

A) PATIENT INTAKE/TREATMENT FORM

- 1) Patient Name: _____ 2) Social Security #: _____
- 3) Home Phone number: (____)_____, Cell: (____)_____, Work: (____)_____
- 4) Address: _____
City, State, Zip Code
- 5) Gender: M F 6) Date of Birth (DOB): ____/____/____
- 7) Marital Status: S: ___ M: ___ Other: ___
- 8) Emergency contact: _____ Relation: _____ Emergency #: _____

B) MAJOR MEDICAL INSURANCE INFORMATION:

- 1) Health Insurance Name: _____
(Please verify with secretary/front desk if there are any requirements needed to proceed with physical therapy treatment such as referrals or pre-certifications)
- 2) Policy Holders Name: _____ 3) Policy holders DOB: ____/____/____
- 4) Policy Holders Social Security #: _____
- 5) Insurance ID#: _____

* If applicable please provide Secondary Insurance:

- 1) Health Insurance: _____
- 2) Policy Holders Name: _____ 3) Policy holders DOB: ____/____/____
- 4) Policy Holders Social Security #: _____
- 5) Insurance ID#: _____

C) Is this a Workers Compensation Case (WC)? YES NO
(If Not, skip to section D)

- a. Date of Accident: ____/____/____ b. Carrier Name: _____
- b. WCB # _____ and Case #: _____
- c. Name of Adjuster: _____ Phone #: _____
- d. Employer Name: _____ Phone #: _____
- Address: _____ Fax #: _____
- e. Attorney Name: _____ Phone #: _____
- Address: _____ Fax #: _____
-

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D) Is this a No-Fault Case (NF)? YES NO
(If Not, skip to section E)

- f. Date of Accident: ___/___/___ b. Insurance Name: _____
- g. NF Claim # _____ and Policy #: _____
- h. Name of Adjuster: _____ Phone #: _____
- i. Attorney Name: _____ Phone #: _____
- Address: _____ Fax #: _____

E) Referring MD: _____

1) Which body part(s) has your MD prescribed Physical Therapy for? (please circle)

Neck Back Shoulder Elbow Wrist/Hand Knee Ankle/foot Hip

Other: _____

2) Have you received prior Physical Therapy services for this problem this year?

YES If Yes, describe frequency and duration of treatment: _____

NO If No, Have you received Physical Therapy services this year for anything else? YES NO

3) Have you ever received Physical Therapy services? YES NO

F) How did you hear about us? (please circle)

Doctor Family Friend TV Ad Print Ad Website Other: _____

G) Please provide us with your email address so that we may send you our Monthly Newsletter: _____

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Millennium PT&SM P.C** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Millennium PT&SM P.C** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____

Responsible Party Signature

Responsible Party Print Name

Date

PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Back injuries |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neck Injuries | <input type="checkbox"/> Jaw injuries/TMJ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures (broken bones) | <input type="checkbox"/> Gastrointestinal problems |
| | <input type="checkbox"/> Dislocation (joints) | |

PLEASE MARK THE FOLLOWING IF YOU HAVE RECENTLY EXPERIENCED:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling, numbness or loss of feeling |
| <input type="checkbox"/> Falls | <input type="checkbox"/> Balance problems | <input type="checkbox"/> Pain with coughing/sneezing |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Change in bowel and bladder habits |
| <input type="checkbox"/> Muscular pain at rest | <input type="checkbox"/> Unusual weakness | <input type="checkbox"/> Unusual skin coloration |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Blurred/double vision | |
| <input type="checkbox"/> Constant pain unrelieved by rest / movement | <input type="checkbox"/> Unexplained weight loss | |
| | <input type="checkbox"/> Shortness of breath | |

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS

DATE: _____

DATE: _____

DO YOU SMOKE? YES / NO. **ARE YOU PREGNANT?** YES / NO **ALLERGIES** YES/ NO _____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:

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

- | | | |
|----------------------------------|-------------|----------------|
| <input type="checkbox"/> X-RAYS | DATE: _____ | RESULTS: _____ |
| <input type="checkbox"/> MRI | DATE: _____ | RESULTS: _____ |
| <input type="checkbox"/> EMG/NCV | DATE: _____ | RESULTS: _____ |

Please Describe Your Problem: _____ **Date of Onset:** _____

1. PAIN: Please rate your pain. Where O = No Pain and 10 = Maximum Pain: _____

PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN

- | | | | |
|---|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> CONSTANT | <input type="checkbox"/> INCREASING | <input type="checkbox"/> NIGHT PAIN | <input type="checkbox"/> DULL/ACHY PAIN |
| <input type="checkbox"/> INTERMITTENT | <input type="checkbox"/> DECREASING | <input type="checkbox"/> STIFFNESS | <input type="checkbox"/> SHARP PAIN |
| <input type="checkbox"/> PAIN UPON WAKING | <input type="checkbox"/> OCCASIONAL | <input type="checkbox"/> STATIC | |

PAIN IS AGGRAVATED BY: _____

PAIN IS EASED BY: _____

2. How would you rate your ability to perform routine daily activities:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3. How would you rate your ability to perform the activities associated with your job:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. How many days since your current injury? 0-30 days 31-90 days 90+ days

I _____ have provided all of the above information to the best of my knowledge at the time of this visit and will notify this office if any information above has changed during the care of MPTSM.

Signature: _____ Date: _____

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Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office patient policies are as follows. Please read carefully the following policies and sign below.

GENERAL OFFICE POLICIES

- 1) We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in *to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.*
- 2) There is a **\$50.00** charge for a cancellation without proper notice. This charge will probably not be covered by your insurance company, but will have to be paid by you personally.
- 3) You should understand that when you no-show, three people get hurt: 1) yourself because you don't get the treatment you need as prescribed by the doctor and our staff, 2) the therapist who now has a "vacancy" in their schedule since the time was reserved for you personally, and 3) another patient who could have been given treatment if you had given us proper notice.
- 4) **Regarding Lateness:** If you are late, you may not get in your full treatment because it would mean other patients are delayed.
- 5) **Regarding Being Early:** Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.
- 6) For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist prepares a report for your doctor.
- 7) Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists, and you are responsible for payment personally.
- 8) **Co-pays, deductibles, and payments** if you are a self-pay patient, are due at the time of service. We accept payments by credit card, check, cash or money order **only**.
- 9) We will allow, on special occasions, a long term payment plan budgeted on the individual according to need. In any event, if you request such a plan, you will sign a written agreement which must be given final approval by the Clinical Director.
- 10) If at any point you have a problem regarding billing and payment, talk to our secretary and they will arrange for you to see our office manager.

After you have read carefully the above, please sign the following:

I _____, agree to be treated in this Physical Therapy clinic by the Physical Therapist and their staff and I also agree with the terms specified above.

Patients Signature

Date

MILLENNIUM PHYSICAL THERAPY & SPORTS MEDICINE

CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM

Although Millennium is not required by law to obtain a signed consent from you for treatment, payment or healthcare operation purposes, we encourage you to sign this consent so that you are aware of our practices regarding protection of your personal health information.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

The Notice is available by contacting the Privacy Officer. Please note that Millennium reserves the right to change the privacy practices described in the Notice. Should you wish to obtain a revised Notice, please contact the Privacy Officer.

By signing this consent, you agree that Millennium may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have the right to request that Millennium restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. However Millennium is not required to agree to such restrictions. If Millennium does agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that Millennium has taken action in reliance to your consent.

Acknowledgment and Agreement:

I consent to Millennium sending protected health information to the insured in the event I am receiving treatment but am not insured under my insurance policy. Such information may include, but not being limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected health information mailed to the insured, then I will notify Millennium of my objectives and will complete a request for Restriction of use and Disclosure form.

In addition, I understand and accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I and other patients are treated simultaneously I understand that none of my protected health information may be inadvertently overheard by other patients and/or therapists. I also agree not to disclose any protected health information that I might inadvertently overhear about other patients while I am receiving treatment in the open treatment area.

I consent to Millennium releasing my protected health information to the following individuals.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I have received a copy of Millennium Physical Therapy's Notice of Privacy Protection.

I hereby notify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

Patient's name: _____ Date: _____

Signature of Patient or Representative: _____

Name of Representative: _____

Relationship to patient: _____