PAPPAS PHYSICAL THERAPY

Patient Name: ____ Date: ________________________

DO NOT WRITE
ON THIS SIDE

I MEDICAL HISTORY (circle yes or no)

1. Yes No Do you have high blood pressure? ( ) Controlled with medication?
2. Yes No Do you have heart problems?
3. Yes No Do you have a pacemaker?
4. Yes No Do you experience frequent heart palpitations?
5. Yes No Do you have angina (chest pain with exertion)?
6. Yes No Do you have a heart murmur?
7. Yes No Do you have an abnormal heart rate?
8. Yes No Do you have high cholesterol? ( ) Controlled with medication?
9. Yes No Do you have problems with shortness of breath?
10. Yes No Do you have asthma?
11. Yes No Do you have any chronic lung problems?
12. Yes No Do you have heart chronic heartburn, stomach or intestinal upset?
13. Yes No Do you have a history of ulcers?
14. Yes No Have you experienced significant recent weight loss or gain?
15. Yes No Do you have any bowel and/or bladder problems?
    (i.e. constipation, diarrhea, urgency to urinate)
16. Yes No Do you have a thyroid problem? Type: __________________________
17. Yes No Do you have **diabetes**? Are you Medication dependant? Yes No
18. Yes No Do you have low blood sugar? (Hypoglycemia)
19. Yes No Do you have any **cancer**?
    Where? __________________________
20. Yes No Do you have osteoporosis?
21. Yes No Do you have a history of neck and/or back pain?
22. Yes No Do you have migraine headaches?
23. Yes No Do you have a history of seizures?
24. Yes No Do you have unusual joint pain and swelling unrelated to trauma?
25. Yes No Do you have a history of fractures?
    Where? __________________________
26. Yes No Do you have metal implants?
    Where? __________________________
27. Yes No Do you smoke? How many per day __________________________
28. Yes No Do you participate in a regular physical exercise program?
    How often? __________________________
29. Yes No Do you wear contact lenses or glasses?
30. Yes No Do you have impaired hearing?
31. Yes No Do you have any chronic immune deficiency conditions?
    (i.e. Lupus, etc.) List __________________________
32. Yes No Are you currently being treated for any other condition not listed?
    (i.e. Depression, Anxiety, etc.) List __________________________
33. Yes No Do you have any allergies? List __________________________

II OB/GYN (circle yes or no)

1. Yes No Are you pregnant or suspect pregnancy?
2. Yes No Do you have dysmenorrheal (abnormal menstrual cycles)?

PLEASE COMPLETE BACK SIDE OF QUESTIONAIRE AS WELL

III SYMPTOMS (circle yes or no)

1. Yes No Do you have a "pins and needles" or numbness sensation in your extremities?
2. Yes No Do your arms, hands, legs or feet swell as a result of your current condition?
3. Yes No Do you have any weakness in your arms or legs?
4. Yes No Do you have any coordination and/or balance problems?
5. Yes No Do you have difficulty walking?
6. Yes No Do you experience dizziness/vertigo (feeling of spinning) with a change in position? (i.e. getting up from lying down)
7. Yes No Do you have episodes of blurred or double vision?
8. Yes No Have you experienced headaches as a result of your condition?
9. Yes No Do you have ringing in the ears?

MEDICATIONS – Please list all medications, dosages and purpose.

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___

TYPE OF SURGERIES/DATE

___

___

DIAGNOSTIC TESTS – check test for **current** problem only

( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Blood Chemistry
( )Myelogram ( )Bone Density ( )Other (please specify) ___

HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEM?

( )Physician/MD ( )Chiropractor ( )Podiatrist ( )Orthopedic Surgeon
( )Neurologist/neurosurgeon ( )Osteopathic Physician/DO ( )Dentist
( )Physical Therapist Date: ___

CHIEF COMPLAINT/CURRENT CONDITIONS: Please describe: ___

___

Please rate your pain in this scale of 0-10

0 1 2 3 4 5 6 7 8 9 10

no pain — worst pain imaginable

SYMPTOMS

Symptoms this episode to be marked on body diagram

I believe all information to be true and complete

Signature: ___ Date: ___ P.T. ___

PAPPAS PHYSICAL THERAPY

OFFICE POLICES AND PROCEDURES

We have developed this information to make you aware of our billing policies at the time of your initial office visit. Please review these policies carefully. By signing this form, you are agreeing to abide by the terms of our office policies and procedures.

Physical therapy services are reimbursed under the provisions of most health insurance polices. Our office personnel are familiar with the various coverages offered by health insurance companies, but **you**, as the subscriber, **are primarily responsible for knowing the terms of your policy**. Your insurance co-payments are payable at the time services are rendered. If you (the subscriber) should receive a check from your insurance company that is intended for this practice (the provider) for services rendered, you should immediately remit this to our office for credit to your account. Failure to do so will result in our office billing you for the complete balance and you will be responsible for payment of this amount in full. If your insurance requires a referral from your primary care physician, you are responsible for obtaining this or have your doctor's office fax to us. If your insurance has a deductible, you may be asked to pay for services if it has not been met.

Liability cases are accepted, but your health insurance must be billed and co-pays collected. **WE DO NOT BILL ATTORNEYS**.

Worker's compensation patients will be accepted according to the new Worker's Compensation Law enacted in 1992. Should your claim be denied by the RI Worker's Compensation Court, we will bill your medical insurance carrier and you will be responsible for any deductibles and co-payments. If you do not have a third party insurance, please speak with the Billing Department to make arrangements for payment of your account. Failure to attend physical therapy may jeopardize your worker's compensation benefits.

MEDICARE PATIENTS

Medicare patients who do not have supplement insurance will be billed for their yearly deductible and 20% of the Medicare allowable. If Medicare denies payment, the patient will be billed for 100% of the allowable.

MEDICAID

Medicaid does not pay for physical therapy in a private practice.

NO SHOW AND CANCELLATION POLICY

In order to maintain efficient patient scheduling, we have developed a NO SHOW and CANCELLATION policy for our office. Your scheduled appointment is reserved for you. If you are unable to keep your appointment, you must cancel at least (24) twenty-four hours in advance by direct communication with our office staff or voice mail service. **A $25.00 fee will be charged for all missed appointments not cancelled with a 24 hour notice**. This fee must be paid prior to the next visit.

If you are going to be late for your appointment, you should call to inform us of your expected time of arrival. **Your appointment may need to be re-scheduled at the discretion of the therapist**. This policy is to ensure that your late arrival will not interfere with the treatment of the patient scheduled after you.

PLEASE COMPLETE OTHER SIDE AND BRING THIS WITH YOU ON YOUR FIRST VISIT

CO-PAYMENTS are due at the time of service. Please contact the customer service department of your insurance company for information regarding your Out-Patient Physical Therapy Benefits, your co-payment amounts and the amount of your deductible if it is applicable. Thank you.

CO-PAYMENTS: INITIAL VISIT WITH TREATMENT ____________________

EACH FOLLOW-UP VISIT ____________________________

I have read and understood the contents of your office policies and procedures as well as the Notice of Information Practices. I request that payment of insurance benefits for services rendered to me, be paid directly to Pappas Physical Therapy. I authorize Medicare to send claims to my secondary insurance for crossover benefit payments. I authorize Pappas Physical Therapy to release medical information to my insurance carrier to determine benefits payable. I understand that I have the right to restrict how my medical information is used and disclosed. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

PATIENT NAME ____

PATIENT SIGNATURE ______________________________ DATE ________________

GUARDIAN SIGNATURE ___________________________ DATE _________________

DESIGNATED INDIVIDUALS AUTHORIZATION

I herby authorize Pappas Physical Therapy to release information regarding my treatment, if requested, to the following designees.

NAME _________________________________ RELATIONSHIP ___________________

NAME _________________________________ RELATIONSHIP ___________________