REDBUD PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name: ______________________________ **Birthdate:** ______________ **Age:** ______

Address: ______________________________ **Home Phone:** ______________________

City: ____________________ **State:** _______ **Zip:** __________ **Cell Phone:** ______________________

Employer: ______________________________ **Work Phone:** ______________________

Preferred Contact Method for Appointment Reminders: ☐Home Phone ☐Cell Phone ☐Text Message

Email Address: ______________________________ **Soc. Sec.#** ______________________

Please keep in mind that communication via email over the Internet is not a secure form of communication.

By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Spouse's Name:** ______________________

Financial Responsibility: ☐Self ☐Other (If Other, please complete Guarantor Assignment Form)

Emergency Contact: ______________________ **Phone:** ______________ **Relation:** ______________

PCP/Referring Physician: ______________________ **Referred to RB by:** ______________________

Have you had Home Health Care in the last 30 days? ☐Y ☐N Home Health provider: ______________________

Have you had physical therapy treatment since January of this year? ☐Y ☐N # of visits ________

Have you had chiropractic treatment since January of this year? ☐Y ☐N # of visits __________

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above named patient, performed by the staff at Redbud PT and/or as directed by my referring services.

Patient/Guardian Signature: ______________________________ **Date:** ______________________

INSURANCE INFORMATION

Primary Insurance Carrier: ______________________ Policy#______________________ Group#______________

Secondary Insurance Carrier: ______________________ Policy#______________________ Group#______________

*A copy of your insurance card(s) will be kept on file. It is the patient's responsibility to provide RB current insurance information.

Is this physical therapy care the result of an injury related to an Auto Accident, 3rd Party incident or Employment? ☐Y ☐N

**If YES, please fill out the Accidental Injury Questionnaire

AUTHORIZATION

I assign payment to Redbud PT and authorize the filing of claims to my insurance company for payment of services rendered. I am fully aware that I am ultimately responsible for deductibles, co-pays, co-insurance and non-covered services. I authorize Redbud PT to release any information acquired in the course of my treatment necessary to process insurance claims or to discuss my treatment with other practitioners.

By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys, and other information relating to your therapy services via the communication channels you provided above.

My signature below also acknowledges receipt of Redbud Physical Therapy's Notice of Privacy Practices (effective 01/01/2018).

Patient/Guardian Signature: ______________________________ **Date:** ______________________

If you do not have personal health insurance OR you do not want Redbud PT to file claims to your personal health insurance, please read and sign below:
I have asked Redbud PT to **NOT** file claims to my personal health insurance carrier. If I decide at a later date to have Redbud PT send claims to my personal health insurance carrier, I understand Redbud PT will only do so at its discretion because possible contract obligations, per-certifications, per-authorizations, etc., may not have been performed, which would prohibit the likelihood of benefit coverage of my services. I understand and accept responsibility for full payment of any unpaid claims.

Patient/Guardian Signature: ______________________________ **Date:** ______________________

MEDICARE SECONDARY PAYER (MSP) FORM

Patient Name: ____

Account #: ______________________ **Medicare Number:** ____________________________________

1. Do you receive Veteran's benefits? Yes ☐ No ☐
2. Are you receiving benefits under the Black Lung Program? Yes ☐ No ☐

   If yes, date benefits began ______________________

   If yes, are the services you will be receiving related to a non-black lung condition? Yes ☐ No ☐
3. Was this injury/illness due to a work related accident/condition? Yes ☐ No ☐

   If yes, date of injury/illness __________________________
4. Was the injury/illness related to an automobile accident? Yes☐ No☐

   If yes, date of accident ________________________
5. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending?

   Yes ☐ No ☐

   If yes, please provide: Attorney's name: ____

   Address: ____

   Phone number: ____
6. Are you entitled to Medicare based on:
   - ☐ Age (65 & over)—go to question 7
   - ☐ Disability—go to question 7
   - ☐ End Stage Renal Disease

     Do you have group health plan coverage? Yes ☐ No ☐

     Are you within the 30 month coordination period? Yes ☐ No ☐
7. Are you currently employed? Yes ☐ No ☐ Date of retirement _______________________________

   a. Is your spouse employed? Yes ☐ No ☐ Date of retirement ___________________________

   b. Do you have a group health plan as primary coverage based on your own or a spouse's current (or former) employment? Yes ☐ No ☐

   c. Does the employer that sponsors your group health employ 20 or more employees? Yes ☐ No ☐

If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Insurance Co:____

Address: ____

Policy/Cert #: ____

Group name and number: ____

____

Signature of Patient/Representative **Date**

____

Relationship to patient

REV: 04/03/19

PATIENT'S AUTOMOBILE INSURANCE

Policyholder Name:_______________________________ Policy#:_________________________

Insurance Name: _______________________________ Phone #: _________________________

Address of Insurance:____

____

Claim #:_______________________________________

Do you carry Personal Injury Protection and/or MedPay? ☐ Y ☐ N Limit $ _______________

Do you carry Uninsured Motorist? ☐ Y ☐ N Limit $ _______________

If your condition is the result of a Third Party claim, you must furnish the following information:

Name of 3rd Party Insurance Carrier: ____

Address of Insurance Carrier: ____

____

Adjuster Name:_______________________________ Phone: _________________________

Claim #: _______________________________________

If your condition is the result of a work related injury, you must furnish the following information:

Name of your Employer: _______________________________ Phone:_____________________

Address of Employer:____

____

Employer's WC Carrier: _______________________________ Phone:_____________________

Address:____

____

Worker's Compensation Claim or Case #: _________________________

Nurse Case Manager Name:___________________________ Phone:_____________________

Adjustor Name:_______________________________ Phone:_____________________

If you are filing your claims with your group health plan, it may have a reimbursement provision for claims resulting from an act or omission of a third party. The term "third party" can be a person, a business, or other entity. In most cases, the third party has insurance to cover your claims. The medical expenses that your group health plan pays, which are also paid by the third party's insurance, may need to be reimbursed to your group health plan.

I hereby authorize any third party or insurer to reimburse my group health plan for benefit payments made on my behalf as a result of this accident involving myself and/or my dependents. The above answers are true and completed to the best of my knowledge. I understand that I am fully responsible for any balance for services rendered. I also understand that if payment is denied by the above mentioned parties I will be personally responsible for the full amount charged for all services rendered.

I understand it is the policy of Redbud PT to file medical liens on all Motor Vehicle and Personal Injury claims.

Patient/Guardian Signature: _______________________________ **Date:** _________________

PHOTO/VIDEO AUTHORIZATION RELEASE

I grant to Redbud PT and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization. **AGREE** ☐ **DECLINE** ☐

Patient Signature: ____ **Date:** ______________________

Parent/Guardian Signature: _______________________________________ **Date:** ______________________

NOTICE OF PRIVACY PRACTICE

(Patient/Representative Initials) _______ I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact Tina Lehman, the Confluent Health Compliance & Privacy Officer, on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Patient Signature: ____ **Date:**_________________________

Parent/Guardian Signature: _____________________________________ **Date:** ________________________

For questions or complaints, please contact:

Compliance Department

Toll free: 888-937-4479

Patient Name:___________________________

PATIENT HEALTH QUESTIONNAIRE

Occupation: ______________________________

Leisure Activities: ______________________________

Height: __________ Weight: __________ Age: __________

Are you currently experiencing or do you have any of the following:

Condition		
Allergies	□Yes	□No
Anemia	□Yes	□No
Anxiety or Panic Disorders	□Yes	□No
Asthma	□Yes	□No
Cancer	□Yes	□No
Site:______________________		
Cardiac Conditions	□Yes	□No
Chemical Dependency	□Yes	□No
Cardiac Pacemaker	□Yes	□No
Currently Pregnant	□Yes	□No
Depression	□Yes	□No
Diabetes	□Yes	□No
Dizzy Spells	□Yes	□No
Emphysema/Bronchitis	□Yes	□No
Fractures	□Yes	□No
Gall Bladder Problems	□Yes	□No
Gastro Intestinal Disease	□Yes	□No
Heart Attack	□Yes	□No
Hepatitis	□Yes	□No
Type:______________________		
High Blood Pressure	□Yes	□No
Incontinence	□Yes	□No
Kidney Disease/Problems	□Yes	□No
Metal Implants	□Yes	□No
Multiple Sclerosis	□Yes	□No
Osteoporosis	□Yes	□No
Osteoarthritis	□Yes	□No
Parkinson's	□Yes	□No
Peripheral Vascular Disease	□Yes	□No
Prosthesis/ Implants	□Yes	□No
Rheumatoid Arthritis	□Yes	□No
Seizures	□Yes	□No
Speech Problems	□Yes	□No
Stroke/TIA	Yes	□No
Thyroid Disease	□Yes	□No
Tuberculosis	□Yes	□No
Vision Problems	□Yes	□No
Pacemaker	□Yes	□No
Spinal Cord Stimulator	□Yes	□No
Lung Disease	□Yes	□No
Blood Clots	□Yes	□No
Autoimmune Disease	□Yes	□No
Type:______________________		
Stomach Ulcers	□Yes	□No
HIV	□Yes	□No
Recent fever, chills, sweats	□Yes	□No
Ringing in ears	□Yes	□No
Hearing Loss	□Yes	□No
Nausea Vomiting	□Yes	□No
Headaches	□Yes	□No
Difficulty Swallowing	□Yes	□No
Unexplained Weight Changes	□Yes	□No
Pain wakes me at night	□Yes	□No
Chest Pains - Angina	□Yes	□No
Cough	□Yes	□No
Shortness of Breath	□Yes	□No
Bowel or Bladder Disorder	□Yes	□No

Social History/ Wellness

Question		
Do you drink alcoholic beverages?	□Yes	□No
Do you use tobacco?	□Yes	□No
Do you exercise regularly?	□Yes	□No

List current medications (including prescription, over-the-counter, and herbal):

	Name	Dosage	Frequency	Administration
1.	__________	__________	__________	Oral, Patch, Topical, Other
2.	__________	__________	__________	Oral, Patch, Topical, Other
3.	__________	__________	__________	Oral, Patch, Topical, Other
4.	__________	__________	__________	Oral, Patch, Topical, Other
5.	__________	__________	__________	Oral, Patch, Topical, Other

Surgery / Hospitalization: Include date and reason

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Patient Name:___________________________

1. List any known allergies (include medications, latex, etc): ____

2. List the dates and results of any X-rays: ____
MRI: ____
Bone Density test: ________________________________
Nerve Conduction test: ____________________________
Other: ____

3. Please rate your **current** pain on the line below:
0……………………………………………….5…………………………………………….10

4. On a scale from 0-10 (0 = no pain; 10 = worst pain imaginable), what is the **worst** your pain has been in the past several days? ______/10. What is the **best** your pain has been? ______/10

5. Do you have any numbness, tingling, or burning? □Yes □No Constant or Intermittent

6. When did this problem first begin? ______/______/_______ (Approximate date)

7. How did this problem begin? ____

____

8. Have you ever had this problem before? □Yes □ No How many times? ___________

9. Are your symptoms worse in? □ Morning □ Afternoon □ Evening □ Night □ Same all day

10. How are you able to sleep at night?
□ Fine □ Moderate difficulty □ Only with medication □ Change positions all night

11. My pain/problem is slowly getting: □ worse □ better □ staying the same

12. My symptoms bother me: □ constantly 100% □ most of the time 75% □ occasionally 50% □ once in a while 25% or less

13. How often have you completed a least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? □ At least 3 times per week □ 1-2 times a week □ Seldom or Never

14. During the past month, have you often been bothered by feeling down, depressed, or hopeless? □Yes □No

15. During the past month, have you often been bothered by little interest or pleasure in doing things? □Yes □No

16. How many times have you fallen in the past 12 months? __________ Did it result in an injury? □Yes □No

17. This is a statement other patients have made. "***I should not do physical activities which (might) make my pain worse***." Please rate your level of agreement with this statement below. (Circle number)

0	1	2	3	4	5	6
Completely Disagree			Unsure			Completely Agree

Please provide your email so we can send your home exercise program: ________________________________
Please keep in mind that communication via email over the Internet is not a secure form of communication.

PATIENT'S SIGNATURE: ____ DATE: ______/______/______

Patient Name:_____________________________

Please indicate your current symptoms on the diagram below:

Deep Ache = ZZZZ
Sharp/Stabbing = ////
Pins and needles = 0000
Burning = XXXX
Throbbing = ++++
Cleared = ✓