SYMMETRY
PHYSICAL THERAPY

270 Main Street
Portland, CT 06480-1859
860-788-7976 phone
877-532-7987 fax
www.symmetryusa.net

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: ______________________

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PATIENT MEDICAL HISTORY

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
High Blood Pressure
High Cholesterol
Diabetes
Osteoporosis
Cancer: Type:______________
Year:______________
Stroke
Depression
Smoker
Liver Disease
Fibromyalgia
Chronic Fatigue Syndrome
Multiple Sclerosis
Thyroid dysfunction Hypo Hyper
HIV/AIDS

Recent weight GAIN / LOSS
Numbness/tingling
Night Sweats
Rheumatoid Arthritis
Kidney Dysfunction
Dialysis
Blood Disorder
Total Joint Replacement
Type:______________
Headaches
Heart Disease
Pacemaker
Shortness of Breath
Angina
Spinal cord injury

Chest pain
Dizziness/Lightheadedness
Lyme Disease
Asthma
Emphysema
COPD
Tuberculosis
Seizures/Epilepsy
Back injury
Neck Injury
Hernia
Pregnant?______ mos.
Liver Dysfunction
Hepatitis A B C (circle)
Traumatic brain injury

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

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Patient Authorization Record

Initial here	
	Authorization for Treatment ➢ 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.
	Authorization for Release of Information ➢ 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.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Symmetry Physical Therapy for services rendered.
	Patient Agreement ➢ 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.
	Medicare, Medicaid, and Similar Benefits ➢ 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.
	Workers Compensation ➢ 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.

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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:____________

The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE:______/ 80**

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.