Welcome New Patients!

Updated May, 2016

DOWNTOWN PHYSICAL THERAPY & WELLNESS

Orthopedic Care | Sports Rehab | Fitness

Welcome to Downtown Physical Therapy & Wellness where it is our duty to provide friendly, professional, timely service to the community by adhering to exemplary moral and ethical standards. We treat everyone with dignity and respect at all times. Through an environment of trust, we work hard to exceed our client's expectations while developing healthy relationships as we go.

All appointments require a 24-hour cancellation notice to avoid a NO SHOW fee.

Please help us to better serve you and others by keeping scheduled appointments. Unless cancelled 24 hours in advance, we reserve the right to charge for second and additional missed appointments at the rate of $30.

This charge is the responsibility of the patient, not the insurance carrier. Cancellation penalties are expected to be paid in full at the time of your next appointment.

It is ultimately the patient's responsibility to remember his/her scheduled appointments. We do make every attempt to confirm appointments on the business day prior. We must have a valid email address or valid daytime phone number for you to confirm these appointments. Please advise our office staff of your preference and the appropriate email address or phone number to use for confirmation.

I have read and understand the above policy.

_____ _____

Print Name Date

_____ _____

Signature of Patient or Responsible Party Date

251 N Illinois Street Suite 190 Indianapolis, IN 46204

P (317) 634-0600 **F** (317) 634-0606

Email: downtownpt2@hotmail.com

www.downtownphysicaltherapy.com

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251 North Illinois Street Suite 190 Indianapolis, IN 46204(317) 634-0600 F (317) 634-0606

Patient Information

First Name:_____ Last Name: _____ Middle Initial_____ Date:_____

Address_____

City_____ State_____ Zip Code_____

Telephone # (Home)_____ (Cell)_____ (Work)_____

Single___ Married___ Spouse's Name_____ Phone _____

E-Mail Address_____

Date of Birth_____ SS#_____ Sex: F M

Emergency Contact Name_____ Phone_____

Referring Physician_____ Phone_____

Occupation_____ Hours per week_____ Retired_____

Employer _____Employer Address & Phone (WComp patients)_____

How did you hear about us? _____

Insurance Information

☐Health ☐Auto ☐Workman's Comp ☐Self Pay

Primary Insurance_____ Subscriber ID#_____
Phone_____ Group #_____
Policy Holder Name_____ Relationship to patient_____
Policy Holder Date of Birth_____
Co-pay $_____ Deductible $_____ Met $_____ Office Visits/yr. _____
Claims Address_____

Secondary Insurance _____ Subscriber ID#_____
Phone_____ Group # _____
Claims Address_____

Work Comp – Case Manager or Adjuster Name_____
Phone_____

I understand that it is my responsibility to call my insurance company to verify eligibility for physical therapy through my policy. I agree to pay any eligible fees including co-pays and deductibles that my insurance may require. ***It is my responsibility to attend scheduled therapy appointments, otherwise I am subject to a 24 hour cancellation/ no show fee of $30****. I authorize release of information necessary to process my insurance claims and for payment to be sent directly to Downtown Physical Therapy & Wellness. I understand it is my responsibility to pay for any collection costs and attorney fees that may result from unpaid balances on my account. I have been given instruction and understand the responsibility for payment to Downtown Physical Therapy & Wellness.*

I authorize Downtown Physical Therapy & Wellness to render the appropriate physical therapy treatment according to reasonable and customary physical therapy practice.

_____ _____

Signature of Patient or Responsible Party Date

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PATIENT HEALTH HISTORY

First Name:_____ Last Name: _____ Middle Initial_____ Date:_____

Your therapist will review this questionnaire to better address your needs. If you do not understand a question, simply leave it unanswered.

1. Describe what you are being treated for: _____

_____

2. When did your symptoms start? _____

3. What caused your symptoms?_____

_____

4. Did you have surgery? Yes / No Date of surgery _____

5. How often do you experience your symptoms during the day? (Check one that applies):
❒ Constantly (76 –100% of the day)
❒ Frequently (51–75% of the day)
❒ Occasionally (26–50% of the day)
❒ Intermittently (0-25% of the day)

6. What symptoms are you having? (Check all that apply)
❒ Swelling ❒ Loss of Motion ❒ Weakness ❒ Pain
❒ Stiffness ❒ Loss of Balance ❒ Numbness ❒ Tingling
❒ Other

7. Describe your pain (Check all that apply)
❒ Sharp ❒ Dull Ache ❒ Radiating
❒ Burning ❒ Stabbing ❒ Pins and needles

Intensity of pain 0 –no pain 10 – worst pain imaginable
Best – 0 1 2 3 4 5 6 7 8 9 10 Worst – 0 1 2 3 4 5 6 7 8 9 10

8. Are you worse in the:
❒ Morning ❒ Afternoon ❒ Evening ❒ Doesn't matter

9. What activities increase your symptoms? (i.e. sitting, walking, driving)

_____

10. What eases your symptoms? (i.e. ice, rest, lying on your side)

_____

11. Do your symptoms interrupt your sleep?
❒ Yes ❒ No

12. How are your symptoms changing?
❒ Getting better ❒ No change ❒ Getting worse

13. Who have you seen for this injury/these symptoms?
❒ No one ❒ Medical Doctor ❒ Physical Therapist
❒ Chiropractor ❒ Massage Therapist

14. What treatment did you receive? And when? _____

_____

15. What diagnostic tests have you had?

❒ X-rays Date:_____ ❒ MRI Date:_____

❒ CT Scan Date:_____ ❒ EMG Date:_____

❒ Other _____ Date: _____

16. Do you have any of the following medical conditions?

❒ High blood pressure	❒ Heart disease	❒ Pacemaker
❒ Diabetes	❒ Allergies/Skin sensitivity	❒ Sensitivity to heat or cold
❒ Seizures	❒ Headaches	❒ Gout
❒ Stroke/CVA	❒ History of falls	❒ Balance problems
❒ Vision problems	❒ Hearing problems	❒ Metal implants
❒ Osteoarthritis	❒ Osteoporosis/Osteopenia	❒ Rheumatoid Arthritis
❒ Cancer	❒ Recent weight loss/gain	❒ Pulmonary disease
❒ Autoimmune disorders	❒ Liver disease	❒ Kidney disorders
❒ Thyroid disease	❒ Pregnant	❒ Past surgeries
❒ Recent fever	❒ Shortness of breath	❒ Easy bruising
❒ Night sweats	❒ Muscle cramps	❒ Circulation problems
❒ Dizziness	❒ Depression	❒ Anxiety/panic attacks
❒ Muscle Weakness	❒ Swollen legs or feet	❒ Bowel/bladder incontinence
❒ General fatigue	❒ Nausea/vomiting	❒ Stomach ulcers
❒ Indigestion/heartburn	❒ Other	❒ **None of the above**

_____

17. Please list and give dates of any major illness, injury, motor vehicle accident, or surgery that has occurred in the past:_____

_____

18. What medications are you currently taking? _____

_____

_____

19. What activities or sports are you currently involved in? (Please list activity/frequency per week) ____

_____

_____

20. What goals or activities do you want to achieve with Physical Therapy? _____

_____

_____

21. Are you nursing or pregnant? _____

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HIPPA

NOTICE OF PRIVACY PRACTICES FOR
PROTECTED HEALTHCARE INFORMATION
Effective 01/01/2008

This Notice describes how your medical information may be used and how you are privy to this information.

Downtown Physical Therapy & Wellness is committed to protecting the privacy of your health care information. Your rights and the process of how your records are disclosed are described below.

Downtown Physical Therapy & Wellness honors your rights that are outlined by the Federal Policy Standard. Unless required by law, your health information will not be disclosed without your consent or authorization. Health information is defined as verbal communication, hard documentation, electronic information, or facsimile.

It is our responsibility to provide the minimum necessary information appropriate for use of your health information, maintain the privacy of your health information, and respect and protect your confidentiality

The following categories describe how your information is used and disclosed.

- *Treatment:* Medical information may be used to provide or arrange medical treatment or services.
- *Worker's Compensation:* Health information will be disclosed to the extent authorized by and necessary to comply with worker's compensation laws.
- *Correctional Institution:* If you are an inmate of a correctional institution, information will be disclosed that institution necessary for your health and the health and safety of others.
- *Payment:* We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
- *Department of Health and Human Services (DHHS):* Health information will be disclosed to this oversight agency as necessary to determine appropriate compliance.
- *Emergencies:* We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition in the event of an emergency or of your death.

ADDITIONAL DISCLOSURES THAT ARE PERMITTED OR REQUIRED WITHOUT YOUR PERMISSION:

- Disclosures for law enforcement activities or compliance with a subpoena
- Disclosures in response to judicial and administrative proceedings
- Disclosures for health oversight activities such as civil, administrative, and criminal investigations
- Disclosures to a public health authority for public health activities such as the reporting of disease, injury or vital events

- Disclosures required by state or federal law including disclosures regarding abuse, neglect and domestic violence
- Disclosures to coroners and medical examiners regarding decedents
- Disclosures for organ and tissue donation purposes
- Disclosures to avert a threat to the health or safety of a person or the general public
- Disclosures for special government functions such as military tasks

PUBLIC HEALTH

As required by law, we may disclose your health information to public health authorities for purposes restricted to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting Food and Drug Administration problems with products and reactions to medications, and reporting disease and infection exposure.

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Downtown Physical Therapy & Wellness is not required to agree to the information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information. You have a right to a paper copy of the Notice of Privacy Practices at any time upon request.

All other uses of health information must be made with your authorization. You may revoke this authorization by providing written notice.

ACKNOWLEDGEMENT OF RECEIPT

I have received a copy of the Notice of Privacy for Protected Healthcare Information.

_____ _____
Print Name Date

_____ _____
Signature of Patient or Responsible Party Date