SUMMIT PHYSICAL THERAPY

Date: _____ **Name:** _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security Number: _____

Email: _____ Marital Status: S M D OTHER

Address: _____City: _____

State: _____ Zip Code:_____ HOME Phone:_____

CELL Phone: _____ Employer Name: _____

Occupation: _____ WORK Phone: _____

Employer Address: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Insurance Company: _____ Primary Insured Name:_____

Primary Insured DOB:_____ Primary Insured SSN: _____ Place of Employment: _____

Cause of Injury: *(circle one)* Work Injury Personal Accident Motor Vehicle Other: _____

How were you injured? _____ Date of Injury: _____

How did you hear about us? _____ Family Doctor: _____

Referring Physician: _____ Physician Re-Check Appointment: _____

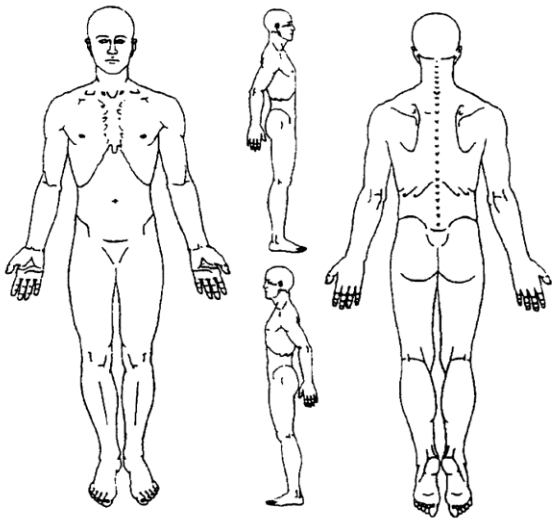
LIST MEDICATIONS: _____

PAIN DIAGRAM INSTRUCTIONS:

Indicate on the diagram where your pain is located and what type of pain you feel at the present time.
Do not indicate areas of pain which are not related to your present injury or condition.
Use the symbols below to describe your pain.

Symbols:

/// = Stabbing **XXX** = Burning **000** = Pins & Needles = = = Numbness #### = Aching



On a scale of **0 - 10** (10 = emergency room-type pain, 0 = no pain), please circle your pain level:

RIGHT NOW: ***0 1 2 3 4 5 6 7 8 9 10*** **BEST:** ***0 1 2 3 4 5 6 7 8 9 10*** **WORST:** ***0 1 2 3 4 5 6 7 8 9 10***

PATIENT HISTORY

1. What is your primary problem? _____
2. Have you had anything similar before? **YES / NO** If YES, describe _____

_____

3. Were you free of symptoms before this onset? □ **YES** □ **NO**
4. Have you received prior treatment for this current problem? _____
5. On a functional scale (100% is normal), where do you feel your injured area is functioning? _____ %
6. Is your pain: □ **CONSTANT** (24/7) **or** □ **INTERMITTENT**
7. What activity lessens your pain? _____
8. What makes the pain worse? _____

PERSONAL MEDICAL HISTORY

1. Do you have any of the following conditions? *(please check)*

□ lumps, growths or tumors
□ high/low blood pressure
□ cancer
□ gallbladder condition
□ respiratory/lung condition
□ neurological condition
□ rheumatism, arthritis
□ ear, nose, throat, eye problems
□ kidney/bladder condition
□ stomach or intestine condition
□ circulatory/vascular condition
□ recurrent infections condition
□ diabetes or hypoglycemia
□ psychological, emotional disorders
□ rheumatic fever
□ heart ailment
□ hernia or rupture
□ birth defect/abnormality
□ epilepsy or convulsive disorder
□ skin or dermatologic condition

2. Have you had any other orthopaedic problems? If YES, describe: _____
3. Have you had any surgeries in the past? _____
4. Are you allergic to anything? _____
5. Are you currently pregnant? □ N/A □ No □ Yes (Due Date:_____)
6. What are your goals or expectations from receiving physical therapy: _____

_____

JOB CHARACTERISTICS **(worker's comp. only)**

1. Check the activities or positions you are required to perform at work.

____ standing ____ sitting ____ bending ____ reaching ____ reaching over-head
____ squatting ____ walking ____ climbing ____ push/pull ____ kneeling

2. What is the maximum weight (in pounds) that you would ever have to lift or carry at work? _____ lbs.

3. Are you currently working? ( ) **YES** ( ) **NO** ( )with restrictions

4. If NOT working, what was the last date you did work? _____

Summit Physical Therapy Authorizations / Acceptances

Name: _____ Insurance Company:_____

Assignment of Benefits

The undersigned hereby assign(s) to Provider, any and all private medical insurance benefits (primary and secondary) or Medicare benefits to which the patient may be entitled for services rendered by provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on the patient's behalf. The undersigned authorizes payment of medical benefits directly to Summit Physical Therapy.

Financial Responsibility

1. The undersigned assumes full financial responsibility for services rendered and for any balance after insurance payment. The undersigned agrees to pay deductible, co-insurance or co-payment and any charges not reimbursed by insurance carrier.
2. The undersigned agree(s) to execute such other documents and perform such acts as Provider may reasonably request to effectuate the foregoing.
3. If this claim is determined by the undersigned's worker's compensation carrier to be non-work related, the undersigned agrees to be financially responsible.
4. The undersigned understands that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. The undersigned understands that he/she is responsible for knowing and meeting the requirements of the insurance plan.
5. The undersigned hereby agrees to pay on the account as services are rendered promptly upon receipt of the statement. It is understood that responsibility for the payment of services provided in this office is that of the undersigned and they are due and payable at the time services are rendered unless other financial arrangements have been made. The undersigned further understands that a 1 ½% finance charge (18%) annually will be added to any balance over 60 days. In the event of default, the undersigned agrees to pay such collection costs and reasonable attorney fees as may be required to effect collection of the indebtedness.
6. To see optimal results, it is important for you to attend therapy regularly. We firmly believe in total commitment to physical therapy. We understand that sometimes life brings unexpected happenings and you may need to cancel your appointment. If you know of any circumstance within 24 hours, please contact our office to cancel. We do make occasional exceptions to this rule. It is our goal to continue to provide the much needed one-on-one time between therapist and patient. Therefore, three inconsistent occurrences in treatment such as not showing, canceling or arriving more than 10 minutes late to appointments will result in automatic discharge from our facility. Each occurrence is subject to a $50.00 fee. To insure quality of care and individual patient attention, we cannot afford to have missed appointments or time deducted from your treatment; it costs you and us valuable time. _____ **(Initial)**

Authorization for Treatment

The undersigned hereby authorizes Summit Physical Therapy ("Provider") to render any and all therapy services, or other related services, that the Provider feels are necessary to the patient treatment in conjunction with the physician referral. The patient shall cooperate fully with all requests of Provider in connection with physical therapy services.

Release of Information

The undersigned hereby authorizes Provider to release any medical or other pertinent information furnished Provider or obtained by Provider in connection with the patient's treatment to any physician, insurance company, adjuster, or attorney involved in the case. The undersigned acknowledges receipt of Summit Physical Therapy Privacy Practices and the Indiana Direct Access Notification.

_____ _____ _____ _____

Patient Signature Date Witness Date