

Patient Name: _____ DOB: _____ Date : _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail: _____ Do you want e-mail appointment reminders? Y N

Employer: _____ Work Phone: _____

Emergency Contact _____ Phone: _____ Relation? _____

Attorney Name: _____ Phone Number: _____

Have you had any prior Therapy this past year? Y N How many visits? _____

How did you hear about us? Friend/Family Newspaper Internet Doctor Insurance Prior Patient

Other, please describe: _____

.....Please answer highlighted only.....

Referring Physician: _____ **NPI #:** _____

Primary Insurance Co: _____ **WC HMO PPO MC Other** _____

Address: _____

City _____ State _____ Zip _____

Phone: _____ Billing Fax: _____

Policy/claim#: _____ Group#: _____

Effective date of insurance: _____ Pre-Cert Required? #: _____

Insured's Name: _____ **Insured's DOB:** _____

Insured's Relationship to Patient: Self Spouse Parent/Guardian Other

In Network: Deductible: \$ _____ Co-Pay: \$ _____ Co-Insurance (% covered): _____ %

Out of Network: Deductible: \$ _____ Co-Pay: \$ _____ Co-Insurance (% covered): _____ %

Visit Limit per Dx: _____ Per Year: _____ Fiscal Limit per Dx: \$ _____ Per Year: \$ _____

Out of pocket Max: _____ Deductible Met: Y N Remaining amount: _____

Secondary Ins: _____

Policy/claim#: _____ Group#: _____

Effective date of insurance: _____ Pre-Cert Required? #: _____

Insured's Name: _____ Insured's DOB: _____

Name: _____ Date of Injury: _____

Family Physician: _____ Phone: _____

Referring Physician: _____ Body Part: _____

Medications: _____

Allergies: _____

Did you have surgery? _____ Date of Surgery: _____ Procedure: _____

Have you had any of the following for your condition? PT X-ray MRI Chiropractic Injections

MEDICAL HISTORY QUESTIONNAIRE

- | | | |
|--------------------------------|---------------------------|---------------------------|
| Arthritis | Recent weight GAIN / LOSS | Chest pain |
| High Blood Pressure | Numbness/tingling | Dizziness/Lightheadedness |
| High Cholesterol | Night Sweats | Lyme Disease |
| Diabetes | Rheumatoid Arthritis | Asthma |
| Osteoporosis | Kidney Dysfunction | Emphysema |
| Cancer: Type: _____ | Dialysis | COPD |
| Year: _____ | Blood Disorder | Tuberculosis |
| Stroke | Total Joint Replacement | Seizures/Epilepsy |
| Depression | Type: _____ | Back injury |
| Smoker | Headaches | Neck Injury |
| Liver Disease | Heart Disease | Hernia |
| Fibromyalgia | Pacemaker | Pregnant? _____ mos. |
| Chronic Fatigue Syndrome | Shortness of Breath | Liver Dysfunction |
| Multiple Sclerosis | Angina | Hepatitis A B C (circle) |
| Thyroid dysfunction Hypo Hyper | Spinal cord injury | Traumatic brain injury |
| HIV/AIDS | | |

Other, not listed above:

Please check your current pain level, 0 = no pain, 10 = emergency room pain:

0 1 2 3 4 5 6 7 8 9 10

Pain when it is at it's worst:

0 1 2 3 4 5 6 7 8 9 10

SYMMETRY

PHYSICAL THERAPY

Patient Authorization Record

Initial here

	<p style="text-align: center;"><u>Authorization for Treatment</u></p> <ul style="list-style-type: none"> ➤ I hereby authorize Symmetry Physical Therapy to provide physical therapy treatment and/or procedures that have been described to me. The inherent risks and benefits of such procedures have been explained, as well as alternate treatment options. I understand that my decision to allow Symmetry Physical Therapy to provide such treatment and/or procedures is completely voluntary and I have the right to refuse any such treatment and/or procedures at any time.
	<p style="text-align: center;"><u>Authorization for Release of Information</u></p> <ul style="list-style-type: none"> ➤ I agree that Symmetry Physical Therapy may provide information from my medical record to persons involved in my medical care. ➤ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Symmetry Physical Therapy for services rendered. ➤ I agree that Symmetry Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➤ I have read or been offered the “Notice of Privacy Practices” mandated by HIPAA.
	<p style="text-align: center;"><u>Authorization for Release of Payment</u></p> <ul style="list-style-type: none"> ➤ I authorize that direct payment of any benefits available to me be released to Symmetry Physical Therapy for services rendered.
	<p style="text-align: center;"><u>Patient Agreement</u></p> <ul style="list-style-type: none"> ➤ I agree to pay Symmetry Physical Therapy charges for services rendered to me during my course of treatment. ➤ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Symmetry Physical Therapy collections costs including attorney and court fees.
	<p style="text-align: center;"><u>Medicare, Medicaid, and Similar Benefits</u></p> <ul style="list-style-type: none"> ➤ I agree that the information given to Symmetry Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Symmetry Physical Therapy may give Social Security Administration or its fiscal intermediary’s information necessary to process claims.
	<p style="text-align: center;"><u>Workers Compensation</u></p> <ul style="list-style-type: none"> ➤ I agree that the information given to Symmetry Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Symmetry Physical Therapy may give intermediary’s information necessary to process claims.

Cancellation and No Show Policy

Failure to keep your scheduled appointments hinders our ability to provide the best possible care to all of our patients. *Symmetry Physical Therapy* asks that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient. ALL missed appointments MUST be made up the same week so you may fully recover from your condition.

Our Cancellation Policy is:

∞ **Failure to give 24 hours notice prior to cancellation will result in a “No-Show Appointment Fee” of \$25.**

This fee cannot be billed to your insurance company and will be your direct responsibility.

∞ Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and our other patients, therefore:

3 late cancellations or no shows will result in discontinuing physical therapy.

I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

Patient/legal guardian INITIAL HERE: _____

RELEASE OF INFORMATION

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Symmetry Physical Therapy to disclose my health information that is directly related to my current treatment at Symmetry Physical Therapy to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

NAME	RELATIONSHIP

I attest that all of the above information has been documented accurately and to the best of my knowledge, and I agree to adhere to all policies and procedures outlined above,

Patient/Legal Guardian/LPOA signature: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 6 - Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 7 - Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 8 - Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

<p><i>SECTION 4 - Reading</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> I can read as much as I want to with no pain in my neck. <input type="checkbox"/> I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> I can read as much as I want to with moderate pain in my neck. <input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck. <input type="checkbox"/> I cannot read as much as I want because of severe pain in my neck. <input type="checkbox"/> I cannot read at all. 	<p><i>SECTION 9 - Sleeping</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no trouble sleeping. <input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless). <input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless). <input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless). <input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless). <input type="checkbox"/> My sleep is completely disturbed (5-7 hours).
<p><i>SECTION 5 - Headaches</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no headaches at all. <input type="checkbox"/> I have slight headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come frequently. <input type="checkbox"/> I have severe headaches which come frequently. <input type="checkbox"/> I have headaches almost all the time. 	<p><i>SECTION 10 – Recreation</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> I am able to engage in all of my recreational activities with no neck pain at all. <input type="checkbox"/> I am able to engage in all of my recreational activities with some pain in my neck. <input type="checkbox"/> I am able to engage in most, but not all of my recreational activities because of pain in my neck. <input type="checkbox"/> I am able to engage in a few of my recreational activities because of pain in my neck. <input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck. <input type="checkbox"/> I cannot do any recreational activities at all.

For office use only, SCORE: