GREENDALE
PHYSICAL THERAPY LLC

Welcome! Please fill out as much information as possible. If you have any questions or need any assistance please ask the receptionist. Thank you! **(HEALTH INSURANCE)**

Confidential Patient Information

Name (First, Middle, Last):	What do you prefer to be called?	Date	
Street Address	City/State	Zip Code	
Home Phone ( )	Work Phone ( )	Cell Phone/Pager ( )	
Email Address	Date of Birth	Current Age	Sex ☐ M ☐ F
Social Security #			

Health Insurance Information

Name or Insurance Company Phone #:	Billing Address	Policy # and Subscriber
Name of Insured/DOB	Relationship to insured ☐ Self ☐ Spouse ☐ Child	Insured's Employer

How were you referred to us?

☐ Patient Name or resource:	☐ Physician Name	☐ Primary Care Physician

Primary Care Physician:	Phone #: ( )
Referring Physician name:	Phone #: ( )

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Full-time Student ☐ Part-time Student

Employer: Phone #: ( )		Occupation and Job Responsibilities
Employer Address	City/State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Spouse's Name_____

Primary Language Spoken_____ **Hand Dominance**: ☐ Left ☐ Right ☐ Ambidextrous ☐ N/A

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Jon Dooley, MSPT and whomever he may so designate as his assistant, to administer physical therapy care as he deems necessary to my son/daughter, _____, dated _____, 20____ at Greendale Physical Therapy.

Signature: **Witnessed**:

IN CASE OF EMERGENCY

Who should we contact?		Relation
Home Phone	Work Phone	Cell Phone

The reason for this visit is as a result of: ☐ Work ☐ Sports ☐ Auto Accident ☐ Trauma ☐ Chronic ☐ Other_____
Explain what happened:_____
_____

When did you first notice this condition:
Did it begin: ☐ Immediate or ☐ Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms spread? ☐ No ☐ Yes Where?
How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)
Is this condition progressively: ☐ Worsening ☐ Improving or ☐ Unchanged
What is the intensity of your symptoms? ☐ Slight ☐ Moderate ☐ Severe ☐ Emergency
What makes your symptoms worse?
What makes your symptoms better?
Is the condition interfering with your: ☐ Sleep ☐ Work ☐ Daily Routine If so, Explain:
Have you had this condition in the past? ☐ Yes ☐ No If so, Explain:_____ What treatment did you receive?_____ Was that treatment effective? ☐ Yes ☐ No
Have you sought any other treatment for your current condition? ☐ Yes ☐ No If so, where and by whom?
Have you been treated by a physical therapist before? ☐ Yes No If so, where and by whom?
Do you regularly exercise or work out? ☐ Yes ☐ No If so, how often?

Health History

Are you taking any of the following medications:

☐ Nerve pills ☐ Non prescription pain killers ☐ Muscle relaxes ☐ Stimulants
☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other_____

Please list any previous surgeries, serious traumas, or serious accidents, include dates if known.

1._____ Date_____
2._____ Date_____
3._____ Date_____

Do you have, or have you ever had, any of the following diseases or conditions? Check all that apply:

☐ No Past Medical History	☐ Emphysema/Glaucoma	☐ Multiple Sclerosis	☐ Alcohol/Drug Abuse
☐ Fainting/Seizures/Epilepsy	☐ Muscular Dystrophy	☐ Anemia	☐ Frequent Neck Pain
☐ Osteoporosis	☐ Arthritis	☐ Heart Surgery/Pacemaker	☐ Frequent Headaches
☐ Blood Disorder	☐ Hepatitis	☐ Shingles	☐ Cancer
☐ High/Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy	☐ HIV+/AIDS
☐ Tuberculosis	☐ Circulation Problems	☐ Kidney Problems	☐ Ulcers/Colitis
☐ Currently Pregnant	☐ Liver Disease	☐ Diabetes	☐ Lower Back Problems
☐ Difficulty Breathing	☐ Mitral Valve Prolapse	☐ Other_____	☐ Other_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

Signature:_____ Date_____

PATIENT ATTENDANCE POLICY

Updated: June 30, 2011

During your initial evaluation, you and your therapist will create a treatment schedule specific to your physical therapy needs. Treatment plans are typically composed of 2-3 appointments per week. A consistent treatment schedule is vital to the success in your physical therapy progress. Failing to abide by the schedule set by you and your therapist could result in failure to achieve desired outcomes.

Cancelling/Rescheduling

As we have reserved your appointment slot for you, we kindly request that you notify us no later than 24 hours prior to your scheduled appointment time should you need to cancel or reschedule. This will allow us to offer this appointment slot to other patients.
Appointments cancelled or rescheduled with less than 24-hours notice, will be considered a late cancellation a $25.00 fee will be assessed.

Late Arrivals

You will be required to reschedule any appointments in which you arrive for more than 15 minutes past the scheduled time. This will be determined on a case-by-case basis and is at the therapist's discretion. In this event, a $25.00 fee will be assessed.

No-Call/No-Show

Any appointment in which you fail to arrive for without prior notification will be considered a no show and a $50.00 fee will be assessed.

Please note…

- In certain situations such as workers' compensation cases, Greendale Physical Therapy is required to report treatment compliance, which includes keeping scheduled appointments, to the utilization reviewer.
- Any fees assessed for non-compliance of Greendale Physical Therapy's Attendance Policy, must be paid by cash or credit card prior to your next visit. These fees are not reimbursable by insurance companies.
- Greendale Physical Therapy reserves the right to discharge any patient with 3 or more Attendance Policy violations.

To optimize the care we provide our patients and minimize scheduling conflicts, Greendale Physical Therapy requires each patient to acknowledge receipt and understanding of our attendance policy.

Patient Signature	**Date**
Patient Name	**Therapist Initials**

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Privacy Notice Acknowledgement

In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, as it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, please contact the Greendale Physical Therapy HIPAA compliance officer, Jon Dooley, MSPT at (508) 853-4590.

I acknowledge that I have received a copy of Greendale Physical *Notice of Privacy Practices and Protected Health Information.*

Patient Signature	Date
Patient Name	Staff Initials