PATTERSON PHYSICAL THERAPY

Patient Information

Patient Name (First, MI, Last)		Sex	Marital Status	Date of Birth	Social Security #
Street Address		City, State, Zip			
Cell Phone	Home Phone	Work Phone		Occupation	
E-mail Address		Reminders (Check one) [ ] Call [ ] Text [ ] E-mail			
Employer	Address			Phone	
Referring Doctor	Address			Phone	

Responsible Party If different from Patient

Guarantor / Guardian Name	Relation to Patient	Phone Number	Social Security #
Street Address		City, State, Zip	Home Phone

Health Insurance Information

Primary Insurance Carrier	Group #		Policy #
Policy Holder	Relation to Patient	Date of Birth	Social Security #
Secondary Insurance Carrier	Group #		Policy #
Policy Holder	Relation to Patient	Date of Birth	Social Security #
Are you currently receiving Home Health Services? ☐ Yes ☐ No			

Workers Compensation Information ☐ Does Not Apply

Carrier Name	Mailing Address	Phone

State Accident Took Place	Date of Injury	Claim #	Adjuster/Case Manager

Accident Information ☐ Does Not Apply

Type of Accident ☐ Motor Vehicle ☐ Other (please explain)	Auto Ins / Med Pay Name	Phone

State of Accident	Date of Injury	Adjuster	Phone #	Claim #

Attorney	Mailing Address

Phone	Fax	Has your insurance company been advised of the accident? ☐ Yes ☐ No Comment:

Financial Policy

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also, some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT. In the event the account is turned over for collections, the collection fees and /or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to Patterson Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy. You are also responsible for durable medical equipment purchased at our clinics, which are not covered by your health insurance.

Patient/Parent or Legal Guardian Signature _____ Date _____

Clinic Policy

If you are a patient with both Patterson Physical Therapy, please be aware that insurance will not cover services rendered at both places on the **same** day. We are considered one facility, and only one claim will be accepted by insurance per date of service. If you need service at both facilities, please be sure to plan accordingly. If you visit both locations on the same day, you will be billed for the appointment that is rejected by your insurance. Please be prepared to pay any copay, coinsurance, deductible payments or payments on your balance when you arrive for your appointment. If you are more than **15 minutes** late, we reserve the right to cancel your appointment. If you are a no show for one of your appointments, we will cancel your remaining appointments, and we can only schedule you one appointment at a time after that. If you are a no show to two of your appointments you will be **discharged** from the plan of care.

Initial _____

E-Mail Usage Policy and Consent

By providing your email address, you understand and agree to receive communications which may include, but are not limited to: appointment reminders, exercise programs, billing, scheduling reminders, special announcements, and information to help you during and following your recovery. Patterson Physical Therapy will never share or sell your email address to a third party.

Initial _____ **_____ I don't have an email address**

Consent for Treatment and Authorization

I hereby agree and give my consent for the admission /treatment to Patterson Physical Therapy. I consent to any and all care which my physician, their associates, partners, assistants or designees may deem necessary or advisable, under the general and special instructions of the same, during my treatment. In consideration of the treatment, to be rendered to me by Patterson Physical Therapy, I agree and consent to the following conditions:

1. **Medical Treatment**: I am aware that the practice of medicine is not an exact science and further state that no guarantee has been or can be made as to the results of the treatments or examinations in the center. I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.
2. **Release of Medical Information**: I authorize Patterson Physical Therapy to release medical and supporting documentation of same as complied in the medical records during this treatment for purposes of benefit payment and consultation with other healthcare professionals involved with my treatment. Medical information may also be released to the following:

   _____ **Relationship: _____**

3. **Personal Valuables and Belongings**: It is understood and agreed that Patterson Physical Therapy shall not be liable for the loss or damage of any articles of personal property while I am in treatment.
4. **Liability**: It is understood that Patterson Physical Therapy does not provide any form of health or accident insurance protection and that I assume this responsibility for family members or myself. I further agree that I accept all risks incidental to activities and hereby release Patterson Physical Therapy from all liabilities deriving from pursuit of said activities by myself and/or members of my family.

Initial _____

Additional Consent for Treatment of Dry Needling

Should your physical therapist recommend dry needling as a potential modality to use during your treatment in physical therapy sessions, you will receive dry needling from a physical therapist that has met the requirements of the State Board of Physical Therapy in Tennessee. Dry needling is not acupuncture, but is similar to it in the same sense that acupuncture needles are introduced into the muscles that are causing discomfort. Research and practice show that dry needling can lessen muscle pain and reduce tension and inflammation.

The possible risk of dry needling includes, but are not limited to the following: bruising, infection, extended or temporary nerve injury, temporary muscles soreness, injury to the muscles causing pooling of blood in your tissue, punctured lungs, or release of hormones causing light headedness or fainting. I have been given time to discuss any questions and potential benefits of the nature this procedure. I am aware that there is no guarantee of results, and I am giving my consent to try dry needling as an option with the other more traditional physical therapy treatments.

There will be an additional $5.00 fee per session.

Initial _____ **_____ I decline**

Patient/Parent or Legal Guardian Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physical therapist's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Patterson Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision accreditation, certifications, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintain compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states' public health department. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the providers practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Patterson Physical Therapy Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

I have read and understand the HIPAA Notice of Privacy Practices

Patient/Parent or Legal Guardian Signature _____ **Date** _____

PATTERSON PHYSICAL THERAPY +

Medical History

Patient Name (Please Print)

Please briefly describe your main concern(s):_____
_____

When did it begin? _____ Is it getting ☐ better ☐ worse ☐ staying the same

Location of pain? _____

Pain Description: ☐ Burning ☐ Throbbing ☐ Dull ☐ Achy ☐ Stabbing ☐ Shooting ☐ Other _____

Work activities mostly include (check all that apply) ☐ Retired ☐ Non-employed
☐ Sitting ☐ Lifting ☐ Use of Computer ☐ Bending ☐ Standing ☐ Walking ☐ Driving

When did your current symptoms begin? (date)_____/_____/_____ or (time period) _____

Have you experienced these symptoms before (please explain)? _____

Do you currently exercise, play sports, or have hobbies (if yes, please explain)? _____

How did your injury occur or symptoms begin (check all that apply)?
☐ Accident - Work Related ☐ Bending ☐ Reaching ☐ Lifting
☐ Accident - Motor Vehicle ☐ Gradual Onset ☐ Falling ☐ Other _____
☐ Accident - Third Party / Liability ☐ Dressing ☐ No Apparent Reason

Indicate daily activities you are having trouble with due to this injury or onset of symptoms (check all that apply)?
☐ Sitting _____ minutes ☐ Rising ☐ Lying ☐ Grooming
☐ Standing _____minutes ☐ Turning ☐ Dressing ☐ Bending
☐ Walking _____ feet ☐ Driving ☐ Reaching ☐ Athletics
☐ Sleeping _____ hours ☐ Stairs ☐ Housework ☐ Other _____

What treatment & testing have you received (check all that apply)?
☐ Physical Therapy ☐ Bracing ☐ Injection ☐ Medication
☐ Occupational Therapy ☐ Orthotics ☐ Myelogram ☐ Chiropractic
☐ Nerve Conduction Study ☐ CT Scan ☐ MRI ☐ X-Ray

Please list all surgeries with dates of operation:

Have you fallen in the past year? ☐Yes ☐No If yes, how many times: _____
If yes to falling, did you sustain an injury as a result of the fall? ☐Yes ☐No

Do you experience frequent episodes of the following (check all that apply)?
☐ Headaches ☐ Dizziness ☐ Nausea ☐ Ear Ringing ☐ Loss of Balance

Are you currently receiving home health services or have you within the last 4 weeks? ☐Yes ☐No

Have you had any physical, occupational, or speech therapy this calendar year? ☐Yes ☐No

Do you have or had any of the following (check all that apply)? ☐ Asthma ☐ Cancer ☐ COPD ☐ Diabetes, Type _____
☐ Epilepsy ☐ Fibromyalgia ☐ Heart Condition ☐ Hypertension ☐ Metal Implants ☐ Migraines ☐ Osteoarthritis
☐ Osteoporosis ☐ Pacemaker ☐ PCOS ☐ Peripheral Vascular Disease ☐ Rheumatoid Arthritis ☐ Stroke History
☐ Hearing Problems ☐ Recent Infection ☐ Joint / Muscle Swelling ☐ Scoliois ☐ Thyroid Issues ☐ Other _____

Use the following scales to rate your **average** symptom level (circle the appropriate level for each body part)
"0" = No Pain, "5" = Moderate Pain "10" = Extreme Pain

Low Back: 0 1 2 3 4 5 6 7 8 9 10 Shoulder: 0 1 2 3 4 5 6 7 8 9 10 Pelvic: 0 1 2 3 4 5 6 7 8 9 10

Mid Back: 0 1 2 3 4 5 6 7 8 9 10 Arm: 0 1 2 3 4 5 6 7 8 9 10 Leg: 0 1 2 3 4 5 6 7 8 9 10

Neck: 0 1 2 3 4 5 6 7 8 9 10 Hand: 0 1 2 3 4 5 6 7 8 9 10 Foot: 0 1 2 3 4 5 6 7 8 9 10

Please indicate on the chart below (reference the KEY), where specifically you feel the pain indicated above:

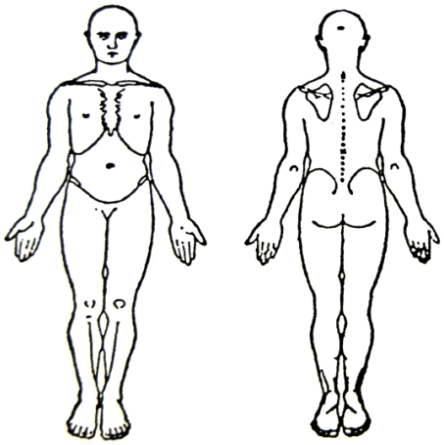
KEY

/ / / / / Stabbing

xxxxx Burning

00000 Pins & Needles

Numbness



Do you take any medications (If Yes, please fill out below or you may provide a list of your medicines):

Prescription Medication	Dosage	Frequency	Medicine Route

Over the Counter Medications (Please check any OTC medications that you take regularly):

☐ Aspirin / Ibuprofen ☐ Antacids ☐ Cough Medicine ☐ Cold Medicine ☐ Vitamins

☐ Allergy Relief ☐ Laxatives ☐ Sleeping Aids ☐ Diet Pills ☐ Other _____

Do you have allergies to ☐ Latex ☐ Lidocaine ☐ Cortisone ☐ None Known ☐ Other: _____

Do you ☐ Smoke ☐ Vape ☐ Chew Amount _____

My next appointment with my doctor is on _____/_____/_____ ☐ No appointment scheduled

Patient Name (Please Print)	
Patient Signature:	Date:
Therapist Signature:	Date:

PATTERSON PHYSICAL THERAPY +

Pelvic Floor ☐ Does Not Apply

Please indicate your current symptoms on the following:

Occurrence of incontinence or leakage
☐ Never ☐ Less than 1/month ☐ Less than 1/week ☐ # _____ leak per day
☐ Almost every day ☐ More than 1/month ☐ More than 1/week

Protection used
☐ No protection ☐ Panty shields ☐ Mini Pad ☐ Maxi Pad ☐ Depends

Severity
☐ No leakage ☐ Few Drops ☐ Wet underwear ☐ Wet Outerwear

Position or activity with leakage
☐ Lying down ☐ Sitting ☐ Standing ☐ Strong Urge ☐ Changing positions ☐ Sexual activity

How long can you delay the need to urinate
☐ Indefinitely ☐ 1 + hours ☐ ½ hour ☐ 15 minutes
☐ Less than 10 minutes ☐ 1-2 minutes ☐ Not at all

Activity that causes urine loss
☐ Vigorous activity ☐ Moderate activity ☐ Light activity ☐ No activity ☐ Type: _____

Frequency of urination (daytime) ☐ 0 time per day ☐ 1-4 ☐ 5-8 ☐ 9-12 ☐ 13+

Frequency of urination (nighttime) ☐ 0 ☐ 1-2 ☐ 3-5

Prolapse (Falling out feeling) ☐ Never ☐ Occasionally / with menses
☐ Pressure - end of the day ☐ Pressure with straining ☐ Pressure with standing ☐ Perineal pressure all day

Fluid intake (includes water and other beverages) Based on **8 oz. glasses a day**
☐ 9+ ☐ 6-8 ☐ 3-5 ☐ 1-2 ☐ How many caffeinated glasses _____

After starting to urinate, can you completely stop the urine flow?
☐ Can stop stream completely ☐ Can slow stream ☐ Unable to slow or stop stream at all

Do you have trouble initiating a urine stream?
☐ Never ☐ More than 1/month ☐ Less than 1/week ☐ Almost every day ☐ Everyday # _____ of times per day

Frequency of bowel movements
☐ 2 times per day ☐ 1 time per day ☐ Every other day ☐ Once every 4-7 days ☐ Weekly

Confidence in controlling your problem?
☐ Complete confidence ☐ Moderate confidence ☐ Little confidence ☐ No confidence

Are you sexually active? ☐ Yes ☐ No Do you have pain with sex? ☐ Yes ☐ No

Are you pregnant or attempting pregnancy? ☐ Yes ☐ No
Number of pregnancies: _____ Complications: _____

History of present sexually transmitted disease? ☐ Yes ☐ No If yes, describe: _____

Have you ever been taught or prescribed to do pelvic floor / Kegel exercises? ☐ Yes ☐ No If yes, how often: _____
If yes, when: _____ By whom: _____

Patient Name (Please Print):

Patient Signature:	Date:
Therapist Signature:	Date: