

NEW PATIENT REGISTRATION

Patient First Chiro. & P.T.

Please print clearly to help avoid billing errors

Patient Last Name _____ First _____ MI _____

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip _____

(_____) _____
Home Telephone _____ Cell Number _____ Work Telephone _____

Check Box if you would like to receive our free monthly newsletter via e-mail

Email Address _____

Date of Birth _____ Age _____ Social Security # _____

Marital Status: Single Married Divorced Other _____ Sex: Male Female _____

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired _____

INSURANCE SUBSCRIBER / GUARANTOR NAME-Person to Bill if Other Than Patient _____

Mailing Address _____ Apt or Unit # _____ City _____ State _____ Zip _____

Assignment and Release: I hereby authorize and direct my insurance benefits to be paid directly to Patient First Chiro. & P.T. I also understand I am financially responsible for any and all non-covered services provided by Patient First Chiro. & P.T.

*** **IMPORTANT:** Who is your Primary Care Physician: _____

Signature: _____ Date: _____

***** Below for Office Use Only *****

DIAGS: (1) _____ (2) _____ (3) _____ (4) _____

INITIAL VISIT PROCEDURES – CHIRO / P.T

Date of Service: _____ Amount Paid This Visit: \$ _____ Provider: BC MO NT LC RG NH

New Chiro. Exam: 99202 99203 99204 99205 _____ New P.T. Exam: 97001

9894 _____ 97014 _____ 97110 _____ 98943 _____ 97140 _____ 97010 _____ 97035 _____ 97112 _____
Manip. E-Stim – Un Thera. Ex. Extra Spine Man. Thera. H/C Packs Ultrasound Neuro Re-Ed

Check Box to **Block Pt. Statements**

PATIENT AUTHORIZATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Signed: _____ Date: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies our staff is trained to inform you of the financial policies of this office. Payment is expected from you at the time of service for "your part" of the charges. We accept payment in the form of cash, check, VISA or MasterCard for your convenience. Your signature below indicated that you understand and accept this policy.

Signed: _____ Date: _____

Do we have permission to:

- | | | |
|---|------------------------------|-----------------------------|
| Leave a message on your answering machine at home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leave a message at your place of employment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leave a message using your e-mail address? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Discuss your medical condition with any member of your household?
If yes, whom?: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Signed: _____ Date: _____

I have been given a copy of the Privacy Practices/HIPPA.

Signed: _____ Date: _____

FOR HMO AND MANAGED CARE PLANS ONLY:

As a member of a managed care plan, I understand I have an obligation to have all medical care coordinated by my PCP. I understand I must obtain a referral from my primary care physician before seeing a Physical Therapist. I understand that I will be personally responsible for payment for services received if denied by my insurance carrier or if I do not have a referral from my PCP for any service dates.

Signed: _____ Date: _____

FOR MEDICARE ONLY:

I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signed: _____ Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associations (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice of the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Medical Information

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice with the effective date in the upper right corner of the first pane.

Informed Consent For Physical Therapy

Dear patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At Patient First, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic Exercise are an integral part of most physical therapy treatment plans. Exercise are an integral part of most physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Patient First, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed.

Patient Name: _____

Patient Signature: _____

Date: ____ / ____ / _____

Last Name: _____ First Name: _____ Date: ___ / ___ / _____

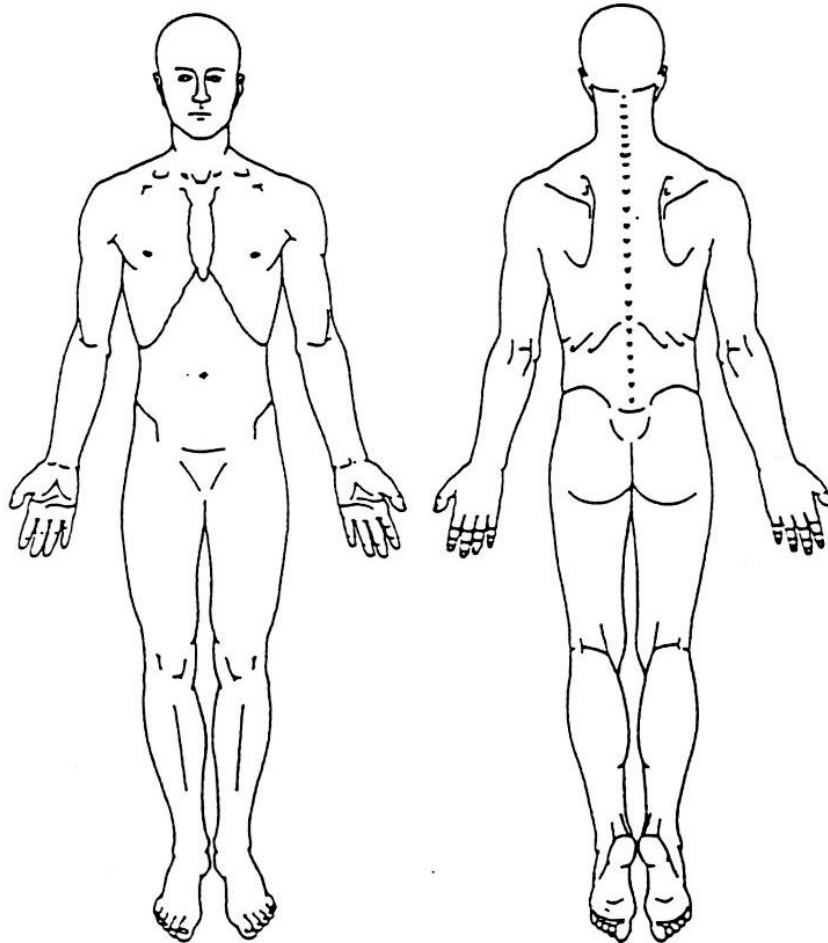
Body Diagram

Instructions:

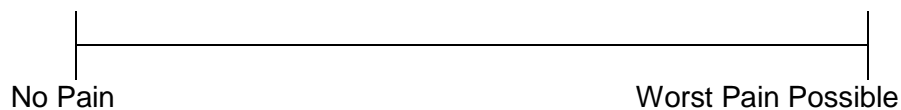
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.

Use the letters below to indicate the type and location of your sensation right now

Key: A = Ache B = Burning N = Numbness S = Stabbing P = Pins and Needles O = Other



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.



HIP EVALUATION

Name: _____ Date: _____ DOB: _____

Referring Physician: _____

Primary Care Physician: _____

SUBJECTIVE:

1. What was the date of your injury, or when did your symptoms begin? _____

2. How did you injure your hip? _____

() Check here if there was no apparent reason.

3. Describe the location of your pain: _____

4. Are your symptoms: () Improving () Getting Worse () Unchanged

5. Are there any radiating symptoms? (extending/spreading) _____

6. Is there any numbness/tingling? () Yes, Location _____ () No

7. Do any of the following **INTENSIFY** your symptoms? () Sitting () Standing () Lying

() Changing from sitting to standing () Walking () Driving

a.m. / as day progresses / p.m.

stationary / on the move

8. Do any of the following **DECREASE** your symptoms? () Sitting () Standing () Lying

() Walking () Rest

8. When is the pain the **MOST** severe? () Morning () Afternoon () Night

9. When is the pain the **LEAST** severe? () Morning () Afternoon () Night

10. Is your sleep interrupted by pain? () Yes () No

What is your position of comfort for sleeping? _____

11. List your current medications: _____

12. Do you have a past medical history of your current problem (including previous surgeries, fractures, etc.)?

() Yes () No If yes, please describe _____

13. Were you hospitalized as a result of your hip injury? () Yes () No

14. Do you have any precautions to treatment, *such as a total hip replacement*? () Yes () No

15. Where you in a cast or splint? Yes, length of time _____ No

16. Prior Treatment: _____

17. Describe overall general health: Normal Good Fair Poor

18. Are you currently employed? Yes No

Can you return to work with restrictions? Yes No

Must you be released with **no** restrictions? Yes No

19. What is your occupation? _____

Is this position: Heavy Activity Moderate Activity Light Activity

20. Are you receiving any additional treatment for this condition (acupuncture, chiropractic, etc.)

21. Have you had any of the following special tests?

X-Ray Date: _____ Results: _____

CAT Scan Date: _____ Results: _____

MRI Date: _____ Results: _____

EMG Date: _____ Results: _____

Other Tests Date: _____ Results: _____

22. Do you have any future test scheduled? Yes _____ No

23. Does your pain/symptoms interfere with your ADL? (Activities of Daily Living)

Yes No

24. Are you able to carry objects in your hand? Yes No

25. Does rest alleviate your symptoms? Yes No

OBJECTIVE: (To be completed by therapist)

1. Range of Motion

	(L) AROM	(R)	(L) AROM	(R)
Hip Flexion	_____	_____	_____	_____
Hip Extension	_____	_____	_____	_____
Hip Abduction	_____	_____	_____	_____
Hip Adduction	_____	_____	_____	_____
Hip Internal Rotation	_____	_____	_____	_____
Hip External Rotation	_____	_____	_____	_____

2. Manual Muscle Test:

Hip Flexion	5	4	3	2	1	0
Hip Extension	5	4	3	2	1	0
Hip Abduction	5	4	3	2	1	0
Hip Adduction	5	4	3	2	1	0
Quadriceps	5	4	3	2	1	0
Hamstring	5	4	3	2	1	0

3. Leg Length (measure leg length for discrepancies):

(L) _____ (R) _____



4. Sensation:

Sharp: Normal/Abnormal Dull: Normal/Abnormal Light Touch: Normal/Abnormal

5. Flexibility Testing:

Hamstring: Normal / Abnormal
Iliotibial Band Normal / Abnormal
Quadriceps: Normal / Abnormal

6. Gait

() Weight bearing: Even / Uneven () Cadence,   () Limping

7. Palpation: _____

8. Special Tests:

Fabere: () Positive () Negative
Noble Compression: () Positive () Negative
Ober Test: () Positive () Negative
Thomas Test: () Positive () Negative
Trendelenburg: () Positive () Negative

9. Treatment Program:

ASSESSMENT:

1. Problem List:

2. Goals:

Short Term:

Long Term:

PLAN OF CARE:
