Patient Information

Patient Name_____ Sex_____ Age_____ Birth Date_____

Address_____ City/State/Zip_____

Home Phone_____ Cell Phone_____

Social Security#_____ E-mail address:_____

Employer_____ Employer Phone Number_____

Referring Physician_____ Phone Number_____

Primary Physician_____

Responsible Party

Mother/Guardian _____ Father/Guardian_____

Phone _____ DOB_____ Phone _____ DOB_____

Employer _____ Employer _____

Emergency Contact

Name_____ Relationship_____

Phone Number_____

Primary Insurance

Insurance Name_____

ID Number _____

Group Number_____

Secondary Insurance

Insurance Name_____

ID Number _____

Group Number_____

Is this an Auto Accident?_____ Workman's Comp Claim_____ Date of Injury_____

Have you received any Physical, Occupational or Speech Therapy within the last 12 months? ____ Yes ____No
If Yes Where:_____

By signing below I give consent to Primary Therapy Source to provide physical, speech, or/and occupational therapy for:_____. I Understand and agree that, (regardless of my insurance status), that I am ultimately responsible for the balance on my account for any services rendered. I have read all the information contained on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.
I agree to notify Primary Therapy Source if I have previously seen another Physical Therapist or if I see another Physical Therapist during my treatment with Primary Therapy Source. If I do not notify Primary Therapy Source, I agree to pay for any unauthorized services that are not paid by my insurance. I authorize Primary Therapy Source to release my records to their billing service, my insurance company and my physician. I understand that these records will be held in strict confidence and will not be released to any unauthorized person. I authorize payment of medical benefits to undersigned physician or supplier of services rendered.
Cancellations and No-shows given less than 8 business hours are assessed a $15.00 fee for each occurrence.

Signature_____ Date_____

Authorization for Release of Information

Please complete and return this form to Primary Therapy Source

Patient Information

Name _____Date of Birth _____Phone _____

Mailing Address _____City _____ST____ Zipcode _____

The names of parties authorized to exchange information:

I Authorize: Primary Therapy Source
254 River Vista Place
Twin Falls, ID 83301

(Check either box or both, as needed) ☐ to release information to: ☐ to obtain information from:

_____ _____ _____
Doctor (If more than one please use extra space below) Address

_____ _____ _____ _____ _____
City State Zipcode Phone

_____ _____
Organization (School, Preschools, etc….) Address

_____ _____ _____ _____
City State Zipcode Phone

_____ _____
Name Address

_____ _____ _____ __ _____
City State Zipcode Phone

Please Disclose the following (please check):

_____ Treatment Records
_____ Evaluation(s)
_____ Progress Notes
_____ Other _____
_____ Medical Evaluation(s)
_____ Service Coordination Plan
_____ IFSP/IEP

By Signing authorization, I understand that the parties named above are permitted to exchange written and verbal information regarding myself or my child as a patient. The authorization will expire within one year of the signature date. I understand that at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to Primary Therapy Source office. I understand that the person of entity who receives my confidential information may not be required to prevent unauthorized use or disclosure. I understand that my signature on this form is not required to treatment, payment, enrollment, or eligibility for benefits and that a copy of this authorization shall be valid as the original.

Print Name _____

Signature _____ Date_____

APPOINTMENT POLICY

Effective June 3, 2013

It is crucial that you follow the appointment schedule that has been set by Primary Therapy Source. Following your physician's and therapist's advice, as well as coming to therapy at your appointed time will help you achieve your health goals.

We understand that there are times when you must miss an appointment due to illness, emergencies or unexpected responsibilities for work or family.

However, it has been our experience that most of the time, missed appointments are not due to emergencies. When you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment. Also, when another patient fails to cancel, we could be unable to schedule you for a visit, due to a seemingly "full" appointment book.

To ensure that all of our patients have access to the highest level of care, Primary Therapy Source has developed the following policy:

If you do not call to reschedule or cancel an appointment at least 24 hours in advance, you will be charged a $15 no show fee. This fee is **NOT** covered by your insurance company or Medicaid and will be due before the next appointment.

ILLNESS: If your child is ill, **WE ALLOW THREE (3) SICK DAYS IN A SIX (6) MONTH PERIOD** **provided** you call to notify us your child is out sick. If you do not notify the office before your child's appointment, the appointment will be considered a missed appointment and subject to the no show fee.

I understand and agree to abide by the above policy.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
"You May Refuse to Sign This Acknowledgement"

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Adult Medical History

Patient Name:
Last Name:_____ First Name_____ Middle Int._____
Date of Birth_____ Telephone _____
Address:_____City:_____State:_____
Zip Code:_____ Circle Selection: Female/Male Left handed/Right handed
SSN:_____
Primary language:_____ Second Language:_____
Type of Insurance: Insurer_____
Workers' Comp:_____Medicare:_____Self-Pay:_____Other:_____
Responsible Party:_____
Responsible Party telephone & address:_____

Social: With whom do you live?
Alone _____Spouse only_____Spouse&Others_____Child_____Other relative(s)_____
Group setting_____Personal care attendant_____
Where do you live?_____
Current Condition(s)/Chief Complaint(s): Describe the problem(s) for which you seek physical therapy:
Who referred you to the physical therapist?_____

Living environment: Does your home have? Do you use?
Stairs, no railing_____ Stairs, railing_____ Cane_____ Walker_____
Ramps _____ Elevator_____ Wheelchair_____ Glasses_____
Uneven terrain_____ Assistive devices_____ Motorized wheelchair_____
Any obstacles_____ Hearing Aids_____

Employment/Work:
Please circle Part-time/Full-time outside the home Part-time/Full-time in the home
Homemaker_____ Student_____ Retired_____ Unemployed_____
Occupation:_____

General Health Status: Please rate your health:
Excellent_____ Good_____ Fair_____ Poor_____
Have you had any major life changes during the past year? (new baby, job changes, death of a family member, move) Yes_____ No _____

Family History: (Indicate whether mother, father, brother/sister, aunt/uncle, grandmother/grandfather, and age of onset if known.)
Heart disease:_____ Psychological:_____
Hypertension:_____ Arthritis:_____
Stroke:_____ Arthritis:_____
Diabetes:_____ Osteoporosis:_____
Cancer:_____ Other:_____

Do you have?
Vision impairment: Yes/No If yes, describe:
Hearing Impairment: Yes/No If yes, describe:
Are there any other family members with similar problems? Yes/No If yes, describe:

Please indicate any diagnostic tests you have had:

Medical/Surgical History:	**YES**	**NO**	Check all that apply	**YES**	**NO**
Arthritis			Multiple sclerosis		
Broken bones/fractures			Muscular dystrophy		
Osteoporosis			Parkinson disease		
Blood disorders			Seizures/epilepsy		
Circulation/vascular problems			Allergies		
Heart problems			Developmental or growth problems		
High blood pressure			Thyroid problems		
Lung problems			Cancer		
Stroke			Infectious disease tuberculosis		
Diabetes/high blood sugar			Hepatitis		
Low blood sugar/hypoglycemia			Kidney problems		
Head injury			Repeated infections		
Depression			Ulcers/stomach problems		
Other			Skin diseases		
Within the past year, have you had any of the following symptoms?					
Chest pain			Difficulty sleeping		
Heart palpitations			Loss of appetite		
Cough			Nausea/vomiting		
Hoarseness			Difficulty swallowing		
Shortness of breath			Bowel problems		
Dizziness or blackouts			Weight loss/gain		
Coordination problems			Urinary problems		
Weakness in arms of legs			Fever/chills/sweats		
Loss of balance			Headaches		
Difficulty walking			Hearing problems		
Joint pain or swelling			Vision problems		
Pain at night			Other		

Have you ever had surgery? Yes/No If yes please describe and include dates:

1.

2.

When did the problem(s) begin? Month_____Year_____

What happened?_____

Have you ever had the problem(s) before? Yes/No

What did you do for the problem(s)?_____

Did the problem(s) get better? Yes/No About how long did the problem(s) last?_____

How are you taking care of the problem(s) now?_____

What makes the problem(s) worse?_____

What are your goals for physical therapy?_____

Are you seeing anyone else for the problem(s)? (Acupuncturist, cardiologist, chiropractor, dentist, osteopath, physician, internist, massage therapist, neurologist, OB/GYN, occupational therapist, podiatrist, rheumatologist?)

Medications: Do you take any prescription medications? Yes/No

If yes, please list:_____

Do you take any nonprescription medications? (Advil/Aleve, Antacids, Ibuprofen/Naproxen, Antihistamines, Aspirin, Decongestants, Herbal supplements, Tylenol, other?

Have you taken any medications previously for the condition for which you are seeing the physical therapist? Yes/No If yes please list:_____

The above information is accurate and true to the best of my knowledge, and I give my consent for the evaluation to be performed.

Signature:_____Date:_____

Printed Name:_____