Pappas
Physical and Hand Therapy

Name:_____ Date:_____

DOB: _____ Height:_____ Weight:_____ Gender: ❑ M ❑ F

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

❑ fatigue
❑ numbness or tingling
❑ constipation
❑ fever/chills/sweats
❑ muscle weakness
❑ diarrhea
❑ nausea/vomiting
❑ dizziness/lightheadedness
❑ shortness of breath
❑ weight loss/gain
❑ heartburn/indigestion
❑ fainting
❑ difficulty maintaining balance while walking
❑ difficulty swallowing
❑ cough
❑ falls
❑ changes in bowel or bladder function
❑ headaches

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

❑ cancer
❑ depression
❑ thyroid problems
❑ heart problems
❑ lung problems
❑ diabetes
❑ chest pain/angina
❑ tuberculosis
❑ osteoporosis
❑ high blood pressure
❑ asthma
❑ multiple sclerosis
❑ circulation problems
❑ rheumatoid arthritis
❑ epilepsy
❑ blood clots
❑ other arthritic condition
❑ eye problem/infection
❑ stroke
❑ bladder/urinary tract infection
❑ ulcers
❑ anemia
❑ kidney problem/infection
❑ liver problems
❑ bone or joint infection
❑ sexually transmitted disease/HIV
❑ hepatitis
❑ chemical dependency (i.e., alcoholism)
❑ pelvic inflammatory disease
❑ pneumonia

During the past month have you been feeling down, depressed or hopeless? ❑ YES ❑ NO
During the past month have you been bothered by having little interest or pleasure in doing things? ❑ YES ❑ NO
Is this something with which you would like help? ❑ YES, BUT NOT TODAY ❑ YES ❑ NO

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (check all that apply)

❑ cancer
❑ heart problems
❑ high blood pressure
❑ diabetes
❑ stroke
❑ depression
❑ tuberculosis
❑ thyroid problems
❑ blood clots

Diagnostic Tests (x-ray, MRI, labs, etc):_____

ALLERGIES: List any medication(s) you are allergic to: _____

Are you allergic to Latex? ❑ **YES** ❑ **NO**
Do you have a pacemaker? ❑ **YES** ❑ **NO**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑ **YES** ❑ **NO**

Smoker: ❑ **YES** ❑ **NO** **If yes, how many/day?**_____

What are your goals for Physical/Occupational Therapy: _____
_____
_____

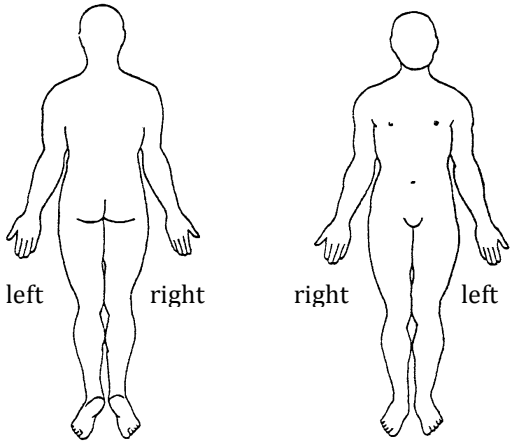
Past Surgical History (list all and date):
_____
_____

Please list all current Medications:
_____
_____
_____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O Dull/aching pain
||| Numbness
= Tingling



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

On the scales below, please circle the number which best represents the severity of your pain:

Average for the last 48 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

Best for the last 48 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

Worst for the last 48 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

I believe all information to be true and complete.

Signature: _____ **Date:** _____ **Therapist:** _____

PAPPAS PHYSICAL & HAND 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.

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 it to us. If your insurance policy has a deductible, you will be responsible to pay towards the stated amount until it has been met. Once met a co-insurance/copay may apply.

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 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.

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/occupational/speech 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 voicemail service. Any missed appointment without a call is considered a no-show. A **$30.00 fee will be charged for all no-show and 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.

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/Occupational Therapy Benefits. This includes your co-payment and/or deductible amounts if they are applicable.

Benefits below were quoted to Pappas Physical Therapy by your insurance company. We strive to be as accurate as possible; however it is your responsibility to verify all terms and benefits of your plan.

CO-PAY ESTIMATE: INITIAL VISIT WITH TREATMENT: _____

EACH FOLLOW-UP VISIT: _____

A $30.00 fee will be charged upon any missed follow-up appointments without contacting the office. This fee will be due before your next appointment.

I have read and understand the 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 my primary insurance to send claims to my secondary insurance for crossover benefit payments. I authorize Pappas Physical Therapy to release medical information to my insurance carrier(s) 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.

PRINT NAME _____ DATE _____

PATIENT/GUARDIAN SIGNATURE _____

E-MAIL ADDRESS _____

Please Send Me: ☐ Appointment Reminders - VIA EMAIL ☐ Monthly Newsletter

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 _____

HOW DID YOU HEAR ABOUT PAPPAS PHYSICAL & HAND THERAPY?

_____