PATIENT INFORMATION

Name:		Date:	DOB:
Age:	If minor, guarantor name:		Guarantor DOB:

Mailing Address:_____Bldg/Apt/Ste_____

City/State/Zip**:**_____E-mail:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____

Would you like to be sent text alerts reminding you of your next appointment? ◯ Yes ◯ No

If yes, what phone number do you prefer to receive text messages: (_____)_____
(Standard text messaging rates may apply)

Social Security #:_____ If minor, guarantor SS#:_____

Occupation:_____ Employer:_____

Primary Care Physician or Referring Doctor contact information:

Doctor Name:_____ Phone Number:(_____)_____

Emergency contact(s) information:

Name:_____Relation:_____Phone#:(_____)_____

Name:_____Relation:_____Phone#:(_____)_____

Are you the primary insured on this health plan? ◯ Yes ◯ No

If no, who is the insured individual? ***(List Below)***

Name:_____Relation:_____DOB:_____SS#:_____

Insurance Plan:_____ Policy#:_____Group#:_____

How did you hear about us? ***(Pease check all that apply)***

◯ **Google** ◯ **Facebook** ◯ **Yelp** ◯ **Friend/Relative** ◯ **Other:**_____

Is your visit today related to an automobile accident? ◯ Yes ◯ No *If yes, date of accident*:_____

Is your visit today related to a work injury? ◯ Yes ◯ No *If yes, date of injury*:_____

Is there any legal action pending that pertains to your visit today? ◯ Yes ◯ No

If yes, describe:_____

Medicare Patients Only:
Have you had Physical Therapy and/or Speech Therapy previously this year? ◯ Yes ◯ No
Have you had a home health episode this year? ◯ Yes ◯ No

I certify that the above information is true and correct:

Patient or Guardian Signature:_____**Date**:_____

****Please note that proof of identity is required for all patients, please bring with you a photo ID on the day of your first therapy appointment.****

PATIENT MEDICAL HISTORY

Name:	Height:	Current Weight:	Age:

1. What is your reason for seeing a Physical Therapist today?_____
   _____
   (IF WE ARE TREATING YOUR KNEES PLEASE BRING SHORTS TO EVERY APPOINTMENT.)

2. When did your problem, pain, or injury begin?_____

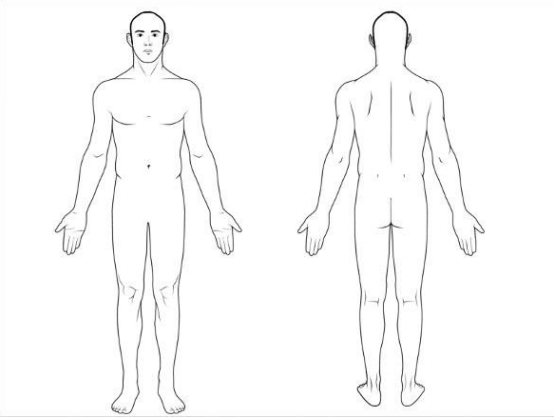
3. How did your problem start? ***(Please check all that apply)***
   ◯ Suddenly ◯ Slowly over time ◯ During sports ◯ At work ◯ Fall ◯ Lifting ◯ Pulling ◯ Auto accident ◯ No cause

4. What are your symptoms? ***(Please check all that apply)***
   ◯ Pain ◯ Swelling ◯ Redness ◯ Bruising ◯ Spasm ◯ Weakness ◯ Tingling
   ◯ Locking ◯ Catching ◯ Give way ◯ Other: _____

5. If you have pain, describe it. ***(Please check all that apply)***
   ◯ Constant ◯ Intermittent ◯ While at rest ◯ At night ◯ With activity ◯ Burning
   ◯ Aching ◯ Sharp ◯ Dull ◯ Other: _____

6. Indicate where your symptoms are located and what type of symptom(s) you are experiencing using the **symbols** listed below. ***(Do not indicate areas of symptoms which are not related to your current injury/condition.)***

Key symbols:	
////	*Stabbing*
XXX	*Burning*
000	*Pins/Needles*
===	*Numbness*



7. Please draw a line straight up and down indicating your pain level on the line scale **below**.

   _____

   No pain ***Moderate pain*** ***Severe pain***

8. What reduces your symptoms? ***(Please check all that apply)***
   ◯ Sitting ◯ Lying down ◯ Stopping activities ◯ Standing ◯ Walking ◯ Medication
   ◯ Physical activity ◯ Ice ◯ Heat ◯ Other: _____

9. What makes your problem worse? ***(Please check all that apply)***
   ◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Cough/sneeze ◯ Exercise (During)
   ◯ Exercise (After) ◯ Other: _____

10. Have you had any diagnostic tests done for this problem (Example: X-Ray, MRI, CT Scan)? ◯ Yes ◯ No
    If yes, specify:_____ When:_____

11. Were you seen in the emergency room for this problem? ◯ Yes ◯ No. *If yes, when*: _____

12. Have you, the patient ever been diagnosed with any of the following conditions? **(Check all that apply)**

- ◯ Vision or hearing problems
- ◯ Thyroid problems
- ◯ Asthmas or emphysema
- ◯ High blood pressure
- ◯ Heart problems
- ◯ Bleeding problems
- ◯ Blood Clots
- ◯ Stomach problems/ulcers/reflux
- ◯ Bowel or bladder problems
- ◯ Kidney disease /failure
- ◯ Diabetes
- ◯ Bone or joint problems
- ◯ Arthritis or rheumatism
- ◯ Incontinence/loss of bladder control
- ◯ Depression
- ◯ Gout
- ◯ Osteoporosis
- ◯ Cancer
- ◯ Skin disorders
- ◯ Seizures or epilepsy
- ◯ Stroke
- ◯ Balance problems
- ◯ Contagious conditions
  - ◯ HIV / ◯ TB / ◯ Hepatitis
- ◯ None of the above

13. Please list all previous surgeries, hospitalizations, or broken bones.

Body area: _____ Date: _____ Body area: _____ Date: _____
Body area: _____ Date: _____ Body area: _____ Date: _____
Body area: _____ Date: _____ Body area: _____ Date: _____
Body area: _____ Date: _____ Body area: _____ Date: _____

14. Please list <u>ALL</u> your current medications and their doses. (Include "over-the-counter" meds and herbals.)

Med:_____ Dose: _____ Frequency:_____ ◯ Oral /◯ Injection /◯ Topical
Med:_____ Dose: _____ Frequency:_____ ◯ Oral /◯ Injection /◯ Topical
Med:_____ Dose: _____ Frequency:_____ ◯ Oral /◯ Injection /◯ Topical
Med:_____ Dose: _____ Frequency:_____ ◯ Oral /◯ Injection /◯ Topical

(Attach additional sheet if necessary, for any additional medications.)

15. Are you, or could you be pregnant? ◯ Yes ◯ No. *If yes, when is your due date?*_____

16. What is your occupation? _____ What are your physical requirements of job? *(Please Explain)*

_____

17. Do/did you use tobacco? ◯ Yes ◯ No. If yes, how much? _____ Quit when? _____

18. Do you drink alcoholic beverages? ◯ Yes ◯ No. How much?_____

19. Have you ever been addicted to prescription or non-prescription drugs? ◯ Yes ◯ No*. If yes, which?*_____

20. Do you live alone? ◯ Yes ◯ No

21. What type(s) of exercise do you do?_____ Frequency?:_____

22. What would you like to accomplish with physical therapy? ***(Please check all that apply)***

◯ Return to sport/hobby/recreation ◯ Return to work ◯ Improve function ◯ Improve strength and motion
◯ Decrease pain ◯ Other: _____

Conditions of Service Agreement

- **Cell Phone Policy:** Please be courteous to our staff and patients by silencing your cell phones during therapy. If you need to take a call for emergency purposes, please notify the therapist before the start of your treatment.
- **Confidentiality:** Clinical records are safeguarded at the facility and are not to be taken off the premises, unless locked securely in a locked briefcase. The patient's written consent is required for the release of information not authorized by law.
- **HIPAA:** Think Back Physical Therapy abides by HIPAA Privacy Practices. If you would like a copy of our HIPAA Policy, it can be provided to you upon request.
- **Assignments of Benefits:** I authorize direct payment to Think Back Physical Therapy of all medical benefits applicable to my treatment at this facility.
- **Release of Information:** I authorize Think Back Physical Therapy to release any information related to my treatment to my insurance company, physician, or any third party payer as necessary to collect payment for services.
- **Consent for Medical Treatment:** I authorize the staff at Think Back Physical Therapy to treat me and create an appropriate treatment plan with the input of the referring clinician.
- **Consistency in Treatment:** Consistency in treatment is vital to your progress and recovery. Please make every effort to keep your appointments. If unable to do so, please kindly give us **24 hour** notice.
- **Missed/No Show Appointments:** If you miss your appointment without calling to cancel your appointment with less than 24 hour notice you will be charged a **$25.00** fee due at your next appointment, which your insurance will not pay. If you miss two or more appointments without calling to cancel, you will be discharged for non-compliance and your referring physician and insurance carrier will be notified. This fee may be deducted from monies previously paid on your account.
- **Late for Appointment:** If you are **15 minutes** or later for any appointment you will have to reschedule your appointment.

Finance Policy and Agreement

- **Insurance Coverage:** We will be happy to bill your insurance for you and assist you with dealing with your insurance company. However, please understand that your insurance policy is a contract between you and them, not with us. The information quoted to us is just a quote and is **NOT** a guarantee of benefits or payment. As a result, any denied claims due to drop of health coverage or miss-quote a self-pay rate will be applied to each date of service not paid by insurance. You, the patient or guardian, are ultimately responsible for all charges incurred.
- **Medicare Patients:** Think Back Physical Therapy is a participating provider; therefore all covered services will be billed for you. If you have secondary insurance coverage, it will be filed by the practice. You are responsible for the coinsurance and deductible amounts not covered by secondary insurance, and non-covered services.
- **Centennial/ Worker's Compensation Patients:** We bill all services directly. If services are denied for reasons of eligibility /cancelation, or denied workers compensation, payment in full will be expected at time of service.
- **Managed Care/Commercial Plans (HMO, PPO):** Co-pays and/or coinsurance amounts are due at the time of service. If your insurance plan requires prior authorization, this will be obtained by the practice before your visit. Benefits will be verified by our business office, and claims not payed within 45 days must be paid using the approved payment methods.
- **Third Party:** Think Back does **NOT** accept third party payers. We will be happy to bill claims to your health or auto insurance as a result from an auto accident. If med pay available you the patient must keep track of funds, if med pay exhausted we can bill additional claims to your health insurance. You the patient are ultimately responsible for all charges incurred.

*If you have questions or concerns about the aspect of our finance and/or conditions policy, please feel free to discuss them with us at your appointment or by phone at (505) 883-7518. Also, a service charge of **1.5%** per month will be applied on all account(s) balances over 30 days old.* ***I have read and acknowledge my understanding of the above information regarding Think Back Physical Therapy conditions and finance policy. I understand that I am responsible for the outstanding balance on my account after all payments and contractual obligations have been recorded.***

Patient or Guardian Signature:_____ **Date:**_____

Think Back Representative:_____ **Date:**_____