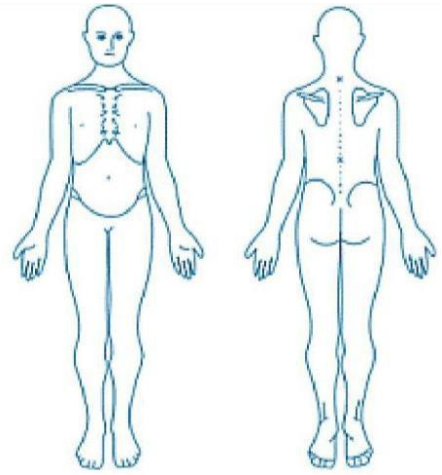
SOUTHLAND PHYSICAL THERAPY

Name: _____ **Occupation or previous occupation**: _____

Height: ____ ft ____ in **Weight**: _____ lbs **Age**: _____

Area(s) of Injury



Using the drawing on the right:

- **Shade in** all areas experiencing symptoms (pain, stiffness, aches, etc…) on the drawing below.
- **Label** the spot of the worst pain with a small X
- **Circle** any areas of numbness or tingling

1. When did your injury occur? __ / __ / __
2. If post-op, when was your surgery? __ / __ / __
3. Pain level:
   - Current Pain Level __ / 10
   - Highest Pain Level __ / 10
   - Lowest Pain Level __ / 10

Medical Questions - (circle yes/no):

1. **Yes / No** Do you have a pacemaker?
2. **Yes / No** Have you experienced significant weight loss recently?
3. **Yes / No** Have you ever had cancer?
4. **Yes / No** Have you had multiple cortisone or prednisone injections?
5. **Yes / No** Are you taking any anti-inflammatory medications?
6. **Yes / No** Are you taking any muscle relaxants for this problem?
7. **Yes / No** Are you taking any pain medications for this problem?
8. **Yes / No** Are you currently taking any other medications?
   a. Please list in chart
9. **Yes / No** Do you have any difficulties with urination?
   a. If YES, please explain

   _____

   _____
10. Have you had any of the following for this specific problem (circle yes/no):

    Yes / No CT Scan

    Yes / No MRI

    Yes / No X-Ray

Medication	Dosage	Frequency

Is there any condition that you feel may affect your treatment in any way? (please circle): heart condition, lung condition, osteoporosis, joint replacements, balance deficit, visual impairment, previous surgeries, skin sensitivity, allergies, dizziness, fainting. Please explain: _____

_____

I acknowledge that the above information I have written is true and accurate to the best of my knowledge. I will notify my therapist of any change in condition.

Patient Signature _____ Date: _____

SOUTHLAND PHYSICAL THERAPY

PATIENT INFORMATION

LAST _____ FIRST _____ MI _____

GENDER: M / F DOB: ____MO./____DAY/_____YEAR SS# _____-_____-_____ MARITAL STATUS _____

PHONE (CELL) _____ PHONE (HOME) _____

EMAIL _____

ADDRESS _____ CITY_____ ST_____ ZIP _____

EMPLOYER _____ ADDRESS_____

OCCUPATION _____ WORK PHONE _____ EXT _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

EMERGENCY CONTACT

LAST _____ FIRST _____ RELATIONSHIP _____

PHONE (CELL) _____ PHONE (HOME) _____

APPOINTMENT REMINDER

Select **one** option below and initial

□**EMAIL REMINDER** ____

□ **TEXT MESSAGE REMINDER**: (Select Carrier) ____

□ALLTel □Boost □Cricket □MetroPCS □Qwest □T-Mobile □Verizon
□AT&T □Cingular □Metrocall □Nextel □Sprint □US Cellular □Virgin Mobile

□ **NO REMINDER** ____

Email/Cell Phone # (If different from above): _____

*Initialing indicates consent for Southland Physical Therapy to provide automatic appointment reminders via the selected method of delivery. I understand that text messaging rates may apply.

REFERRAL SOURCE

WHO MAY WE THANK FOR REFERRING YOU? _____

PATIENT CONSENT

I consent to any medical treatment rendered under the general and special instructions of the physician and/or physical therapist.

I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, therapeutic exercises, neuromuscular education, gait training, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, ultrasound, laser, and special procedures such as: taping, neuromuscular electrical stimulation, mechanical traction, and bladder training, evaluation and treatment of functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.

I understand that I may refuse any therapeutic procedure or treatment at any time.

_____ _____ _____

Patient Name (or Responsible Party) Signature Date

SOUTHLAND PHYSICAL THERAPY

PATIENT FINANCIAL RESPONSIBILITY & APPOINTMENT POLICY

I hereby assign all physical therapy benefits to Southland Physical Therapy for services rendered to me or said minor patient. I authorize any holder of medical information about me or said minor to release to my insurance company any information needed to determine these benefits payable for related services. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY SOUTHLAND PHYSICAL THERAPY, I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO SERVICES RENDERED. This includes, but is not limited to; services deemed 'non-covered' or 'not medically necessary' by my insurance.

Your commitment to attending your appointments, being here on time, and doing your home exercise program is critical for your recovery.

In light of this, we reserve the right to charge a $25 fee for a missed appointment or cancellations with less than 24 hours. This charge will not be covered by insurance and is the responsibility of the patient. 3 "no-shows" (missed appointments without prior or any notification) OR 3 cancellations with less than 24 hours notice may result in the loss of your physical therapy benefits. We are obligated to notify your referring physician about attendance or compliance issues and your physician may decide to discontinue your course of therapy.

I have read and understand the patient financial responsibility & appointment policy and I agree to adhere to its terms. Altering this form in any way will not change the policy as outlined above by Southland Physical Therapy.

I understand my signature requests that payment be made to Southland Physical Therapy, and authorize release of medical information necessary to pay the claim.

_____ _____ _____

Patient Name (or Responsible Party) Signature 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 this policy carefully. For more detailed information, please request a printout.

Understand your health record and information:

When receiving physical therapy services from SOUTHLAND PHYSICAL THERAPY, INC. a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, and your treatment plan. It also contains daily treatment notes and progress notes.

Our pledge regarding medical information:

We understand that your medical information personal and and private. We are committed to protecting your information. Medical records are only disclosed in a limited amount of circumstances which may be regarding; **treatment ,payment, review for quality of care, federal, state, or local law, and lawsuites/disputes.** If for any reason, you would like a copy of your entire record, please make your request in writing. For your protection, please have proper ID with you if picking up records in the office.

I have read and understand all information outlined above.

_____ _____ _____

Patient Name (or Responsible Party) Signature Date

*If you would like more detailed information on any of our policies or procedures, please request a copy from the front office.