Luke Carlson PHYSICAL THERAPY

PATIENT INFORMATION Date: _____

Patient Name: _____ DOB: _____ Age: _____

Married: _____ Single:_____ Widowed:_____ Male: _____ Female: _____

Home Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer:_____ Occupation: _____

Business Phone: _____

IF PATIENT IS INSURED THROUGH SPOUSE/PARENT, COMPLETE THIS SECTION

Insured Name: _____ DOB: _____

Employer:_____ Phone Number: _____

Relationship: _____

APPOINTMENT REMINDERS: _____Text _____Email _____None

STATEMENT PREFERENCE: _____ Paper/Mail _____Text _____Email

OVER →

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: _____

IF DUE TO WORK OR AUTO ACCIDENT, COMPLETE THIS SECTION

Is this a liability injury? Yes _____ No _____ Date of Injury: _____

If yes, please check one: Work Comp _____ Auto _____ Other _____

Insurance Company Name: _____

Contact Person: _____ Phone Number: _____

Claim #: _____

MEDICARE PATIENTS

Have you had any other physical therapy this year? Yes ____ No____

Are you currently having any home health or nursing services? Yes____ No____

If so, have you been discharged from their services? Yes____ No____

Who was the provider? _____ Discharge Date: _____

HOW DID YOU HEAR ABOUT US?

_____ Doctor Referral_____

_____ Personal Referral_____

_____ Ad/Marketing/Internet_____

_____Other _____

MEDICAL INFORMATION

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Reason for therapy: _____ Date Symptoms Began: _____

Referring Physician Name: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Have you **EVER** been diagnosed with any of the following? *(Please circle all that apply.)*

Cancer	Blood Clots	Asthma
Hepatitis	Thyroid Problems	COPD/Emphysema
Stroke	Rheumatoid Arthritis	Osteoporosis
Seizures	Stomach Ulcers	Osteoarthritis
High Blood Pressure	Circulation Problems	Depression
Heart Problems	Kidney Problems	Chemical Dependency
Tuberculosis	Bleeding Disorder	Multiple Sclerosis
Diabetes Type I	Tobacco Use: YES/NO	Amount/Day: _____
Diabetes Type II	Other: _____	

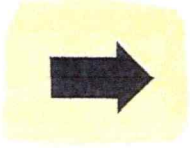
Please list any surgeries and approximate dates:

_____

_____

Please list all prescription/over-the-counter/vitamins/herbal supplements currently taking:

Name	Dose/Frequency	Method (Oral/Injection/Patch)



OVER

Pain Assessment:

1. Please rate your pain on a scale of 0 - 10

   (0 = No pain, 10 = Pain requires immediate/emergency medical attention)

   Current Pain: _____ Best in Last Week: _____ Worst in Last Week: _____

3. How would you describe your pain? *(Please circle all that apply.)*

   Sharp Dull Ache Stabbing/Burning

   Constant Intermittent Other: _____

4. Complete the following statements:

   My pain is made worse by: _____

   My pain improves with: _____

   I take the following medications for pain: _____

Fall Assessment:

1. Have you had any falls in the last year? YES NO

   If yes, how many times? _____

2. Were you injured? YES NO

   If yes, please describe: _____
   _____
   _____
   _____
   _____

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CONSENT/HIPAA/AUTHORIZATION TO RELEASE INFO/FINANCIAL AGREEMENT

Consent for Treatment:
I hereby authorize and give my consent to Luke Carlson Physical Therapy and Sports Medicine to provide me with therapy services including, but not limited to, Physical and Occupational Therapy.

Notice of Privacy Practices:
I acknowledge that I have been given an opportunity to receive and/or read the HIPAA Notice of Privacy Practices for Luke Carlson Physical Therapy & Sports Medicine.

Authorized Person(s):
I authorize you to speak to the following person(s) regarding my account and/or treatment, ***this includes family members and/or physicians other than your referring physician:***

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

Authorization to Release Information:
I authorize the release of any medical information related to my treatment to my insurance carrier(s), or any other individuals or companies deemed necessary to determine my insurance benefits payable for services or supplies received by Luke Carlson Physical Therapy & Sports Medicine.

Financial Responsibility:
Luke Carlson Physical Therapy uses Revenue Rx to submit all claims for charges to your insurance provider as a service to you. If your policy requires a referral, please have it with you at your first visit. Failure to obtain and present this at the time of service may result in a reduction and/or loss of your insurance benefits.

I have read the above policies and agree with them. I authorize Luke Carlson Physical Therapy to furnish information to my physician, insurance company, worker's compensation or attorneys concerning my injury and treatment by any means necessary. I understand that I am financially responsible for the payment of all services that are not paid by my insurance carrier. Should my account be referred for collection, I will be responsible for paying the costs of collection, including any legal fees that may arise from this action.

_____ **Date:** _____
Patient/Responsible Party

_____ **Date:** _____
Office Manager

Luke Carlson PHYSICAL THERAPY

CANCEL/NO-SHOW POLICY

Your treatment is very important and it is our job to help you to succeed with your rehabilitation. We understand that there may be times when you need to cancel an appointment. We kindly ask that you give us 24 hours notice, when possible, if you need to cancel or reschedule an appointment.

Luke Carlson Physical Therapy reserves the right to cancel all future appointments after 3 consecutive Cancel/No-Show visits. If you feel you are unable to be consistent with your treatment at any time, please feel free to have a conversation with your therapist to determine the best course of action for you.

We thank you for your understanding and cooperation.

_____ _____

PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**