Outback PHYSICAL THERAPY

When injury knocks you out, we'll get you back

Name:_____D.O.B:____/____/_____
Title First Last

Address:_____
Street City State Zip

□ Cell Phone:_____ □ Work Phone:_____

□ Home Phone:_____ □ Email _____

Please place an **X** next to your preferred communication method

Do we have your permission to leave a message on your voicemail? Y / N

Referring Physician:_____ PCP:_____

Date of Follow up appointment__/__/__ Date of most recent physical exam__/__/__

Injury (Body part, L/R) _____

Primary Insurance: _____ID#:_____Group#_____

Name of insured_____ Relationship_____ Insured D.O.B ___/___/__

Insured Address_____

Secondary Insurance:_____ID#:_____Group#_____

Name of insured_____ Relationship_____ Insured D.O.B ___/___/__

Insured Address_____

How did you hear about us?

□ Physician (Name) _____ □ Advertising (where?)_____

□ Friend/family/colleague (Name)_____ □ Social Media (What site?)_____

□ Web search (What site?)_____ □ Other (Describe)_____

OFFICE USE ONLY

Benefits Verified: Y/N
Visits:
Co-Pay/Co-ins/Deductible:

Effective:
Benefit cycle:
Appointment Date/Time:

IJ/CD/KT

PAST MEDICAL HISTORY FORM

Are you presently working? □ Yes □ No

1. Have you ever had these symptoms before? □ Yes □ No

2. Please provide a brief description of your injury/ condition:

_____

_____

3. Have you ever had physical therapy for this injury/condition/body part before? □ Yes □ No
If so, when? _____

4. Have you had a related surgery? □Yes □ No

5. If female, are you or could you be pregnant? □ Yes □ No

6. Do you have, or have you had any of the following:

	Yes	No		Yes	No
Diabetes	□	□	Hypoglycemia	□	□
Chest Pain/Angina	□	□	Arthritis	□	□
High Blood Pressure	□	□	Osteoporosis	□	□
Heart Disease	□	□	Hernia	□	□
Heart Attack	□	□	Seizures	□	□
Heart Palpitations	□	□	Metal Implants	□	□
Pacemaker	□	□	Dizziness/Fainting	□	□
Headaches	□	□	Fractures	□	□
Kidney Problems	□	□	Surgeries	□	□
Cancer	□	□	Skin Abnormalities	□	□
Stroke	□	□	Nausea/Vomiting	□	□
Bowel/Bladder Abnormalities	□	□	ringing in your ears	□	□
Bleeding conditions	□	□	Vision impairment	□	□
Asthma/Breathing Difficulties	□	□	Smoking	□	□
Liver/Gallbladder Problems	□	□	Other	□	□

If you answered "Yes" to any of the items above, or have any additional information regarding your medical history, please briefly explain your answer with any applicable dates on the back of this page.

7. Do you have any allergies? □ Yes □ No

If yes, please list your allergies: _____

8. Are you presently taking any medications? □ Yes □ No

If yes, please list what medications and for what condition:

IF MORE ROOM IS NEEDED, PLEASE TURN OVER AND FILL OUT BACK PAGE

9. In the rare instance of an emergency, whom should we contact?

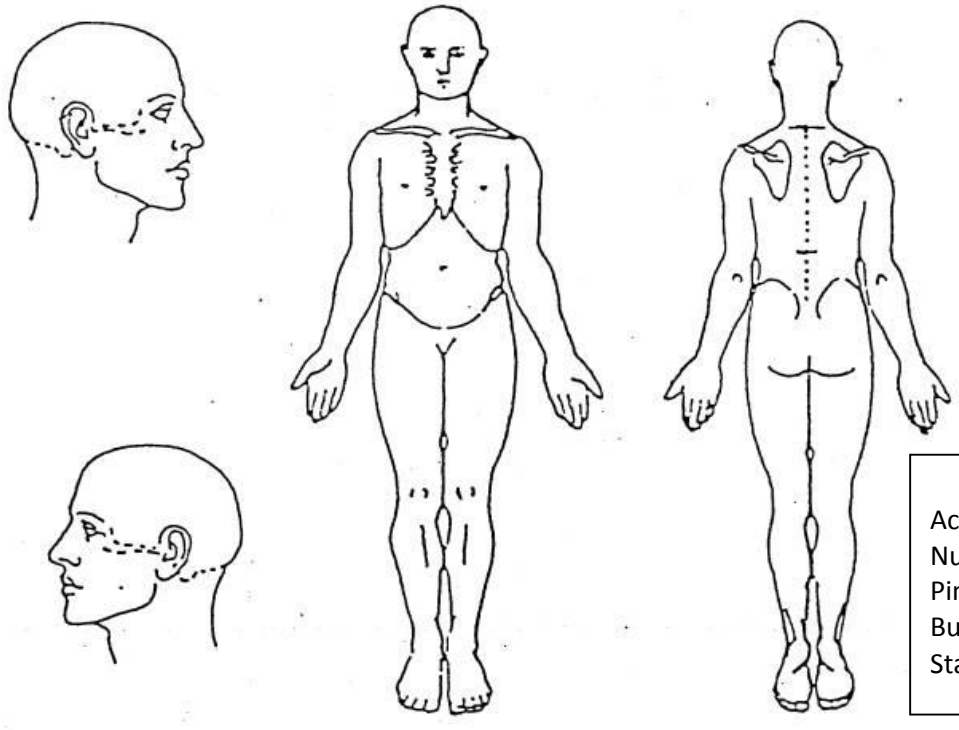
Name (Mr. /Ms.) _____ Phone Number (_____) _____

Relationship_____

10. Do you participate in any sports, exercise programs or activities on a regular basis? □ Yes □ No

Please describe_____

11. Please indicate on the following page where your symptoms are located



KEY	
Aching	+++++++
Numbness	= = = = = =
Pins & Needles	0 0 0 0 0 0
Burning Pain	XXXXXX
Stabbing Pain	/ / / / / / / /

12. If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible. Circle one.

WORST 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
BEST 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
TODAY 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Consent to Treatment

I understand that I have been referred for rehabilitative treatment and care to Outback Physical Therapy. I understand that I have the right to ask and have any questions answered prior to receiving any treatment; including any risks or alternatives to the treatment plan. By signing this agreement, I consent to have Outback Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature.

Signed: _____

Liability

I know and agree that Outback Physical Therapy is not responsible for loss or damage to personal valuables.

Signed: _____

Waiver and Release

I hereby release, discharge and acquit Outback Physical Therapy, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

Signed: _____

Authorization of Payment

I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

Signed: _____

Notice of Privacy

I acknowledge receipt of the Notice of Privacy Practices.

Signed: _____

Acknowledgement of Ultimate Responsibility for Insurance Benefits

I understand that Outback Physical Therapy has contacted my insurance and verified my copay/co-insurance/ deductible information to be _____. I also understand that this information acquired from my insurance may not reflect recent healthcare costs or be fully up to date. Thus, I release OBPT from any responsibility regarding any unexpected costs I may accrue during my treatment, as a result of this misinformation. Lastly, I acknowledge that though Outback PT will do their best to collect accurate information regarding the cost of my healthcare, I am ultimately responsible to know the specifics of my health insurance coverage and pay by copay/coinsurance/deductible in a timely manner.
Signed: _____

Treatment of Minors (leave blank if not applicable)

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
Signed: _____ Relationship to Minor: _____

DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call Outback Physical Therapy to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize Outback Physical Therapy to disclose my health information that is directly related to my current treatment at Outback Physical Therapy to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors, and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to individuals involved in my care.

NAME	RELATIONSHIP

Signed_____

I certify that all of the information provided herein is true and correct

Signed: _____ Witnessed: _____

Print Name: _____ Print Name: _____

Date: ___/___/___

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MEDICARE

The centers for Medicare and Medicaid services (CMS) have instituted the Physician Quality Reporting System (PQRS), whereby CMS hope to promote reporting of quality information by eligible professionals. As physical therapists are considered eligible professionals please answer the following:

1) BMI

Please state your height:_____

Please state your weight:_____

If you are unsure please mention this to your patient care specialist

2) Medications

Please provide a list of all medications that you are currently taking including dosages. If you do not have this list, please write this information down on the back of this form.

3) Pain

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible. Circle one.

WORST	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
BEST	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
TODAY	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

4) Falls: Risk assessment

In the last year, please state the number of times you have fallen: _____ times.

For office use only:

BMI: Bal (Rhomberg)

BP: / FES