



## Patient Information Form

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Referring Dr \_\_\_\_\_ Dr Phone # \_\_\_\_\_

Family Dr \_\_\_\_\_ Dr Phone # \_\_\_\_\_

Date of Injury \_\_\_\_\_ Primary Problem \_\_\_\_\_

Work Related: [ ] Yes [ ] No if yes; State \_\_\_\_\_ Claim # \_\_\_\_\_

MVA or Personal Injury: [ ] Yes [ ] No if yes; State \_\_\_\_\_ Attorney's Name \_\_\_\_\_

Are you currently receiving Home Health Care? \_\_\_\_\_

### PATIENT INFORMATION

Patient's Full Name \_\_\_\_\_ Home Ph# \_\_\_\_\_ Cell Ph# \_\_\_\_\_

Street Address \_\_\_\_\_ Work Ph# \_\_\_\_\_

City, State, Zip \_\_\_\_\_ E-mail \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ [ ] Male [ ] Female

Employer & Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder Birth Date \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_

#### If there is a secondary insurance, complete the following:

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder Birth Date \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

ARE YOU CURRENTLY WORKING? YES NO OCCUPATION \_\_\_\_\_

NEXT APPOINTMENT WITH PHYSICIAN? \_\_\_\_\_

**PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:**

- |   |  |
|---|--|
| <input type="checkbox"/> ANGINA         | <input type="checkbox"/> HEART ATTACKS                 |
| <input type="checkbox"/> STROKES        | <input type="checkbox"/> HEART SURGERY                 |
| <input type="checkbox"/> TUMORS         | <input type="checkbox"/> DIABETES                      |
| <input type="checkbox"/> EPILEPSY       | <input type="checkbox"/> GASTROINTESTINAL PROBLEMS     |
| <input type="checkbox"/> ALLERGIES      | <input type="checkbox"/> CIRCULATORY PROBLEMS          |
| <input type="checkbox"/> OSTEOPOROSIS   | <input type="checkbox"/> NERVOUS OR EMOTIONAL PROBLEMS |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> GOUT                          |
| <input type="checkbox"/> NECK INJURIES  | <input type="checkbox"/> FRACTURES (BROKEN BONES)      |
| <input type="checkbox"/> BACK INJURIES  | <input type="checkbox"/> DISLOCATIONS (JOINTS)         |
| <input type="checkbox"/> WHIPLASH       | <input type="checkbox"/> HEART DISEASE                 |
| <input type="checkbox"/> CANCER         | <input type="checkbox"/> HIGH BLOOD PRESSURE           |
| <input type="checkbox"/> LUNG DISEASE   | <input type="checkbox"/> ALCOHOL ABUSE PROBLEMS        |
| <input type="checkbox"/> ARTHRITIS      | <input type="checkbox"/> JAW INJURIES/TMJ              |
| <input type="checkbox"/> JOINT SPRAINS  | <input type="checkbox"/> MUSCLE STRAINS                |

**CHECK THE FOLLOWING BOXES IF YOU HAVE RECENTLY EXPERIENCED:**

- |  |  |
|--|--|
| <input type="checkbox"/> HEADACHES             | <input type="checkbox"/> MUSCULAR PAIN WITH EXERTION         |
| <input type="checkbox"/> FALLS                 | <input type="checkbox"/> MUSCUALR PAIN AT REST               |
| <input type="checkbox"/> DIFFICULTY SLEEPING   | <input type="checkbox"/> CONSTANT PAIN UNRELIEVED BY REST    |
| <input type="checkbox"/> TREMORS               | <input type="checkbox"/> CHANGE IN BOWEL OR BLADDER HABBITS  |
| <input type="checkbox"/> BALANCE PROBLEMS      | <input type="checkbox"/> UNUSUAL FATIGUE OR WEAKNESS         |
| <input type="checkbox"/> BLURRED/DOUBLE VISION | <input type="checkbox"/> UNUSUAL SKIN COLORATION             |
| <input type="checkbox"/> DIZZINESS             | <input type="checkbox"/> UNEXPLAINED WEIGHT LOSS             |
| <input type="checkbox"/> SHORTNESS OF BREATH   | <input type="checkbox"/> TINGLING, NUMBNESS, LOSS OF FEELING |
| <input type="checkbox"/> HOARSENES             | <input type="checkbox"/> PAIN WITH COUGHING OR SNEEZING      |

**PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS:**

\_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_ DATE \_\_\_\_\_

**DO YOU SMOKE? YES NO IF YES, HOW MANY PACKS PER DAY? \_\_\_\_\_**

**DO YOU CONSUME ACOHOL? YES NO IF YES, HOW OFTEN? \_\_\_\_\_**

**ARE YOU PREGNANT? YES NO**

**ARE YOU ALLERGIC TO LATEX? YES NO**

**ARE YOU ALLERGIC TO ANY MEDICATION? YES NO IF YES, PLEASE LIST: \_\_\_\_\_**

**PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING: \_\_\_\_\_**

**PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED**

\_\_\_ X-RAYS            DATE \_\_\_\_\_            RESULTS \_\_\_\_\_  
\_\_\_ MRI              DATE \_\_\_\_\_            RESULTS \_\_\_\_\_  
\_\_\_ CAT SCAN        DATE \_\_\_\_\_            RESULTS \_\_\_\_\_

**PLEASE DESCRIBE YOUR PROBLEM**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN**

\_\_\_ CONSTANT        \_\_\_ INCREASING        \_\_\_ NIGHT PAIN        \_\_\_ DULL/ACHY PAIN  
\_\_\_ INTERMITTENT    \_\_\_ DECREASING        \_\_\_ STIFFNESS        \_\_\_ PAIN UPON WAKING  
\_\_\_ OCCASIONAL     \_\_\_ STATIC              \_\_\_ SHARP PAIN

PAIN IS AGGRAVATED BY \_\_\_\_\_

PAIN IS EASED BY \_\_\_\_\_

HAVE YOU BEEN TREATED BY A **PHYSICAL THERAPIST**? YES NO **CHIROPRACTOR** YES NO

IF YES, APPROXIMATE DATE \_\_\_\_\_

WHAT WERE YOU TREATED FOR? \_\_\_\_\_

I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONNAIRE TO THE BEST OF MY KNOWLEDGE: \_\_\_\_\_

SIGNATURE

DATE

PARENTAL CONSENT FOR MEDICAL TREATMENT

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Social Security # (child)

\_\_\_\_\_  
Date of Birth (child)

**\*\*Parent/Guardian's Information\*\***

\_\_\_\_\_  
Name

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Work Phone #

This consent serves as permission for treatment by Mountaineer Physical Therapy.  
I agree to pay for all services provided to my child.

Signatures:

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## MOUNTAINEER PHYSICAL THERAPY FINANCIAL POLICY

We are committed to provide you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our *Financial Policy* is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

All patients must complete our *Patient Information, Medical History, and Financial Policy* forms before being treated.

**REGARDING INSURANCE:** Insurance is a contract between you and your insurance carrier. **We strongly encourage you to contact your insurance carrier to determine what coverage they provide for physical therapy.** We cannot guarantee what your insurance carrier will pay. We file insurance claims as a courtesy to our patients. You must provide all necessary information for us to assist you with your billing. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other than to supply factual information as necessary. Some medical equipment and supplies may not be a covered service in your insurance plan; therefore, you are responsible for those charges. You are responsible for the timely payment of your account.

**HMO/POS:** If you are covered by any of these, your co-payment is due at the time of service.

**MEDICARE:** We are providers for Medicare, and we will take the responsibility of submitting your claim for you. We will bill your secondary insurance if applicable. However, you are responsible for the deductible if it has not been met at the time of service, and the co-insurance if there is no secondary insurance.

**AUTO ACCIDENTS AND PERSONAL INJURY:** If you have been injured due to a motor vehicle accident or from personal injury, please inform us upon registration. Arrangements must be made with the billing department regarding your account.

We accept payment by **cash, check, Visa or MasterCard.**

*I understand and accept the conditions of this financial policy.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## GENERAL OFFICE INFORMATION

Welcome to Mountaineer Physical Therapy. We look forward to serving your physical therapy needs and wish you a speedy recovery.

**Cancellation Policy:** Appointment times are reserved exclusively for you. If you are unable to keep your appointment, we request 24 hours notice to allow us time to offer that appointment to someone else. There is a \$15.00 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid personally.

**NOTE:** This policy does not apply to Workers' Compensation and Medicaid patients. For Workers' Compensation and Personal Injury patient's, documents of any missed or cancelled appointments are forwarded to your case manager and primary care doctor and this could jeopardize your claim, prolong or stop any benefits you may be entitled to.

We do understand that extenuating circumstances sometimes occur for missing appointments and should be discussed with the front office.

**Authorization for Release:** I hereby authorize Mountaineer Physical Therapy to release any information concerning my care to the appropriate individuals of insurance companies and physicians. I accept full responsibility for any deductibles and co-insurance, or any amount not covered by my insurance company for service rendered to me by this facility. I authorize payment of medical benefits to Mountaineer Physical Therapy.

**Treatment Consent Authorization:** I am fully aware of my medical diagnosis and I give my consent to Mountaineer Physical Therapy to provide treatment for my condition.

**Medicare Signature on File:** I authorize payment of my Medicare Benefits to Mountaineer Physical Therapy for services rendered.

**Primary/Secondary Insurance Signature on File:** I authorize payments of my medical benefits to Mountaineer Physical Therapy for services rendered.

**Notice of Privacy Practices:** I have received a copy of Mountaineer Physical Therapy's Notice of Privacy Practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- Home Telephone\_\_\_\_\_
    - O.K. to leave message with detailed information
    - Leave message with call back number only
  
  - Work Telephone\_\_\_\_\_ul style="list-style-type: none;">  - O.K. to leave message with detailed information
  - Leave message with call back number only
- 
- Written Communication
  - O.K to mail to my home address
  - O.K. to mail my work/office address
  - O.K. to fax to this number\_\_\_\_\_
- 
- Other\_\_\_\_\_

I have been offered a copy of the HIPAA privacy rule. If I have any questions regarding this matter I will notify MPT in writing. I am fully aware that my Protected Health Information will not be released unless for: Treatment, Payment, Health Care Operation (or to request other medical notes)

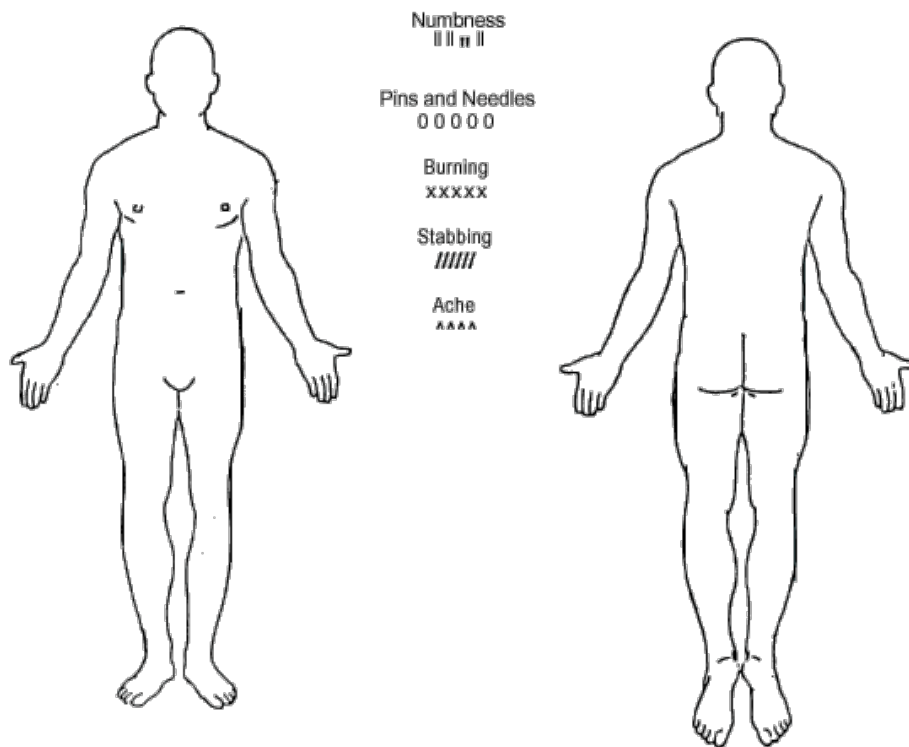
Patient Signature\_\_\_\_\_

Date\_\_\_\_\_

**PLEASE COMPLETE THE ENTIRE PAGE**

NAME: \_\_\_\_\_  
 DATE: \_\_\_\_\_

**Please use the following diagram below to indicate where you feel symptoms right now. Use the key below to indicate the different type of pain or location of problem.**



**Please use the scales below to rate your pain over the past 24 hours also rate your pain at its worst and best over the past 24 hours.**

**CIRCLE YOUR ANSWERS**

0 = No Pain 10 = Max. Pain

Right Now:                    0 1 2 3 4 5 6 7 8 9 10  
 Worst In Past 24 Hours:    0 1 2 3 4 5 6 7 8 9 10  
 Best In Past 24 Hours:     0 1 2 3 4 5 6 7 8 9 10

Comments:

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