

Progressive Physical Therapy Patient Information

Patient:

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Date of Birth: ____/____/____ Soc. Sec. No.: ____/____/____

Emergency Contact: _____ Phone: _____

Referring Doctor: _____

How did you hear about us? _____

Have you had any other prior Physical Therapy? yes no

If so for what reason: _____

Signature of Patient or Beneficiary

Date

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="text"/>			<input type="radio"/> Female	<input type="text"/>		
<input type="text"/>			<input type="radio"/> Male	<input type="text"/>		
Patient name Last First MI			Patient date of birth			
Patient address				City	State	Zip code
Patient insurance ID#		Health plan		Group number		
Referring physician (if applicable)		Date referral issued (if applicable)		Referral number (if applicable)		

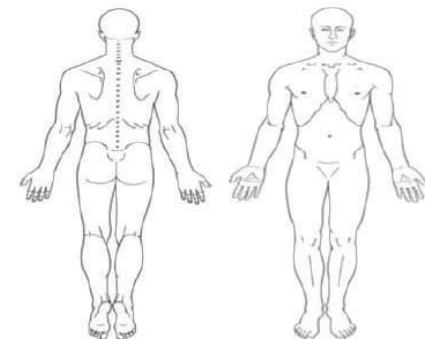
Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)					2. Federal tax ID(TIN) of entity in box #1					
<input type="text"/>					<input type="text"/>					
3. Name and credentials of the individual performing the service(s)					4. Alternate name (if any) of entity in box #1					
<input type="text"/>					<input type="text"/>					
5. NPI of entity in box #1					6. Phone number					
<input type="text"/>					<input type="text"/>					
7. Address of the billing provider or facility indicated in box #1					8. City		9. State		10. Zip code	
<input type="text"/>					<input type="text"/>		<input type="text"/>		<input type="text"/>	

Provider Completes This Section:

Date you want THIS submission to begin: <input type="text"/>	Cause of Current Episode (1) Traumatic (2) Unspecified (3) Repetitive (4) Post-surgical (5) Work related (6) Motor vehicle	Date of Surgery <input type="text"/>	Type of Surgery (1) ACL Reconstruction (2) Rotator Cuff/Labral Repair (3) Tendon Repair (4) Spinal Fusion (5) Joint Replacement (6) Other	Diagnosis (ICD code) Please ensure all digits are entered accurately 1° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Patient Type (1) New to your office (2) Est'd, new injury (3) Est'd, new episode (4) Est'd, continuing care	DC ONLY Anticipated CMT Level (1) 98940 (2) 98942 (3) 98941 (4) 98943	Current Functional Measure Score Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/> <input type="text"/> (other) <input type="text"/>		
Nature of Condition (1) Initial onset (within last 3 months) (2) Recurrent (multiple episodes of < 3 months) (3) Chronic (continuous duration > 3 months)				

Patient Completes This Section:

Symptoms began on: <input type="text"/>	Indicate where you have pain or other symptoms: 
1. Briefly describe your symptoms: <input type="text"/>	
2. How did your symptoms start? <input type="text"/>	
3. Average pain intensity: Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain	
4. How often do you experience your symptoms? (1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)	
5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) (1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely	
6. How is your condition changing, since care began at this facility? (0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better	
7. In general, would you say your overall health right now is... (1) Excellent (2) Very good (3) Good (4) Fair (5) Poor	

Patient Signature: X Date: _____

Consent for Treatment

I hereby give my consent to allow Progressive Physical Therapy, LLC to evaluate me and render physical therapy treatment. I recognize that I am financially responsible for all charges for medical care and services rendered by Progressive Physical Therapy, LLC. I am aware that a payment is due at the time of service. I understand that charges will be submitted to my insurance company, as a courtesy to me and if for any reason the insurance company will not pay the claim, then I am fully responsible for that payment, unless prior arrangements are made in writing. I agree to turn over any and all checks received personally from my insurance company for services rendered at Progressive Physical Therapy, LLC. With regard to most participating insurance plans, I understand my financial responsibility for the deductible, co-insurance or co-pays. In regard to unpaid bills, after 90 days from the date of service, interest in the amount of 1.5% per month may begin to accrue. If my account is referred to an attorney or agency for collection, I agree to pay for all attorney or collection costs, including but not limited to, court costs and suit fees.

I acknowledge that I will not hold Progressive Physical Therapy, LLC responsible or accountable for any injuries, temporary or permanent as a result of any of the therapeutic or evaluative measures employed, assuming Progressive Physical Therapy, LLC uses usual and normal procedures and precautions in caring for and evaluating my medical condition.

I hereby authorize Progressive Physical Therapy, LLC to release any records pertaining to my medical condition to my doctors, my attorney, my insurance company and any other agency which is deemed appropriate per the discretion of Progressive Physical Therapy, LLC.

I hereby waive my right to the three year statute of limitations for the collection of any physical therapy services provided by Progressive Physical Therapy, LLC.

Patient signature

Date

Witness signature

Date

Cancellation Policy

In order that Progressive Physical Therapy, LLC may better serve those in need of our services, we ask that you abide by the following guidelines regarding cancellation of appointments.

1. When unable to make a scheduled appointment, please call at least 24 hours in advance to cancel the appointment. We do understand emergencies come up and we will be flexible when needed.
2. If you should miss more than one appointment without calling in advance Progressive Physical Therapy, LLC reserves the right to charge a fee of **\$50.00** for each occasion. Payment of this fee is the responsibility of the patient and will not be covered by insurance.
3. Regular attendance at therapy is critical to a successful outcome. If you should miss more than three appointments, either no shows or failure to cancel, we may remove all further existing appointments from the schedule. In this instance, you must contact us to reschedule, and in some cases, a new physician referral would be required before resuming treatment.

Patient signature

Date

Notice of Private Practices Acknowledgment

The Notice of Private Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **The Progressive Physical Therapy, LLC's Notice of Private Practices is attached below.**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. Besides providing information about the ways we may use and share medical information about you, we also describe your rights and certain duties we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private,
- Give you notice of your legal duties and privacy practices with respect to medical information about you, and
- Follow the terms of the notice that is currently in effect.

We have the right to:

- Change our privacy practices and the terms of the notice at any time, provided the changes are permitted by law.
- Make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about the Notice of Privacy Practices or wish to request further information, please contact the privacy officer. If you believe your rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be retaliated against for filing a complaint.**

Receipt Acknowledgment

By signing below you acknowledge receiving the Notice of Private Practices and acknowledge having been provided an opportunity to review it.

Printed name

Birthdate

Signature

Date

Progressive Physical Therapy, LLC Notice of Private Practices

The Notice of Private Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Not every use or disclosure is listed.

We may disclose medical information about you to:

- Your personal doctors, hospitals, nurses, technicians, medical students, or other health care personnel who are involved in taking care of you or to assist them in treating you.

We may use or disclose medical information for/to:

- Payment purposes. A bill may be sent to you or a third party payer, which may include your medical information.
- Review our treatment and services and to evaluate the performance of our staff in caring for you.
- Public health activities. These generally include prevention or control of disease, injury or disability; report of child abuse or neglect; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; notify the appropriate government authority if we believe the patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- A health oversight agency for activities authorized by law, necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Prevent a serious threat to the health and safety to you or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Comply with required federal, state, or local law.
- In response to a court order, subpoena, warrant, summons or similar process; identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if we are unable to obtain the person's agreement; crimes on our premises; and crimes in emergency circumstances.

We may release information about you to:

- A friend or family member who is involved in your medical care, unless you object.
- Worker's compensation or similar programs that provide benefits for work-related injuries or illness.
- A coroner or medical examiner to aid in an investigation.
- Military command or foreign military authorities if you are a member of the armed forces.
- Correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official.

Other uses and disclosures of medical information not covered by this notice or the laws that apply will be made only with your written permission. You may revoke that permission in writing at any time. If you revoke that permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that action has already been taken prior to your revocation.

Your Rights Regarding Medical Information About You

You have the right to:

- Inspect and copy medical information that may be used to make decisions about your care, including, medical and billing records.
- Request an amendment to your medical information if you feel that the information about you is incorrect or incomplete. You must provide a written reason that supports your request, or we may deny your request. In addition, we may deny your request if you ask us to amend information that was not created by us, is not part of the information generated by us, or is inaccurate and incomplete.
- Request an accounting of disclosures of medical information. Your request must state a time period. This time period may not be longer than six years and may not include dates before April 14, 2003.
- Request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, health care operations, and on the medical information we disclose about you to someone who is involved in your care.
- Request that we communicate with you about medical matters in a certain way, location, and/or confidentially.
- Request a copy of this notice at any time.

You must submit all your requests in writing. If you request a copy of information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.