ) -	Alternate Phone (Cell, Pager): ( ) -	Spouse:	

How did you hear about us? ☐ Dr. _____ ☐ Insurance Plan ☐ Family ☐ Friend ☐ Former Patient

☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:_____

WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext:
Occupation:	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr. / PCP:	PCP Phone: ( ) -

AUTO/WORK INJURY CLAIM (Please fill out the section below if you are here due to an Auto/Work Injury)

Insurance Name: ☐ Auto: ☐ Labor & Industries:

Adjuster/ Claim Manager:	Phone: ( ) -	Ext:	
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: ( ) -	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY CONTACT

Name of Local Friend or Relative (Not Living at the Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

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INFORMED CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

Responsible Party (for Minor): _____

- I understand that my physician has ordered therapy for my medical condition.
- I understand that therapy is provided through usual and customary procedures, which have been effective in the treatment of various medical conditions. The proposed procedures have been fully explained to me.
- I understand the goals and anticipated outcome of my therapy.
- I understand that informed consent for treatment does not guarantee that my services will be covered by my insurer.

Financial Agreement: I understand that Manual Physical Therapy Specialists submit claims to insurance carriers as a courtesy to patients. I understand that I am responsible for the balance owed to Manual Physical Therapy Specialists after they have billed my insurance carrier(s) and I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any insurance carrier, unless prohibited by law or contract. In addition, unless other arrangements are made in advance, I consent to Manual Physical Therapy Specialists to use and disclose of my health information to any person or organization that is legally or contractually responsible for payment of my bills for the services I received. I also consent to Manual Physical Therapy Specialists disclosure of my health information to attending and consulting providers for billing purposes.

I authorize my insurance company and/or my managed care company to make payment directly to Manual Physical Therapy Specialists.

Valuable Release: I understand and agree that Manual Physical Therapy Specialists is not responsible for my valuables, personal belongings or any property kept in my possession or in my room while I am a patient at this clinic. I herby release Manual Physical Therapy Specialists from any responsibility for loss of or damage to any personal property or money kept in my possession or in my room while I am a patient.

I certify that this Consent and Release Form has been explained to me or that I have read it or have had it read to me, and that I understand its contents.

Patient Signature Date

Responsible Party Signature Date

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Patient Information

Scheduling

We will work with you and your physician to optimize the outcome of your therapy. It is important that you attend all of your scheduled therapy sessions. **Please give at least 24-hour notice if you must cancel.** It is your responsibility to call and cancel your appointment if you are unable to keep it.

If you miss three appointments in any combination of no show and/or cancellations, you may be discharged and your physician will be notified. You will then need a new prescription from your physician to return to therapy.

It is your responsibility to arrive for your appointments on time. If you are more than 10 minutes late, you might not be treated that day. It is your responsibility to dress appropriately for your therapy appointments. Your therapist will let you know what you need to wear. Changing clothes is not part of therapy time, and can cut your session short.

Insurance

Please Note: We are providing this information to help you have a better understanding of your insurance requirements. Patients are responsible for knowing their benefits and assuring that authorization, if required is obtained.

If your doctor requests services for Physical Therapy these services may be payable under your insurance contract. Your therapy must be medically necessary and you must be making documented progress. Your insurance company may request medical records prior to payment. Maintenance services are never paid. Please contact your insurance company directly for an explanation of your benefits. Some Insurance companies restrict payment for certain diagnoses. You may wish to talk with your therapist regarding your particular diagnosis and check with your insurance company for any special restrictions.

Information received from your insurance company is not a guarantee of payment. Determination of insurance payment can only be made after your insurance company has reviewed our billing and documentation.

You will be responsible for paying any amount due that your insurance does not cover. **You must notify us immediately to discuss any changes in your insurance when you are undergoing therapy.**

We look forward to serving you. If you have any questions regarding your insurance, please contact us.

_____ _____

Patient Signature Date

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

NOTE: This is not a medical records release for physical therapy records. You must sign a separate Medical Release Form to obtain records from our office.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or cell phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If **Yes**, please provide the name and numbers of the members:-

_____

_____

Patient Name (Please Print): _____

_____

Signature Date

_____

Responsible Party Signature Date

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MEDICAL HISTORY AND SUBJECTIVE INFORMATION FORM

Please answer the following questions as completely as possible.

Name: _____ Birth Date: _____ Today's Date: _____

*Date of injury/problem:	*Date you went to your doctor for help with this injury/problem:

*Briefly describe how your problem occurred. (Include dates if possible.)

What would you like to accomplish in therapy (what are your goals)?

Rate your pain on a scale from 0-10 (0=no pain, 10=worst pain): *Current _____ *Best _____ *Worst _____

Describe your pain: ❑ Constant ❑ Intermittent ❑ Sharp/Stabbing ❑ Dull/Aching ❑ Burning ❑ Throbbing ❑ Other: _____

What makes your Pain/Symptoms...

*Better (or decreases your pain): _____

*Worse (or increases your pain): _____

When are your symptoms better: ❑ AM ❑ PM ❑ Other: _____

When are your symptoms worse: ❑ AM ❑ PM ❑ Other: _____

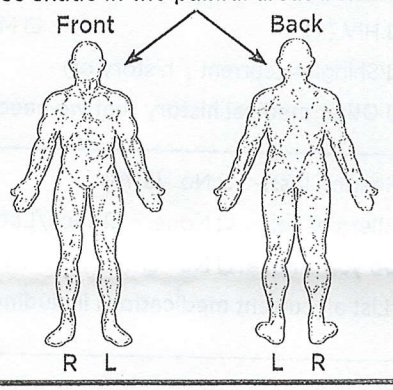
Does your pain wake you? ❑ No ❑ Yes: _____

Do you sleep through the night? ❑ No ❑ Yes: _____

*Do you have numbness? ❑ No ❑ Yes, location: _____

*Do you have tingling ❑ No ❑ Yes, location: _____

Please shade in the painful areas below:



*PREVIOUS TREATMENT(S) for this condition (please check all that apply): ❑ None

Health Care Provider	Name/Date	Health Care Provider	Name/Date
❑ Family Doctor		❑ Physical Therapist	
❑ Specialist		❑ Occupational Therapist	
❑ Psychiatrist/Psychologist		❑ Speech Therapist	
❑ Pain Clinic		❑ Chiropractor	

*DIAGNOSTIC TEST(S): Have you had any of the following for your current condition? (If yes, please check and state results.)

Test	Date/Result	Test	Date/Result
❑ None		❑ MRI	
❑ X-rays		❑ EMG	
❑ CT Scan		❑ Other	

Therapist Notes:

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Name: _____ Birth Date: _____

*MEDICAL HISTORY:

*Any past surgeries? ❑ No ❑ Yes, please list and date:

(Please check each box that applies) ❑ Reviewed with patient (Unremarkable)

Have you had any of the following:

Is there any chance you may be pregnant? ❑ No ❑ Yes, _____# of months

❑ Heart disease/attack	❑ Lung disease/asthma	❑ Stroke	❑ Arthritis (type:_____)
❑ Pacemaker/defibrillator	❑ Kidney disease	❑ Head injury	❑ Osteoporosis/osteopenia
❑ High blood pressure	❑ Liver disorder/hepatitis: _____	❑ Headaches	❑ Metal implants
❑ Circulation problems	❑ Thyroid disease	❑ Seizures	❑ Stomach disorders
❑ Diabetes (type:_____)	❑ Skin disease	❑ Dizziness	❑ Frequent nausea/vomiting
❑ Blood issues/history of clot	❑ Cancer (type:_____)	❑ Swallowing problems	❑ Bowel/bladder issues
❑ HIV (+)	❑ MRSA/VRE (+)	❑ Mental health issues	❑ Neuromuscular disease

❑ Shingles (current / history of)

❑ Other medical history that we need to be aware of, i.e., accidents or other? _____

Hearing loss: ❑ No ❑ Yes Hearing aids: ❑ No ❑ Yes Glasses/Contact lens: ❑ No ❑ Yes

Allergies to: ❑ None ❑ Tape/Latex ❑ Adhesive ❑ Environmental ❑ Drug Type _____

Do you smoke? ❑ No ❑ Yes, how many packs/day:_____ Do you drink alcohol? ❑ No ❑ Yes, how much:_____

*List all current medications including over-the-counter types (*If you have a list, we will photocopy it.*): ❑ None

_____

_____

*EMPLOYMENT:

Are you currently working? ❑ Full-time ❑ Part-time ❑ Retired ❑ Disabled ❑ Student ❑ Unemployed

Occupation / Job Title / Responsibilities: _____

List any restrictions: _____

What problems are you having at work due to your condition: _____

_____

List any hobbies: _____

_____

PERSONAL INFORMATION/ACTIVITIES OF DAILY LIVING:

Home: ❑ 1-story with/without basement ❑ 2-story with/without basement
❑ Apartment with/without elevator ❑ Mobile Home
❑ Other: _____

Stairs: Maximum # of stairs in your home: ____
When going up the stairs, are handrails on the
❑ Left ❑ Right ❑ Both ❑ None

Lives (with): ❑ Spouse ❑ Alone ❑ Family ❑ Friend(s) ❑ Other: _____

Equipment: Equipment used at home (lift chair, bathroom rails, etc.): ❑ None ❑ Yes, equipment used: _____

Prior to this, did you walk using a device? ❑ No ❑ Cane ❑ Crutches ❑ Standard Walker ❑ Rolling Walker ❑ Other: _____

Falls: Number of falls you have had in the last month/year? ❑ None ❑ Yes (if yes, number of falls last month:_____ /last year:_____)

Patient's signature: _____ Date: _____

Therapist's signature: _____ Date: _____