PATIENT INFORMATION SHEET

WELCOME TO FAIRHOPE PHYSICAL THERAPY

Patient's Name:_____Date of birth:_____
Social Security Number:_____Age:_____Sex: M F
Address:_____
City:_____State:_____Zip code:_____
Home Phone Number: ( )_____ Work:( )_____Cell( )_____
Is it OK to contact you by our cell number: Yes No

Patient Employer:_____Student:_____
Occupation:_____
Marital Status:◯Single ◯Married ◯Divorced ◯Widow
Spouse's Name:_____Parent's Name if minor:_____
Emergency Contact:_____Relationship:_____Phone:( )_____
Referring Physician:_____
Are you currently receiving home health services or been recently discharged from home health?
◯ Yes ◯ No
If yes, how many?:_____ Discharge date?_____
Have you had physical/speech or occupational therapy this year? ◯ Yes ◯ No
If yes, how many visits?_____
Date of last visit with physican:_____Next appt:_____

Type of injury:◯ Workers Compensation ◯ Auto Injury ◯Other

***********COPY OF INSURANCE CARD AND DRIVERS LISCENSE IS REQUIRED*************

Primary Insurance:_____

Name of insured:_____

Relationship to patient:_____DOB (Insured):_____

Social Security Number:_____Policy Number:_____

Secondary Insurance(if any):_____

I hearby authorize Fairhope Physical Therapy Services Inc. to furnish insurance carriers information concerning my treatments. I authorize the release of medical records to these companies and to other physicians for the purpose of continuity of care.

Signature of responsible party:_____Date:_____

Fairhope Physical Therapy Services, Inc.

Patient name:_____Date of birth:_____Date:_____

Please list individually the names of your medications, dosage of your medications, frequency and route of your medications.

Medication	Dosage	Frequency	Route
(Example) Aspirin	***81mg***	***Daily***	***By mouth***

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Name:_____Date of first visit:_____

Date of birth:_____Age:_____Height:_____Weight:_____

Date of onset of problems:_____Auto/Work/Sport related_____

Do you participate in any sports/recreational activities:_____

What are your personal goals you want to achieve in PT/OT?_____

Do you have implants in your body?◯ Yes ◯No Type:_____

Have you had any surgical procedures/hospitalizations◯ Yes ◯ No

DATE	Reason for surgery or hospitalization

Please list any previous treatment for your current condition:_____

Did those treatments help?: ◯ Yes ◯ No

Do you have allergies? (bee stings, latex, medications, skin sensitivity, etc):_____

Do you smoke:◯ Yes ◯ No Do you consume alcoholic beverages:◯ Yes ◯ No

If you are a female is there a possibility that you are pregnant:◯ Yes ◯ No

Please check if you have a history of any of the following:

◯ Stomach disorders◯ High blood pressure◯ Arthritis◯ Asthma◯ Heart disease◯ Pacemaker

◯ Hepatitis◯ Psychiatric◯ Diabetes◯ Bleeding disorder◯ Blood clot◯ Cancer◯ Seizures

◯ Bowel/Bladder◯Osteoporosis◯ Thyroid◯ Orthopedic Surgery

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PAIN QUESTIONAIRE

Name:_____Date:_____

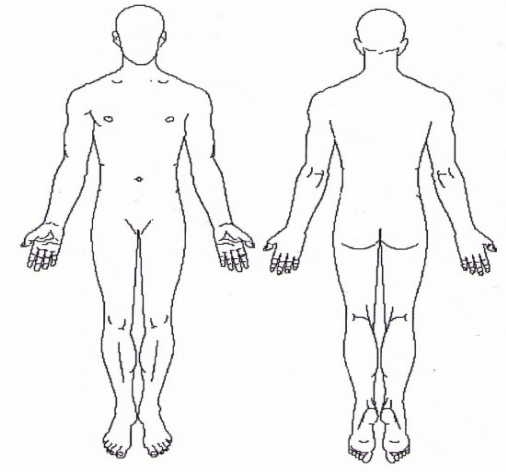
Indicate the quality of your symptoms. (Mark all that apply):

◯ Constant ◯ Intermittent ◯ Dull ◯ Sharp ◯ Ache ◯ Other:_____

It is worse in the:◯ Morning ◯ Daytime ◯ Evening ◯ At work ◯ Other:_____

Please indicate the type and location of your pain in the picture below:

Burning, Pinching, Stabbing, Aching, Pins and needles etc….



Rate your current pain by circling the corresponding number. Zero would be no pain. Ten would be pain that would send you to the emergency room.

1.1 2 3 4 5 6 7 8 9 10

Provoking and alleviating factors:

What makes your pain better:_____

What is your realistic pain goal?:_____

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Do we have your permission to leave a message on your answering machine/voice mail with a family member or legal representative regarding appointments, billing or other matters regarding your treatment?

◯ Yes ◯ No ◯ Other (email) _____

May we call you at work? ◯ Yes ◯ No

ACKNOWLEDGEMENT

Patient name:_____

Patient or personal representative signature:_____Date:_____

If personal representative's signature appears above, please describe personal representative's relationship to patient._____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided the Notice of Privacy Practices from Fairhope Physical Therapy Services, Inc.

It informs me of how Fairhope Physical Therapy will use my health information for the purposes of my treatment, payment for my treatment and health care operations.

The notice explains in more detail how Fairhope Physical Therapy may use and share my health information for other than treatment, payment, and health care operations.

Fairhope Physical Therapy will also use and share my health information as required/permitted by law.

Patient's **complete legal name** (please print)_____

Patient's Date of Birth_____ Todays date_____

Signature_____
Patient or legal representative*

*May be requested to show proof of representative status

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WELCOME TO FAIRHOPE PHYSICAL THERAPY

Please take a moment to review our payment policies. Our office staff will be happy to answer any questions you may have.

Payment Policies

Since we are a Medicare Rehabilitation provider, our billing office will file claims for your services directly with Medicare and any supplemental insurance you may have. You will be responsible for paying any unmet deductibles. You will be responsible for paying 20% co-insurance if you do not have supplemental insurance.

Financial Responsibility

We will make any effort to inform you of any charges necessary for your treatment that is not covered by Medicare or your supplemental insurance. All charges that are not covered are your responsibility to pay. We ask that you make payment to us for any non-covered items at the **end of each visit**.

The following services that are provided by Fairhope Physical Therapy, upon physician's request, or are not covered by Medicare:

Electrodes (used with electrical stimulation treatment)	$10.00 (one time charge)
Orthotics, heel lifts, heel cups	prices vary
Supplies	prices vary
TENS Unit	$50.00

Therapy services that are denied for medical necessity reasons

I have read and understood the payment policies of Fairhope Physical Therapy Services:

Signature:_____Date:_____