RE: Initial Evaluation for Physical Therapy

Dear new Patient,

Thank you for choosing Foothills Physical Therapy for your treatment.

For your first scheduled appointment at Foothills Physical Therapy and to help to serve you better, please complete and bring with you the attached paperwork. All of the **highlighted areas** need to be read, completed and signed.

We ask that you arrive (15) minutes prior to your scheduled appointment, in order for us to answer any questions you may have regarding your paperwork, and to complete your patient chart for the Physical Therapist. We also ask that you call your health insurance company prior to your first appointment and verify your **out-patient physical** therapy benefits. If you have a managed care plan, the necessary referrals and co-payment information will need to be verified. You may also be limited to the number of days and/or the number of visits you will be entitled to with your health insurance plan, as well as a maximum allowance ($) amount for **Physical Therapy**. Again, we strongly recommend that you verify your coverage prior to your first appointment.

If you have any questions regarding the above information, please call our office at (207) 625-4300, and we will be pleased to answer any questions that you may have.

You have been scheduled for a **one-hour appointment**, and we know that your time is as valuable as ours. We would appreciate a 24 -hour notice if there is a need to change your appointment. Please bring the following information with you at your first appointment: insurance card(s), prescription/referral from your doctor (unless it was faxed to us by your doctor), and new patient paperwork.

We look forward to helping you with your Physical Therapy needs.

Sincerely,
Foothills Physical Therapy

FOOTHILLS PHYSICAL THERAPY LLC

Patient Information Form

NAME:	HOME PH:	EMPLOYER:
ADR 1:	WORK PH:	MARITAL: S M D
ADR 2:	SOC SEC#:	STUDENT: Y N
CITY:	BIRTHDATE: / /	EMER. CONTACT:
STATE: ZIP:	DATE OF INJURY: / /	EMER. PHONE:
	REFERRING DOCTOR:	

Other doctors involved in your care:
Name and address

PLEASE COMPLETE THE CORRESPONDING INSURANCE INFORMATION BELOW.

☐ **HEALTH INSURANCE** ☐ **WORKER'S COMP.** ☐ **AUTO ACCIDENT**

HEALTH INSURANCE INFORMATION

SUBSCRIBER:		INS. CO. NAME:	
ADR 1:		ADR 1:	
ADR 2:		ADR 2:	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
GROUP #:	CERT.#:	REL. TO SUBSCRIBER:	
TELEPHONE:		S.S.# OF SUBSCRIBER:	

WORKER'S COMPENSATION INFORMATION

SUBSCRIBER:		INS. CO. NAME:	
ADR 1:		ADR 1:	
ADR 2:		ADR 2:	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
TELEPHONE:		TELEPHONE:	
CONTACT:		CONTACT:	
DATE OF INJURY:		CLAIM #:	

AUTO ACCIDENT INFORMATION

SUBSCRIBER:		INS. CO. NAME:	
ADR 1:		ADR 1:	
ADR 2:		ADR 2:	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
TELEPHONE:		TELEPHONE:	
DATE OF INJURY:		CONTACT:	
ATTORNEY:		CLAIM #:	

MEDICAL INFORMATION AND PAYMENT AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS NECESSARY TO PROCESS THE ABOVE CLAIM FOR SERVICES RENDERED TO ME BY FOOTHILLS PHYSICAL THERAPY.

SIGNATURE OF PATIENT______________________ DATE______________

I AUTHORIZE PAYMENT OF BENEFITS FOR THE ABOVE CLAIM TO FOOTHILLS PHYSICAL THERAPY.

SIGNATURE OF PATIENT______________________ DATE______________

SIGNATURE OF PARENT/LEGAL GUARDIAN______________________

WELCOME TO FOOTHILLS PHYSICAL THERAPY, PA
PHYSICAL THERAPY

OFFICE POLICY:

We are dedicated to providing you with the best possible health care. We are ready to help you receive your maximum allowable benefits if you have medical insurance. In order to achieve these goals, we need your assistance, and understanding of our payment policy.

Your **co-pay** amount is **due at the time services are rendered** unless payment arrangements have been approved in advance. If your deductible amount is ***less than $500.00***, you will be billed once we receive notification from your insurance company. If your deductible is ***$500.00 or more***, we require a payment of **$50.00 per visit to be applied toward your deductible until it has been met.** We accept cash, checks, MasterCard and Visa.

There is a $25.00 service charge on all returned checks. Balances older than 30 days are subject to additional interest charges of 1.5% per month. You are also responsible for any collection fees for overdue accounts sent to a collection agency. Any person missing 3 appointments due to no shows or cancellations is subject to discharge.

Please realize that:

- Your insurance is a policy between you, your employer, and the insurance company. ***We are not a party to that contract.***

- Our fees reflect current market price. Outpatient Physical Therapy Clinics offer services at substantially less cost than larger institutions. Most insurance companies pay a percentage (such as 80%) of "UCR" or ***their fee schedule***. "UCR" is defined as Usual, Customary and Reasonable.

- Each insurance company determines what Physical Therapy services are covered under different policies and at what cost they will cover. Not all services are a covered benefit in all policies. Each insurance company arbitrarily determines what services they will cover.

We emphasize that as health care providers, our relationship is with you, not your insurance company. The filing of **primary** insurance claims is a courtesy that we extend to our patients. **Due to the rising costs of doing business today, we are unable to be responsible for filing your secondary insurance claims.** ***All charges are your responsibility from the date services are rendered.*** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I have read the above Office Policy and understand it. As Parent/Guardian I/we accept financial responsibility for the minor child.

______________________________	______________________
SIGNATURE	DATE
______________________________	______________________
PARENT/GUARDIAN SIGNATURE	PARENT/GUARDIAN SS #

PLEASE COMPLETE REGISTRATION ON OTHER SIDE

Informed Consent and Service Contract

As your sole provider of Physical Therapy, it is our goal to develop a professional and personable relationship with you. With your permission, we will seek to contact members of your healthcare team to better understand your particular condition.

We will explain to you all of the treatment details during your Physical Therapy Program before choosing a specific course of treatment. We invite you to be a part of the decision making process along the way as we work in concert with you and your healthcare team.

- Ask questions
- Be aware that there may not be an answer(s) to your question(s) or a complete explanation for your illness.

- You may need to change the way you go about your daily activities including work in order to succeed at healing and afterwards to prevent a recurrence.
- Dedicate yourself to improved fitness at work, home and leisure.

1. I understand that my informed consent to Physical Therapy Treatment is acknowledged.
2. I will participate in my rehabilitation to the best of my ability.
3. In the event we need to contact you may we leave a message at your home? Yes/no
4. Can we leave a message on your answering machine? Yes/no
5. Please leave names of designated people we can leave a message with.

____

____

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Patient Consent and Service Form continued

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operators such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________

Witness: ______________________________

Foothills Physical Therapy, L.L.C.

Orthopedic Manual Physical Therapy
Sports & Work Injury

16 Old Pike Rd., P.O. Box 48
Cornish ME, 04020
Tel: (207) 625-4300
Fax: (207) 625-7300

Thomas J. Thoman, DPT
Sarah K. Rogers, MPT
Jim G. Stevenson, PT, FAAOMPT
Hayes A. Sweeney, MPT

MEDICAL RECORDS RELEASE AUTHORIZATION

CLIENT NAME: ______________________________ DATE: ______________

I AUTHORIZE THE RELEASE OF RECORDS PERTAINING TO SERVICES RENDERED BY FOOTHILLS PHYSICAL THERAPY TO OTHER MEDICAL OR HEALTHCARE PROVIDERS PER PATIENT REQUEST.

DIRECT RECORDS TO: ______________________________

AUTHORIZED SIGNATURE: ______________________________

WITNESS: ______________________________

Foothills Physical Therapy, P.A.

Orthopedic Manual Physical Therapy
Sports & Work Injury

Past Medical History

Patient Name: ______________________ **Date of Birth:** ___/___/____ **Date** ___/___/____
Primary Care Providers: __________________ **Other Specialist(s):** _____________________

In the last 30 days have you received services from a hospital, nursing home or home health agency? Yes / No. **If yes, who:** _________________________ **When:** ______________

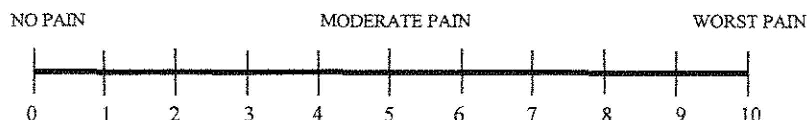
What are we seeing you for? ____
____

Have you seen any other medical providers for this problem? Yes / No
Primary Care Provider / PT / OT / Chiropractor Other: ________________________

Have you had images for this problem or a related problem? Yes / No
X-ray: When: ___________________ Where? ___________________________
CT scan: When: ___________________ Where? ___________________________
MRI: When: ___________________ Where? ___________________________
Ultrasound: When: ___________________ Where? ___________________________

Surgical History:
Heart Surgery (pace maker, stents, etc.): _______________________ **Date:** _________
Joint Replacement:________________ **Date:** ________ **Surgeon:** ______________
Joint Replacement:________________ **Date:** ________ **Surgeon:** ______________
Joint Replacement:________________ **Date:** ________ **Surgeon:** ______________
Other:_____________________________ **Date:** ________ **Surgeon:** ______________

Pain: Please place a check mark on the line that best describes the current level of pain.



Location of pain: ______________ **When did the pain start?** ______________

Yes	No		Yes	No	
		High Blood Pressure			Epilepsy or other seizure disorders
		Heart Disease			Problem with eyes (glasses/contacts?)
		Heart Attack			Problems with Ears (hearing aid?)
		Angina (chest pain)			Currently Pregnant (due date)
		Allergies (latex, tape)			Lung Problems
		Stroke			Asthma
		Diabetes			Bleeding Disorders (blood thinner?)
		Cancer			Arthritis (OA/RA)
		Osteoporosis			Dizziness / Vertigo (current / past)
		Broken Bones			Other: ____________________
		Metal Implants (including IUD's, bullets, staples, plates, etc.)			

OPTIMAL INSTRUMENT NAME:

Difficulty–Baseline DATE:

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1.* 12 *2.* 8 *3.* 13)

1.____ 2.____ 3.____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. 12)

Primary goal. ____

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NAME: ______________________

DATE: ______________

Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking–short distance	1	2	3	4	5	9
11. Walking–long distance	1	2	3	4	5	9
12. Walking–outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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