PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Date: _____ Account #: _____

Patient Name: _____

Address:

_____

Home Phone: _____ Cell Phone:_____
*Which number(s) is our staff authorized to leave phone messages?
Home_____ Cell_____

Date of Birth: _____ SS#:_____

Sex: M F Marital Status: S – M – D – W Email _____

In Case of an Emergency Call: _____

Name Relation to Patient _____ Phone _____

Patient Employer Name: _____

Address:

_____

Phone: _____*May we contact you at this number? Y___ N___

Insurance Company Name:

_____
(for internal use: benefits verification completed _____)

How did you hear about us?: (mark all that apply)

___physician ___self-research ___internet ___advertising (type_____)
___friend (name_____) ___other_____

Referring Physician's Name: _____ Phone_____

Physician's Address:

_____

Name of Primary Care Physician:_____

Women: Name of OB/GYNE: _____

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Medical History

Name: _____ **Account #:** _____ **Date:** _____
Date of birth and age:_____

Date last seen by your Physician for this condition?_____
Have you been treated this year by a physical or speech therapist?_____
Have you been treated this year by an acupuncturist or chiropractor?_____
Have you received Home Health treatment or services in the last 30 days? _____
Are you currently receiving other care for this condition? _____
At the present time, would you say that your health is: ____excellent ____very good ____fair____poor?

Please mark the medical conditions that apply:

- ☐ Arthritis
- ☐ Broken Bones/Fracture
- ☐ Blood disorders
- ☐ Circulatory / Vascular Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Cancer-type _____
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes / High Blood Sugar
- ☐ Low Blood Sugar / Hypoglycemia
- ☐ Kidney Problems
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Skin Disorders
- ☐ Head Injury
- ☐ Prostate Conditions
- ☐ Neurological Problems
- ☐ Depression

Other (please describe):_____

Allergies (list):_____

Medications (list):_____
_____
_____

Recent Medical Testing:_____

Surgeries (include date):_____
_____
Do you have metal/hardware in your body as a result of surgery?_____

Have you experienced any of the following symptoms during the last year?

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Dizziness or Blackouts
- ☐ Joint Pain or Swelling
- ☐ Pain at Night
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Bowel Problems
- ☐ Urinary Problems
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Headaches
- ☐ Weight Loss or Gain
- ☐ Coordination Problems
- ☐ Weakness in Arms or Legs

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Patient Name _____ Acct.# _____ Date_____

PATIENT DOCUMENTATION OF CURRENT MEDICATIONS

Medicare requires all Medicare patients to document their current list of medications. This list must include ALL prescription medications that you are currently taking, over the counter medications and ALL herbal/vitamin/mineral/dietary/nutritional supplements. You MUST document the medication name, dosage, frequency and route of administration below. Please use more than one sheet if needed.

Medication **OTC** **Supplement**	**Dosage**	**Frequency**	**Route of Administration** **(oral, topical, suppository, intravenous)**

I _____, do herby attest that this information is true, accurate

(Patient Name - Please Print) and complete to the best of my knowledge.

_____ _____

Patient / Guardian Signature Date

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Patient _____ Date _____

Check Your Risk for Falling

Please circle "Yes" or "No" for each statement below.			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are liked to falls.
Total _____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

Reviewed by _____ Date _____

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

PATIENT CONSENT FORM Account# _____

Please read and sign below - All information provided herein is true and correct:

Consent to Treatment: I consent to physical therapy treatment at Pelvic & Orthopedic Physical Therapy Specialists (POPTS) under the prescription of my referring practitioner.

Information Release: I give permission to POPTS) to release information, verbal and written, contained in my medical record, and other related information, to my physician, insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons.

Privacy of Information: I acknowledge that POPTS has made available a copy of their HIPAA Privacy Policy, located in the waiting area of the clinic. A copy may be obtained for my records by request. Information without patient identifiers may only be used for quality assurance and/or outcomes purposes (i.e.-research).

Payment Responsibility: I expressly guarantee full payment of this account for all services rendered by POPTS. Regardless of my quoted insurance benefits, I understand that I am fully responsible for all charges incurred. POPTS will file all claims to my insurance carrier and my insurance carrier will either: 1) reimburse POPTS directly if they are in-network with my insurance plan, or 2) reimburse me for these services and I am then responsible to remit payment in full to POPTS. If I have insurance benefits for physical therapy, I am expected to remit payment at each visit for my quoted deductible balance, coinsurance or copayment.

Cash Payment – No Insurance: If I have no insurance coverage to be billed by POPTS, I understand that payment is due in full to POPTS at the time of service. POPTS's cash patient option provides a 15% discount off of total treatment charges (does not apply to durable goods purchased).

Medicare Patients: I have been informed that Medicare applies a combined 2018 annual limitation for physical therapy and speech language pathology services of $2,010.00. I understand that I am responsible for my 2018 annual deductible of $183.00, any remaining balance after Medicare and my supplement have paid, and 100% of the charges if I exceed the $2,010.00 annual limitation. I have also been informed that Medicare does not allow for any overlap of outpatient physical therapy services with home health care and/or services provided at a skilled nursing facility. It is my responsibility to confirm my home health discharge date. I am responsible for all charges denied by Medicare that overlap with home health care.

Durable Goods Payment: I have been informed that my insurance may not cover charges incurred for any durable goods purchased, including sales tax. I am responsible to pay all durable goods in full at the time of service. POPTS can provide me a receipt for such purchases that I can submit to my insurance for possible reimbursement. I understand that I am fully responsible for all charges incurred.

Auto Insurance Patients: I have been informed that POPTS will not bill third-party auto insurance carriers, as they will not pay my medical bills until the claim is settled. POPTS will bill all claims to either my confirmed auto carrier and/or my health insurance for charges related to an auto accident. It is my responsibility to inform POPTS if my auto insurance medical benefits have been exhausted at any time during my course of treatment with POPTS. My auto insurance carrier will not inform POPTS when I reach or exceed the medical benefit. I am fully responsible for all unpaid balances, including all deductible, coinsurance or copayments at the time of service.

X_____

Patient Signature (or Guardian if a minor) Date Rev. 01/01/18

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Patient Cancellation Policy

We take great pride in the TIME and SERVICE we provide to our patients. We take your time very seriously and are committed to serving you with the highest level of respect, integrity and in the most cost-effective manner.

While some patient cancellations are inevitable, cancellations with less than 24-hours notice, missed appointments (no-shows), arriving late or leaving early from an appointment, have unfortunately become a great expense to our organization.

Our cancellation policy:

- **There will be a $75.00 charge for each appointment cancellation with less than 24-hour notice and each no-show appointment.**

- **There will be a $25.00 charge for each 15 minutes you arrive late to an appointment or depart early from an appointment.**

Patient to complete and sign:
I have read and understand the above Cancellation Policy. As an active patient of **Pelvic & Orthopedic Physical Therapist Specialists** , I will adhere to this policy and will be financially responsible for any fees incurred as a result of this policy.

_____ _____
Patient Signature Date

_____
Patient Name

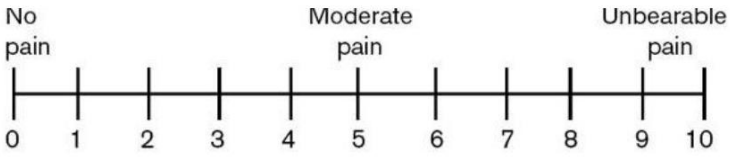
(Rev. 01/01/2018)

PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

Patient Name_____ Acct#_____ Date_____

VISUAL PAIN SCALE

Please mark the number on the line that corresponds to your current level of pain



PAIN BODY MAP

Please indicate the location of any and all current pain and/or irritation on the body diagram