LoCicero Health
Physical Therapy

Physical Therapy New Patient Paperwork

Scheduled for: _____

ENROLLMENT INFORMATION

First Name:	**Last Name:**	**M.I.**	***Nickname*** (if any)
DOB: **Age:**	**Gender:** MALE **or** FEMALE	**SS #** _____-____-_____	
Street Address:	**City:**	**State:**	**Zip:**
Marital Status: **S**ingle **M**arried **W**idowed **D**ivorced			
Home Phone #	**Cell Phone #**	**Email:**	
Currently Employed: **No:** *Retired* *Disabled* OR **Yes:** *Full Time or Part Time:* *Name of Employer:* *Employer's Phone:*			

EMERGENCY CONTACT INFORMATION

Name:	Relationship:
Cell Phone #:	Alternate #:

PROVIDER CARE INFORMATION

Referring Physician: **Other Referral Source:**	**Reason for therapy (area of the body):**

Are you currently receiving Home Health Care Services: No Yes** (*If yes, please inform front desk)*

Is the nature of your condition / injury or the therapy to be provided related to any <u>AUTOMOBILE OR WORKERS COMPENSATION CLAIM</u>? _____ No _____ Yes * If yes, please provide Date of Accident _____. Is there any pending litigation? _____No _____Yes ** If Yes, please provide Name of Attorney:_____Phone_____
CaseManager:_____Phone_____

INSURANCE INFORMATION

Name Primary Insurance:	**Insurance Phone #**
Subscriber's Name: REFER TO INSURANCE CARD	DOB
ID # REFER TO INSURANCE CARD	Group Policy #
Name of Secondary Insurance:	
Subscriber's Name: REFER TO INSURANCE CARD	**Insurance Phone #**
ID # REFER TO INSURANCE CARD	Group Policy #

By signing below, I certify that all of the information above (to the best of my knowledge) is true, correct and complete.

Patient's Signature: _____ **Date:** _____

HEALTH HISTORY FORM

Printed Name of Patient:	**Date:**

What is your reason for consulting our center? _____

Date of Injury/Onset _____ Cause of Injury _____

Is this condition related to one of the following? _____Work Related Injury _____Auto Injury

Have you experienced this before? _____ Yes _____ No

Have you had recent: _____ X-rays _____ MRI _____ Nerve Conduction Test _____Bone Scan

Results: _____

Have you recently been hospitalized or had surgery? _____ Yes _____ No

If yes, date and reason: _____

What activities are you having difficulty with now? _____

_____

_____

(i.e. self-care, household chores, walking/moving around, lifting & carrying objects, changing positions, hobbies or other activities)

Activities/sports you participate in: _____

(i.e. pickleball, golf, water aerobics, cards, walking, sewing, etc.)

*What personal goals/outcomes you would like to achieve? _____

Are you currently working? ____ Yes _____ No _____ Retired

If yes, what is your occupation? _____ Hours/week _____

*Have you had any falls in the past year? _____ Yes _____ No

- If yes, how many? _____ 1 fall _____ 2 or more
- Describe any fall-related injuries _____

How would you describe your general health? ___ Excellent ___ Good ___Fair ___Poor

Do you smoke? _____Yes _____ No If yes, # of years: _____ Packs/day: _____

Have you ever had physical therapy before? _____ Yes _____ No

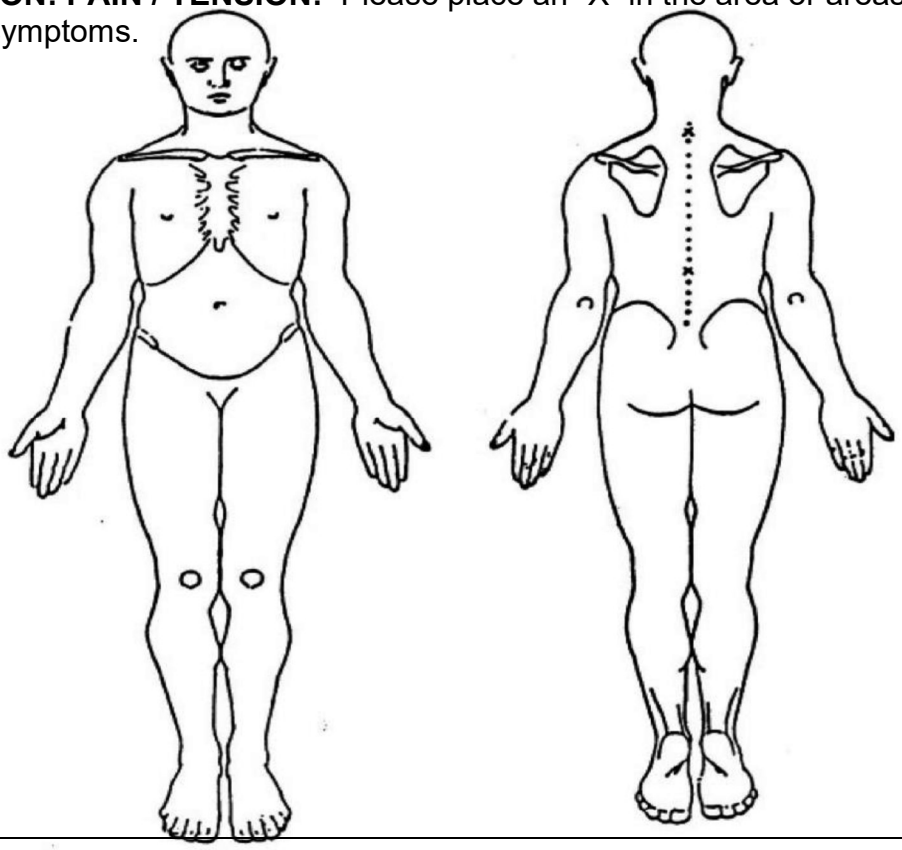
- If yes, approximate date and reason: _____

Have you had any Home Health services within the past six (6) months: _____ Yes _____ No

- If yes, approximate date and reason: _____

Printed Name of Patient:	**Date:**

PRESENT CONDITION: PAIN / TENSION: Please place an "X" in the area or areas where you are experiencing pain / symptoms.



What best describes your symptoms? (circle all that apply)

Sharp Dull Achy Stabbing Burning Radiating Stinging Nauseating

Numbness Tingling Throbbing Weakness Other_____

Is the Pain? _____Constant _____Intermittent

What increases your pain/symptoms? _____

What decreases your pain/symptoms? _____

Is your condition? _____Improving _____Getting Worse _____Not Changing

Rate your pain on a scale of 0 – 10. *(0 being no pain and 10 needs to be taken to the hospital)*

CURRENT level of pain?	0	1	2	3	4	5	6	7	8	9	10
Level of pain at its **WORST**?	0	1	2	3	4	5	6	7	8	9	10
Level of pain at its **LEAST**?	0	1	2	3	4	5	6	7	8	9	10

Printed Name of Patient:

YOUR HEIGHT: _____'_____" CURRENT WEIGHT: _____ lbs.

MEDICAL HISTORY: Do you have or have you had any of the following?
(Check only those that apply to you please)

_____ Anemia
_____ Asthma
_____ Balance problems
_____ Coordination problems
_____ Bowel/bladder issues
_____ Cancer: Type_____
_____ Depression
_____ Diabetes: *Insulin Dependent – Y or N*
_____ Dizziness/fainting/vertigo
_____ Excessive fatigue
_____ Shortness of breath/breathing problems
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Heart attack
_____ Heart disease
_____ **PACEMAKER**
_____ Hypoglycemia *(low blood sugar)*
_____ Osteoarthritis
_____ Osteoporosis/osteopenia
_____ Rheumatoid arthritis
_____ **METAL IMPLANTS**
_____ Hepatitis

_____ Low Exercise Level
_____ Vision problems
_____ Allergies
_____ Stroke
_____ Parkinson's Disease
_____ Multiple Sclerosis
_____ Nausea/vomiting
_____ Difficulty swallowing
_____ Kidney problems
_____ Headaches
_____ COPD
_____ Tuberculosis
_____ Thyroid problems
_____ Fibromyalgia
_____ Liver/Gallbladder problems
_____ High cholesterol
_____ Nervousness / Anxiety
_____ Seizures
_____ Ringing in ears
_____ Unexplained weight loss
_____ Difficulty sleeping
_____ HIV/AIDS

Any condition/concern not listed above? _____

List any **Operation/Implants/Replacements** you may have had (or provide separate list):

Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____

List any **Medications** you are taking **along with dosage** OR _____ See attached list of medications
(please provide separate list)

Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
(Use back side of this sheet if necessary to write out medications).

I have read and reviewed the information herein and represent that my answers are true, correct and complete. I understand that LoCicero Health and its health practitioners are relying upon the information in rendering treatment.

Patient's Signature: _____ Date: _____

HIPAA NOTIFICATION OF PRIVACY PRACTICES

Printed Name of Patient:

I understand LoCicero Health is required by law to keep my health information confidential. With my consent, LoCicero Health may use and disclose protected health information (PHI) about me to carry out treatment, payment, coordination of care, and other healthcare operations. If I wish to know more about its privacy practices, I shall refer to LoCicero Health Notice of Privacy Practices for a more complete description of such uses and disclosures. If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I have the right to review and request a copy of the Notice of Privacy Practices prior to signing this consent. I understand that LoCicero Health reserves the right to revise its Notice of Privacy Practices at any time.

I have the right to request a copy of my personal health information.

I have the right to be notified when it has been determined that a breach of my unsecured PHI has occurred.

I understand this authorization is voluntary. According to HIPAA regulations, LoCicero Health may not release information about me to my family or friends without my written consent. LoCicero Health will discuss health related information to the person I list as my emergency contact.

I may revoke this authorization at any time, provided that I do so in writing.

I am entitled to receive a copy of this authorization.

LoCicero Health may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance issues and any calls pertaining to my care.

LoCicero Health may mail to my home or other designated location any items that assist the practice in carrying out healthcare operations such as patient statements and other office communication.

By signing this form, I am consenting to LoCicero Health use and disclosure of my protected health information (PHI) to carry out treatment, payment, coordination of care and other healthcare operations.

Any concerns I have regarding any violation of my privacy rights will be communicated to an LoCicero Health Compliance Officer and/or to the Office Manager at LoCicero Health. I, also, have the right to report any concerns that I have with my privacy rights to the Office of Civil Rights, U.S. Department of Health and Human Services.

Patient's Signature: _____ Date:_____

OFFICE POLICIES

Printed Name of Patient:

CONSENT FOR CARE & TREATMENT: I consent and authorize LoCicero Health to perform physical evaluation, Physical Therapy, Strength therapy, exercise and related services. In so doing, I understand, acknowledge and affirm services may involve bodily contact, touching and / or direct contact.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize LoCicero Health to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered to LoCicero Health.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered. You understand that we are required to fully cooperate and communicate with claims adjusters, case managers and Workers' Compensation carriers.

CANCELLATION & NO-SHOW POLICY: Please be aware that we require 24-hour notice for cancelling or rescheduling an appointment. The charge for cancellation without proper notice is $25 for a physical therapy visit. This charge will not be covered by nor billed to insurance and will have to be paid by you personally prior to receiving additional treatment.

NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient funds may be subject to a $25 processing fee (or higher – depending upon charges assessed by the financial institution).

FINANCIAL POLICY: As a courtesy to you, we will bill your insurance carrier(s). You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 90 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. **If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us.** If formal collection procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. For any questions or concerns regarding your insurance coverage, you are strongly encouraged to contact your insurance company directly and inquire about your benefits.

INSURANCE VERIFICATION / FINANCIAL RESPONSIBILITY	
Deductible:	Co-Pay / Co-Insurance:

I understand the quote of financial responsibility as outlined above. I agree to pay all Co-payments at the time of service OR deductible and co-insurance upon receipt of a statement from LoCicero Health. I agree to pay my portion of this bill. Payment is due at the time that services are rendered unless prior arrangements have been made in writing.

Patient's Signature: _____ Date: _____

Informed Consent

Printed Name of Patient:

I seek the services of LoCicero Health and its employees ("LoCicero Health"). I am executing this consent to confirm my discussion with LoCicero Health and understanding of the risks, benefits and alternatives to treatment by LoCicero Health.

1. **Benefits of Treatment by LoCicero Health**

I understand that services and treatments offered by LoCicero Health are intended to help me recover, maintain and enhance my ability to live an active, independent lifestyle.

2. **Risks**

I understand that the treatment, modalities and equipment employed by LoCicero Health may carry certain risks. I understand that the physical response to a specific treatment can vary widely from person to person and that it is not always possible to predict an individual's response to a given modality or procedure. I understand that the services I receive from LoCicero Health may cause discomfort, pain or injury or may aggravate a previously existing condition. I understand that if I have any questions or concerns about the services I receive from LoCicero Health, I should raise these with my physical therapist or another LoCicero Health representative.

3. **Alternatives**

I understand that my health care provider may recommend alternatives to services from LoCicero Health to help me meet my health goals, and that if desired, I should ask my health care provider for more information about alternatives to physical therapy.

4. **Representatives**

I understand that LoCicero Health makes no representations, claims or guarantees that my medical or health problems or conditions will be helped by undergoing treatment or services with LoCicero Health. I understand that my failure to comply with treatment recommendations may impede results.
I am responsible to disclose to LoCicero Health all medications, care and assessments that I receive elsewhere and to provide medical records as needed from other providers to ensure that care is coordinated and compatible.
I understand that my treatment with LoCicero Health may include recommendations that I seek other types of treatment or services from other health professionals who are not affiliated with LoCicero Health. I understand that LoCicero Health does not supervise these professionals and is not responsible for them.

I certify that I have read and understand the foregoing Informed Consent. If its contents have raised any questions for me, I have asked and received satisfactory answers to my questions. I hereby agree and accept all of the terms above.

Patient's Signature: _____ Date: _____