TOMSIC physical therapy

PATIENT RECORD

Please fill out completely. Thank you

Date_____ Referring Physician_____

Last Name_____ Legal First Name_____MI ____

Mailing Address_____ Home Phone _____

City_____ST._____Zip_____ CellPhone _____

Sex_____ Birth Date_____ Social Security #_____

Email address: _____

Employer Name_____ Phone #_____

Employer Address (**Worker's Comp only**)_____

****Preferred Method of Appt Reminders: Text Msg, Voice Call or Email (circle one)_____******

Are You a Student?_____ Single or Married?
Name of Spouse_____ Spouse's Cell Phone _____
Name of Insured:_____DOB:_____
Relationship to Insured: Mother Father Guardian Spouse

FOR MINOR PATIENTS:

Responsible Party _____

Mailing Address_____City_____State_____ZIP_____

Phone_____DOB_____Social Security #_____

Employer Name_____Phone # _____

Name of Insured:_____DOB:_____
Relationship of Insured: Mother Father Guardian

Emergency Contact Person _____
Relationship to Patient _____Phone Number _____
Primary Care Physician _____Office location _____

Date of Injury_____
Was This Work Related?_____ Auto Accident?_____ Other Accident?_____

****

How did you hear about us? Return patient? _____ Doctor? _____

Friend?Name_____ Phone Book? ____ Other? _____

****

If your insurance company requires a referral from a physician, it is your responsibility to obtain and provide it to us.

Do you have a Secondary Insurance? Company: _____

Name of Insured:_____ DOB of Insured:_____

Consent for Treatment and Uses of Healthcare Information for Purposes of Payment and Healthcare Operations

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Rakita and Tomsic Physical Therapy, Inc. I consent to the release to and, use by, or disclosure of my protected health information to and by Rakita & Tomsic Physical Therapy, Inc., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Rakita & Tomsic Physical Therapy, Inc. I understand that diagnosis or treatment of me by David N. Rakita, Ellen M. Tomsic or their associates, may be conditioned upon my consent as evidenced by my signature on this document

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Any and all protected health care information may be disclosed at any time to: _____ whose relationship to me is _____.

Rakita & Tomsic Physical Therapy, Inc. is not required to agree to the restrictions that I may request. However, if Rakita & Tomsic Physical Therapy, Inc. agrees to a restriction that I request, the restriction is binding on Rakita & Tomsic Physical Therapy, Inc., David N. Rakita, Ellen M. Tomsic and/or their associate. I have the right to revoke any and all consent, in writing, at any time, except to the extent that David N. Rakita, Ellen M. Tomsic or Rakita & Tomsic Physical Therapy, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that Rakita and Tomsic Physical Therapy will bill my insurance as a courtesy to me and any payment disputes are between me and my insurance company. I authorize my insurance company to pay, directly to Rakita and Tomsic Physical Therapy, Inc, all benefits due me under the provisions of my policy. I understand and accept that, although I may be covered by insurance, I am personally responsible for all charges incurred for services rendered to me. I accept liability for all charges not paid for by the insurance, third party or other source.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand I have a right to review Rakita & Tomsic Physical Therapy, Inc.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Rakita & Tomsic Physical Therapy, Inc.

The Notice of Privacy Practices for Rakita & Tomsic Physical Therapy, Inc. is also provided at the reception desk in the office of Rakita & Tomsic Physical Therapy, Inc. This notice of Privacy Practices also describes my rights and Rakita& Tomsic Physical Therapy, Inc.'s duties with respect to my protected health information. Rakita & Tomsic Physical Therapy, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

TOMSIC physical therapy

Physical Therapy Intake Form (Please fill out completely)

Name_____ **Date**_____

DOB _____ **Age** _____ **Ht** _____ **Wt**_____

Current complaints/what brought you to Physical Therapy?

1._____**How Long?**_____

2._____**How Long?**_____

3._____**How Long?**_____

Have you been treated for this problem (PT, Chiropractic, Massage, Injections?) _____

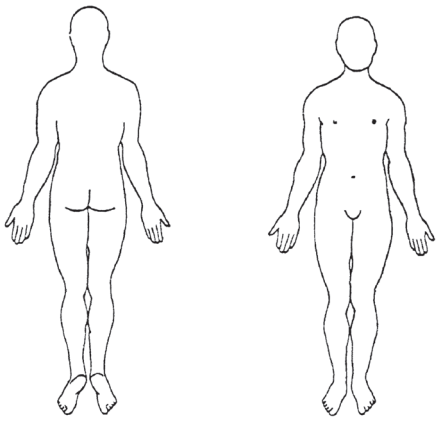
Have you received any special tests for this problem (X-Ray, MRI, Blood, etc.?) _____

My symptoms are currently ❒ Getting Better ❒ Getting worse ❒ Staying the same

I should not do physical activity that might make my pain worse ❒ Agree ❒ Unsure ❒ Disagree

Do you expect to return to the activity levels you were at prior to developing these symptoms ❒ Yes ❒ No

Please mark the location of your pain



List 3 postures or activities that make your symptoms worse

1._____

2._____

3._____

List 3 postures or activities that make your symptoms better

1._____

2._____

3._____

My symptoms ❒ Come and go ❒ Are constant ❒ Are constant but change with activity

How are you able to sleep at night due to your symptoms?

❒ No problem sleeping ❒ Difficulty falling asleep ❒ Awakened by pain ❒ Sleep only with medication

When are your symptoms the worst? ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ After exercise

When are your symptoms the best? ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ After exercise

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survery: 0 1 2 3 4 5 6 7 8 9 10

The best your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

The worst your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Medical Screening Information.

Please fill out completely so we can better understand your overall health and possible contributing factors to your problem.

Occupation, including activities that make up your work day. (sitting, driving, how long, etc.)_____

Leisure activities including exercise routines _____

Are you on any work restrictions from your doctor? _____

Do you use tobacco? (smoke/chew) ❒ Yes ❒ No

Have you ever had cancer? ❒ Yes ❒ No **Body Part/Type**_____ **When**_____

Have you ever taken steroid medications for any medical condition? ❒ Yes ❒ No _____

Have you (circle one) **ever taken or are currently taking a blood thinner or anti-coagulant medication?** ❒ Yes ❒ No

Do you have a pacemaker, transplanted organ, joint replacement, breast implants or any other implants? ❒ Yes ❒ No

If yes, please explain _____

Do you have diabetes? ❒ Yes ❒ No

Have you had a cold or other recent infection in the last 6 weeks? ❒ Yes ❒ No_____

Previous surgeries or injuries. Include date.

_____ _____

_____ _____

_____ _____

Current Medications (Include pills, skin patches, injections and non-prescription/over the counter drugs, and supplements)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Are you allergic to any medications? _____

Have you recently noted any of the following (check all that apply)?

❒ fatigue
❒ fever/chills/sweats
❒ nausea/vomiting
❒ weight loss/gain
❒ difficulty maintaining balance while walking
❒ falls
❒ numbness or tingling
❒ muscle weakness
❒ dizziness/lightheadedness
❒ heartburn/indigestion
❒ difficulty swallowing
❒ changes in bowel or bladder function
❒ constipation
❒ diarrhea
❒ shortness of breath
❒ fainting
❒ cough
❒ headaches

Have you ever been diagnosed with any of the following conditions (check all that apply)?

❒ cancer
❒ heart problems/disease
❒ chest pain/angina
❒ high blood pressure
❒ circulation problems
❒ blood clots
❒ stroke
❒ anemia
❒ bone or joint infection
❒ chemical dependency (i.e., alcoholism)
❒ depression
❒ lung problems/respiratory disease
❒ tuberculosis
❒ asthma
❒ rheumatoid arthritis
❒ other arthritic condition
❒ bladder/urinary tract infection
❒ kidney problem/infection
❒ sexually transmitted disease/HIV
❒ pelvic inflammatory disease
❒ thyroid problems
❒ diabetes
❒ osteoporosis/osteopenia
❒ multiple sclerosis
❒ epilepsy
❒ eye problem/infection
❒ ulcers
❒ liver problems
❒ hepatitis
❒ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following conditions (check all that apply)?

❒ cancer
❒ heart problems
❒ high blood pressure
❒ diabetes
❒ stroke
❒ depression
❒ tuberculosis
❒ thyroid problems
❒ blood clots

What are your goals for physical therapy? _____

Financial Responsibility Policy

In agreeing to be responsible for your medical care, Rakita and Tomsic Physical Therapy, Inc. requires that you be responsible for your financial obligations to us.

EFFECTIVE January 1, 2009

Please read carefully, sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18), your parent or legal guardian must accept financial responsibility on your behalf.

- I understand and accept that I am ultimately financially responsible for all expenses incurred for services provided regardless of my insurance status, including workers compensation claims.
- Payment is expected and due at the time of service for co-payments, co-insurance, or deductibles that is required by my insurance policy. Durable medical equipment must be paid for at the time it is dispensed.
- I understand that I am responsible for the verification of my insurance coverage and benefit level for services rendered by Rakita and Tomsic Physical Therapy, Inc. providers.
- I understand that if, 90 days after billing, my insurance has not paid, my account will be due and payable by me. I understand that all outstanding balances billed to me by Rakita and Tomsic Physical Therapy, Inc., are due and payable within 30 days from billing.
- In the event my account becomes past due, my balance will accrue interest at the rate of 1.5% per month, 18% annually. In addition, I will be responsible for collection costs, attorney fees, court costs, and any other miscellaneous fees and that any court filings will be filed in LaPlata County. I consent to have the collection agency obtain my credit report for the purposes of collection on my account.
- In accordance with guidelines set forth by Colorado State Board of Medical Examiners, if further action must be taken on my account, I may be discharged from this practice and be required to seek further care elsewhere.
- I understand that I will be assessed a $20.00 fee plus any additional charges allowed by CRS 13-21-109 for any returned check. Any payments thereafter must be made with cash or credit cards.
- **I understand that a fee of $25.00 may be charged if I fail to keep my scheduled appointment on the same day. This fee must be paid at the time of or prior to your next visit and is not billable to your insurance.**
- **If I am scheduled for a Functional Capacity Evaluation (FCE), I understand that a fee of $250 WILL be charged if I fail to cancel the appointment within 48 hours of the appointment and after an Appointment Reminder Telephone Call.**
- I understand that all TENS units dispensed by Rakita and Tomsic Physical Therapy, Inc. are not owned by them and the patient will be billed by EMPI. Rakita and Tomsic Physical Therapy, Inc. will bill your insurance $25.00 for the education in use of the TENS unit. This may or may not be a reimbursable service.

Patient's Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____

575 Rivergate Lane Suite 97 Durango, Co 81301 970 259 0574 fax 970 259 0576