

PATIENT INFORMATION

Patient First: _____ M.I.: _____ Last: _____
 SS: _____ Birth Date: _____ Age: _____ Sex: Male Female
 Address: _____ Marital Status: S M D W
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Email (optional): _____
 Employer: _____ Occupation: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Work Phone: _____
 Spouse First: _____ M.I.: _____ Last: _____
 Parent/Guardian First: _____ M.I.: _____ Last: _____
 Relation to Patient (check one) Child Spouse Parent Other: _____
 Parent/Guardian SS: _____ Birth Date: _____ Sex: Male Female
 Parent/Guardian Employer: _____ Phone: _____

INSURANCE

Are you the primary policy holder? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Type: <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> Other: _____ Primary Insurance: _____ Policy #: _____ Group #: _____ Policy Holder Name: _____ Policy Holder DOB: _____ Relation to Patient: _____	Are you the secondary policy holder? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Type: <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> Other: _____ Secondary Insurance: _____ Policy #: _____ Group #: _____ Policy Holder Name: _____ Policy Holder DOB: _____ Relation to Patient: _____
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INJURY

My condition is related to (check one): None Work Auto Sports School Other: _____
 Date of injury/accident/onset: _____ Injury area: _____
 Referring doctor: _____ Primary Doctor: _____
 Diagnosis: _____
 Have you had surgery related to this injury? Yes No If yes, date of surgery: _____
 If your injury is related to work injury, do you have a case manager? Yes No
 If yes, case manager Name: _____ Phone: _____
 Work status: Full Duty Limited Duty Not working
 If your injury is related to an accident, is an attorney involved in your case? Yes No
 If yes, attorney name: _____ Phone: _____

Emergency Contact Name: _____

Phone: _____ Relation: _____

Please initial to the left of each statement in the squares below.

	<p><u>Authorization for Treatment</u></p> <ul style="list-style-type: none">I hereby give authorization for the performance of such rehabilitation procedures as permitted by <i>Kentucky Statutes</i> under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	<p><u>Authorization for Release of Information</u></p> <ul style="list-style-type: none">I agree that Foundation Hand & Physical Therapy may provide information from my medical record to persons involved in my medical care.I authorize the release of medical information necessary to obtain payment of any benefits available to me to Foundation Hand & Physical Therapy for services rendered.I agree that Foundation Hand & Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.I have read "Notice of Privacy Practices" mandated by HIPAA.
	<p><u>Authorization for Release of Payment</u></p> <ul style="list-style-type: none">I authorize that direct payment of any benefits available to me be released to Foundation Hand & Physical Therapy for services rendered.
	<p><u>Patient Agreement</u></p> <ul style="list-style-type: none">I agree to pay Foundation Hand & Physical Therapy charges for services rendered to me during my course of treatment.I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to Foundation Hand & Physical Therapy collections costs including attorney and court fees.
	<p><u>Medicare, Medicaid, and Similar Benefits</u></p> <ul style="list-style-type: none">I agree that the information given to Foundation Hand & Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate.I agree Foundation Hand & Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	<p><u>Workers Compensation</u></p> <ul style="list-style-type: none">I agree that the information given to Foundation Hand & Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Foundation Hand & Physical Therapy may give intermediary's information necessary to process claims.
	<p><u>Acknowledgement of Receipt of Privacy Policy</u></p> <ul style="list-style-type: none">I acknowledge that I have received a copy of the Privacy Policies of Foundation Hand & Physical Therapy LLC and agree to the liability limitations explained there in.
	<p><u>Authorization to Share Medical Information</u></p> <ul style="list-style-type: none">I authorize Foundation Hand & Physical Therapy LLC to share information regarding my care with the individual(s) and to the degree that I have specified below. This release covers information concerning medical conditions and may include my medical history. I understand that this authorization may be revoked at any time (in writing). Authorization will automatically expire in the event that I am no longer a patient of Foundation Hand & Physical Therapy. Foundation Hand & Physical therapy is not responsible for any disclosure that may arise from the requested information. <p>* I authorize _____ (name/relationship) to:</p> <p><input type="checkbox"/> discuss medical condition/treatment <input type="checkbox"/> receive appointment information <input type="checkbox"/> discuss billing/collections on my behalf</p>

Who may we thank for referring you to Foundation Hand & PT: _____

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

(if applicable)

Patient First: _____ M.I.: _____ Last: _____

 Date of Birth: _____ Referring Physician: _____ Sex: Male Female

 Have you **RECENTLY** noted any of the following (check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> Changes in bowel/bladder function | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Dizziness/lightheadedness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness/fatigue |
| <input type="checkbox"/> Difficulty maintaining balance while walking | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Difficulty swallowing |

 Have you **EVER** been diagnosed with any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney/liver problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Pacemaker inserted | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Chemical dependency (ie, alcoholism) | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |

 For women, are you currently pregnant or think you might be pregnant? Yes No

What is your height? _____ Feet _____ Inches

 During the past month, have you been feeling down, depressed or hopeless? Yes No

What is your weight? _____

 Is your injury related to a fall? Yes No
 If yes, how many falls have you had in the last year? _____

 Do you use tobacco products? Yes No

 Do you have stairs in your home? Yes No
 If yes, how many steps? _____

Please list current medications, include name, dosage, frequency and route: _____

 Please list any allergies: _____ Are you latex sensitive? Yes No

Please list any surgeries and date of surgery: _____

Pain at LOWEST level: Rate lowest pain level in last 24 hour

Lowest Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Pain CURRENTLY: Rate pain level at this time.

Lowest Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

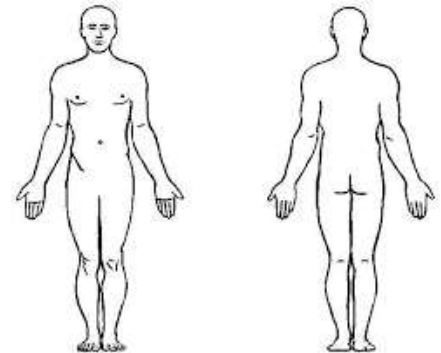
Pain at WORST: Rate highest pain level in past 24 hours.

Lowest Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Body Chart:

Please mark location of your pain and type of pain on the chart

- Key: X sharp, stabbing pain
 O dull achy pain
 Numb/tingling
 ///// Throbbing
 +++++ Burning



What is your goal for therapy at this time? _____

Patient Signature: _____ Date: _____



Therapy Compliance

Effective therapy requires consistency in treatment. The plan of care determined by your therapist and/or physician is specifically designed for you and your condition. Compliance with this plan of care is for your benefit and is essential for optimal recovery. Ideally, all patients will be discharged when their course of treatment has been completed and their highest level of function has been restored. However, excessive no shows and cancellations can significantly limit your level of recovery and occupies appointment times that could be used for other patients. **Administrative discharges may occur if a patient misses three (3) therapy appointments and/or neglects to return calls to reschedule missed appointments.** In order to resume treatment, you must see your physician, case manager (if applicable), and you regarding the administrative discharge from therapy secondary to noncompliance with your plan of care. I have read and understand the therapy compliance policy.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(if applicable)

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