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! **(WORKMAN'S COMPENSATION)**

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	Relationship to insured ☐ Self ☐ Spouse ☐ Child	Insured's Employer

Workman's Compensation Insurance Information

Name or Insurance Company Phone #: ( )	Billing Address	Has your employer been notified? ☐ Yes ☐ No Date Of Injury:__/__/__
Utilization Review (UR) Nurse	UR Phone #	UR Fax #
Employers Name	Claim #	Claims Adjuster Phone #: ( )

How were you referred to us?

☐ Patient Name or resource:	☐ Physician Name	☐ Other

Primary Care 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

IN CASE OF EMERGENCY

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

Accident Information

Date of Accident?	Was the accident reported? ☐ Yes ☐ No When?
Where did the accident occur? Street/Town etc.	
Details of the accident	
Please list the symptoms you felt immediately after the accident?	
Please describe the pain and its location.	
How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)	
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:	
Where were you taken after the accident?	Where you taken to the Hospital by ☐ Ambulance ☐ Private Vehicle ☐ Other_____
Where X-ray taken? ☐ Yes ☐ No	MRI? ☐ Yes ☐ No Catscan? ☐ Yes No
Give the dates you missed work as a result of the accident. Additional Information:	
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?	

Does your work involve: (check all that apply)

☐ Prolonged Sitting	☐ Prolonged Standing	☐ Prolonged Walking	☐ Prolonged Driving
☐ Prolonged Forward Bending	☐ Exposure to Vibrating Tools	☐ Exposure to Temperatures	☐ Frequent Typing
☐ Working With a Bent Neck	☐ Repetitive Overhead Work	☐ Excessive Reaching	☐ Frequent Hand Grasp
☐ Climbing Ladders	☐ Excessive Stair Climbing	☐ Lifting Light Objects	☐ Lifting Heavy Objects
☐ Carrying Light Objects	☐ Carrying Heavy Objects	☐ Repetitive Pushing/Pulling	☐ Rep. Arm Motions
☐ Repetative Foot Motions	☐ Other_____	☐ Other_____	☐ Other_____

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_____

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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