Initial Evaluation:

Day_____ Date: _____ Time: _____

Catamount Physical Therapy

Patient information form

Please print and complete ALL items. If an item doesn't apply, put N/A

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Date of Birth:** ____/____/____ **Age:** ___

Sex: _____ **Emergency Contact:** _____
Name Home Phone Work Phone

Responsibility Information:

Who will be primarily responsible for the bill? _____

I will be paying my share of financial responsibility by: Cash☐ Check☐ Credit Card☐

PRIMARY Insurance Company: _____ **Phone#:** _____

Primary Insurance: ID#: _____ **Group#:** _____

SECONDARY Insurance Company: _____ **Phone#:** _____

Secondary Insurance: ID#: _____ **Group#:** _____

Policy Holder's Name:

_____
Last First Middle

Policy Holder's Date of Birth: ____/____/____

Address: _____
Street City State Zip

Policy Holder's Employer: _____

Employer's Address: _____
Street **City** **State** **Zip**

Position: _____ **Phone:** _____

Referring Physician_____ **Diagnosis** _____

IS THIS A WORKER'S COMPENSATION CLAIM? Yes☐ No☐Date of Injury: _____

IS THIS AN ACCIDENT CASE? Yes☐ No☐ VEHICLE☐ OTHER _____

I hereby authorize Catamount Physical therapy to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize Catamount Physical Therapy to contact he insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: _____ **DATE:** _____

Signature for Minor (under 18 years of age) _____

DATE : _____

MEDICAL SCREENING FORM

Circle YES or NO…

Have you or any immediate family member ever been told you have: .....

	Self	Family
Cancer ?	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes ?	Yes ☐ No ☐	Yes ☐ No ☐
High blood pressure ?	Yes ☐ No ☐	Yes ☐ No ☐
Heart disease ?	Yes ☐ No ☐	Yes ☐ No ☐
Angina/chest pain ?	Yes ☐ No ☐	Yes ☐ No ☐
Stroke ?	Yes ☐ No ☐	Yes ☐ No ☐
Osteoporosis ?	Yes ☐ No ☐	Yes ☐ No ☐
Osteoarthritis ?	Yes ☐ No ☐	Yes ☐ No ☐
Rheumatoid arthritis ?	Yes ☐ No ☐	Yes ☐ No ☐

In the past 3 months have you had or do you experience:

- A change in your health ? ..... Yes ☐ No ☐
- Nausea/Vomiting ? ..... Yes ☐ No ☐
- Fever/chills/sweats ? ..... Yes ☐ No ☐
- Unexplained weight change ? ..... Yes ☐ No ☐
- Numbness or tingling ? ..... Yes ☐ No ☐
- Changes in appetite ? ..... Yes ☐ No ☐
- Difficulty swallowing ? ..... Yes ☐ No ☐
- Changes in bowel or bladder function ? ..... Yes ☐ No ☐
- Shortness of breath ? ..... Yes ☐ No ☐
- Dizziness ? ..... Yes ☐ No ☐
- Upper respiratory infection ? ..... Yes ☐ No ☐
- Urinary tract infection ? ..... Yes ☐ No ☐

Patient Information:

NAME _____

PHONE: _____

Circle YES or NO…

Do you have a history of:

- Allergies/Asthma ? ..... Yes ☐ ... No ☐
- Headaches ? ..... Yes ☐ ... No ☐
- Bronchitis ? ..... Yes ☐ ... No ☐
- Kidney disease ? ..... Yes ☐ ... No ☐
- Rheumatic fever ? ..... Yes ☐ ... No ☐
- Ulcers ? ..... Yes ☐ ... No ☐
- Sexually transmitted disease ? . Yes ☐ ... No ☐
- Seizures ? ..... Yes ☐ ... No ☐

Are you currently:

- Pregnant ? ..... Yes ☐ ... No ☐
- Depressed ? ..... Yes ☐ ... No ☐
- Under Stress ? ..... Yes ☐ ... No ☐

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

Check all that apply…

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco?

☐ **YES** ☐ **NO**

If yes, _____ Packs **X** _____ Years.
Last tobacco use _____

Do you drink alcoholic beverages? ☐ **YES** ☐ **NO**

If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____

List medications currently using:

_____

_____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 48 hours:

No Pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **Worst Pain Imaginable**

Best for the last 48 hours:

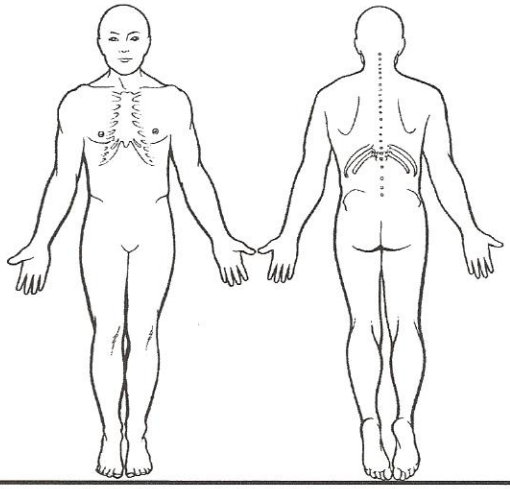
No Pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **Worst Pain Imaginable**

Body Chart:

Please mark the areas where you feel pain on the chart to the right



For the therapist

+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Bldder Chnge
+ / - Numb/Ting.

Please circle the number below which best represents your overall average level of function.

Cannot do anything (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **Able to do everything**

What makes your symptoms better?_____

_____

Please circle the activities which make your pain worse:

☐ lying down ☐ standing ☐ walking ☐ stress ☐ sitting

Any other activities that make your pain worse?:

Please list the best and worst time of day for your symptoms } Best -
Worst -

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1)_____

2)_____

3)_____

Below for the Therapist:

Rating:_____

Rating:_____

Rating:_____

AVG:_____

Therapist Use

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before your (injury or problem)**

CATAMOUNT

PHYSICAL THERAPY

Cancellation/No Show Policy/Consent to Treat

Success in physical therapy depends upon keeping the prescribed number and frequency of visits: consistent attendance results in the most expedient and best outcome.

Additionally, keeping your scheduled appointment shows respect for your physical therapist's schedule. Our PT's have appointments scheduled back-to-back, and often there is a waiting list of patients who were unable to fit in. If you do not show, or you cancel an appointment too late, this is a whole hour of wasted time for the PT and a lost opportunity for another patient to be seen.

Therefore, in an effort to keep your care on track, maintain productive schedules at Catamount PT, and give all patients an opportunity to be seen, **Catamount PT requires 24-hour notice for the cancellation of all scheduled appointments.**

There is a **$30 fee for a cancellation** without proper notice and a **$50 fee for a "no show"** (i.e., not showing up for an appointment without any communication). **THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE CARRIER.** It is your responsibility and payment will be expected at next visit.

After two missed appointments or three cancelled appointments, you may either be discharged from therapy or restricted to day-of-only appointment scheduling.

We understand that extenuating circumstances sometimes occur, which is why we have implemented a "one-strike" policy: **we will allow for one cancellation before charging a fee.**

I understand Catamount PT's Cancellation/No Show Policy and my responsibility to plan appointments accordingly. I will notify Catamount PT if I have difficulty fulfilling my scheduled appointments.

I give permission for Catamount PT to provide the medical treatment appropriate for my physical condition.

I consent to the above, as indicated by my signature below:

Patient signature/Date: _____

Witness Signature Date _____

CATAMOUNT PHYSICAL THERAPY

Notice of Privacy Policy for Protected Health

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result f the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy. Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

HOW WE COLLECT YOUR INFORMATION: Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This insures you that the information we collect is correct.

We may ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION: We collect this information so that we can treat your condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION: To insure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION: Any person or persons you designate in writing, people directly involved in your medical care, people creating

and maintaining your medical record, and those entitles that need your information to process health care claims and obtain payment for our services have access to your Protected health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION: We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your health care or entities who need this information for claims processing have access to your protected Health Information.

YOUR RIGHTS: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. You have the right to request a restriction on the use or disclosure of your health information except as provided by law.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. Your request must be in writing to our office.

You have the right to ask us to amend your health information if you believe it is incorrect or incomplete. This request must be in writing and state a reason that supports your request for amendment.

If you leave this practice your Protected Health Information will continue to receive the protection outlined in this notice.

If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. You will not be penalized for filing a complaint.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office. This notice is effective as of April 14, 2003.

_____ _____

Patient Signature Date