MEDICAL HISTORY FORM TRAILS END PHYSICAL THERAPY

Name (last): _____ **(first)**_____**Age:** _____ **Date:** ____/____/_____

To ensure you receive a complete and thorough initial evaluation at TRAILS END PHYSICAL THERAPY, please provide us with the important background information on this form. If you do not understand a question, your therapist will assist you. Thank you.

Do you have now or have you ever had any of the following?

□ Allergies / Skin Sensitivity	□ Easy Bruising / Bleeding	□ Lung Disease
□ Asthma / Breathing Problems	□ Fainting / Dizziness	□ Multiple Sclerosis
□ Balance or Gait Disturbance	□ Headaches	□ Osteoarthritis
□ Bladder or Bowel Changes	□ Heart Problems / Hypertension	□ Rheumatoid Arthritis
□ Cancer	□ Hepatitis	□ Thyroid Problems
□ Diabetes	□ Kidney Disease	□ Vision Problems

□ Any other previous injury or illness that may affect current care _____

Surgical History

Please list all surgeries and corresponding dates: _____

_____

Personal Data

1) Work Status: □ Light Duty □ Off work □ Normal schedule □ Retired □ Disabled
2) Job position if still working: _____
3) Do you have a pacemaker? YES / NO
4) Do you smoke? YES / NO
5) Are you, or is there a chance you could be pregnant? YES / NO
6) Without wanting to, have you lost at least 20 lbs in the past 6 months? YES / NO
7) Any language needs / barriers? _____
8) Please list all medications: _____

_____

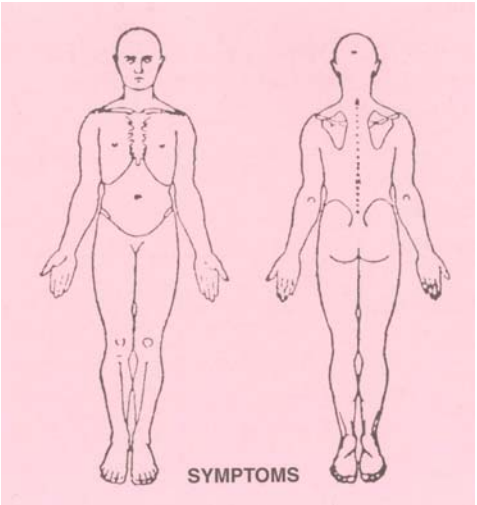
Current Condition

1) Type of injury / condition: _____
2) Onset / Injury date: _____
3) Is your current condition getting better, worse, or staying the same? _____
4) What are your physical therapy goals? _____

Have you had any of the following tests or treatments for this problem?

□ X-Ray □ CT Scan □ Bone Scan □ Arthrogram □ MRI
□ Physical Therapy □ Other: _____

Please indicate the areas of concern



III *Numbness*

XX Pain

Is the pain / numbness: □ constant □ intermittent

_____ _____/_____/_____

Patient Signature **Date**

LIST OF CURRENT MEDICATIONS.
I will notify the therapist of any changes in my medications.

X_____

TRAILS END
PHYSICAL THERAPY

Patient Name_____ Date of Birth_____

Medication	Dose	How and how Often you take the Medication	Reason for taking	Date Started	Prescriber

47608 2/8/06

TRAILS END PHYSICAL THERAPY

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **TRAILS END PHYSICAL THERAPY** to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

_____ Date _____/_____/_____
Patient/ Guardian/ Responsible Party

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I hereby assign all medical and/ or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party insurance companies to TRAILS END PHYSICAL THERAPY. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

_____ Date _____/_____/_____
Patient/ Guardian/ Responsible Party

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit it to TRAILS END PHYSICAL THERAPY.

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if your Worker's compensation benefits are subsequently denied, you may be held responsible for the total amount of charges for services rendered to you.

TRAILS END PHYSICAL THERAPY verifies benefits as a courtesy to you. However, TRAILS END PHYSICAL THERAPY does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/ co-insurance benefits or benefit plan.

INSURANCE PROCESS EXPLANATION

The insurance companies can take several months to fully process your claim. It is common for them to establish an internal *"usual and customary"* fee schedule and then they will send you an explanation of benefits (EOB), not a bill. Please wait until you receive a bill from TRAILS END PHYSICAL THERAPY. If we are *"out of network"* for your policy, you will pay your *"in network"* requirements.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: **TRAILS END PT** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ Date _____/_____/_____
Patient/ Guardian/ Responsibility Party

Acknowledgement of Receipt of Notice of Privacy Practices *

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

Trails End Physical Therapy will use and disclose your personal health information to receive payment for the care we provide, and for other health care operations.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information.
The Terms of the notice may change with time, but we will always have current copies available.

I, _____, have received a copy of this clinic's Notice of Privacy Practices.

Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Other (Specify)_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include completed consent in the patient's medical chart