Inniss Physical Therapy

Patient Name: _____ Date____/____/____

Referred to this office by: _____ Profession: _____

Height: _____ Weight: _____ Age: _____ Birth date: ____/____/_____

Person to notify in case of emergency: _____Phone number: _____

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1. Describe what you are coming to physical therapy for:

_____

_____

2. Describe what caused your symptoms, if applies:_____

_____

3. When did your symptoms start? ___/____/____

4. Did you have surgery? ☐ No ☐ Yes, if yes what was the date of surgery: ___/____/____

5. How often do you experience your symptoms during the day?
   - ☐ Constantly (76-100% of the day)
   - ☐ Frequently (51-75% of the day)
   - ☐ Occasionally (26-50% of the day)
   - ☐ Intermittently (0-25% of the day)

6. Are you worse in the:
   ☐ Morning ☐ Afternoon ☐ Evening ☐ Doesn't matter

7. What activities increase your symptoms? (i.e. stairs, sitting, standing, driving, overhead activities)

_____

8. What eases your symptoms? (i.e. ice/heat, rest, lying on your back)

_____

9. Do your symptoms interrupt your sleep? ☐ Yes ☐ No

10. Describe your pain? (check all that apply):
    - ☐ Sharp
    - ☐Stiffness
    - ☐Dull Ache
    - ☐Pins and Needles
    - ☐Radiating
    - ☐Burning
    - ☐ Stabbing
    - ☐Numbness and Tingling

11. Do you have a history of falls? ☐ yes ☐ no

12. Have you had any falls within the last year? If yes, how many times _____

_____

12. Did the fall result in any injury? If yes, describe the injury and date _____

_____

13. Have you had any diagnostic tests? ☐ X-rays ☐ MRI ☐ CT scan ☐ EMG ☐Other _____

Patient Name: _____ Date____/____/____

14. What treatment have you had for this injury/symptom?

☐ None ☐ Doctor ☐ Physical Therapist
☐ Chiropractor ☐ Other_____

15. What medications are you currently taking? (Please list all medications with dosage, frequency and how consumed) _____

_____

_____

16. Do you have any of the following: (Please check those that apply)

☐ High blood pressure	☐ Heart disease	☐ Anxiety/Panic attacks
☐ Recent weight loss	☐ Are you pregnant	☐ Diabetes (Type I or Type II)
☐ Circulation problems	☐ Hearing problems	☐ Thyroid disease
☐ Pacemaker	☐ Indigestion/Heart Burn	☐ Balance problems
☐ Autoimmune Disease	☐ Allergies	☐ History of Cancer
☐ Gout	☐ Nausea/Vomiting	☐ Sensitivity to heat/cold
☐ Metal implants	☐ Seizures	☐ Osteoporosis
☐ Headaches	☐ Kidney disorders	☐ Rheumatoid arthritis
☐ Vision problems	☐ Fibromyalgia	☐ General arthritis
☐ Stroke	☐ Pulmonary Disease	☐ Bladder/Bowel incontinence
☐ Dizziness	☐ Depression	☐ None
☐ Hernia	☐ Current Smoker	☐ Other:_____

17. Please list **ALL** major illnesses, injuries, or surgeries that have occurred in the past with **DATE.**

_____

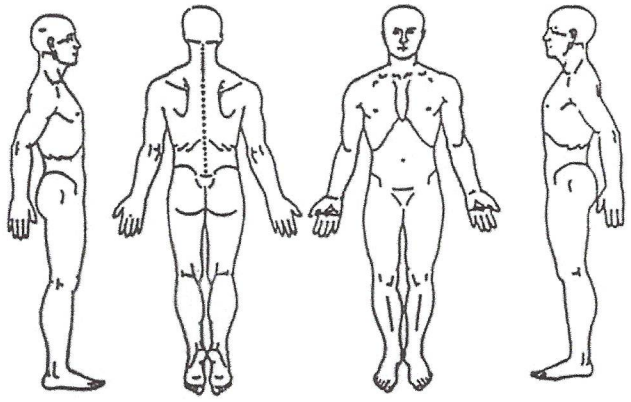
_____

18. What goals or activities do you want to achieve with therapy? _____

_____

29. Please mark the areas where you feel any pain or symptoms and circle your pain level below:

Pain at worst: 0 1 2 3 4 5 6 7 8 9 10
Pain at best: 0 1 2 3 4 5 6 7 8 9 10



INNISS PHYSICAL THERAPY
Patient Consent and Payment Authorization

ALL PATIENTS

Request for Admission, Consent for Treatment and Authorization to Release Information:
I request services from Inniss Physical Therapy and consent to such treatment as ordered by my attending physician.

I understand that my care is directed and monitored by the attending physician and that Inniss Physical Therapy is not liable for any act or omission when following the instructions of said physician, who is neither the employee nor the agent of Inniss Physical Therapy.

I hereby consent to the release of information by any health care provider including any physician, hospital, skilled nursing facility, home health agency, or rehabilitation agency, in which I have been a patient and to disclose all or any part of my medical record to Inniss Physical Therapy. I am in receipt of the Notice of Information Practices.

Patient's Name (Print):_____
Last First MI

Signature:_____ Date:_____

We understand special needs. It may be necessary to set up a payment schedule that is comfortable for both of us. If this situation is necessary for you, please bring the matter to our attention as soon as possible.

MEDICARE

Patient's Certification: Authorization to Release Information and Payment Request:
I certify that the information given by me in applying for payment under Title VXIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

Assignment of Primary/Supplemental Insurance Benefits:
I hereby authorize payment directly to Inniss Physical Therapy of any insurance benefits payable to me. I understand that I am financially responsible to Inniss Physical Therapy for any deductible or coinsurance not paid by the insurance company.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient to execute the above and accept its terms.

Signature:_____ Date:_____
(Patient or Authorized Representative)

PRIVATE PAY

I agree that in consideration of the services to be rendered to me, I hereby individually obligate myself to pay the account of Inniss Physical Therapy for any deductible or coinsurance. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

Assignment of Primary/Supplemental Insurance Benefits:
I hereby authorize payment directly to Inniss Physical Therapy of any insurance benefits payable to me. I understand that I am financially responsible to Inniss Physical Therapy for any deductible or coinsurance not paid by the insurance company.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient to execute the above and accept its terms.

Signature:_____ Date:_____
(Patient or Authorized Representative)

PATIENT BILL OF RIGHTS

The following is our policy regarding the rights of patients receiving services from Inniss Physical Therapy. Each patient has the right to:

A. Request and receive full information about the physical therapy provider's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
B. Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in case of vacations and emergencies), and cancellations policies before beginning therapy.
C. Receive respectful treatment that will be helpful to you.
D. A safe environment, free from sexual, physical, and emotional abuse.
E. Ask questions about your therapy.
F. Refuse to answer any question or disclose any information you choose not to reveal.
G. Request that the physical therapy provider inform you of your progress.
H. Know the limits of confidentiality and the circumstances in which a physical therapy provider is legally required to disclose information to others.
I. Know if there are supervisors, consultants, students, or others with whom your physical therapy provider will discuss your case.
J. Refuse a particular type of treatment or end treatment without obligation or harassment.
K. Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
L. Report unethical and illegal behavior by a physical therapy care provider.
M. Receive a second opinion at any time about your physical therapy or the physical therapy care provider's methods.
N. Request the transfer of a copy of your file to any physical therapy care provider or agency you choose.

Any complaints regarding denial of a patient's rights not satisfied after a discussion with Inniss Physical Therapy, may be registered in confidence with the Physical Therapy Board of California. Upon request, the staff of Inniss Physical Therapy will assist the patient to contact the appropriate office of the state agency.

Signature_____ Date_____

What is involved in Physical Therapy?

Physical Therapy is the treatment of disease, injury or disability by physical and mechanical means. Physical therapists provide services to restore function, improve mobility, relieve pain, prevent or limit physical disabilities. Physical Therapy also promotes health, wellness and fitness.

Your physical therapy experience starts with an opportunity to describe your condition with your therapist. The therapist will ask specific questions to allow you to elaborate on the specifics of your complaint and to clarify various responses.

The next phase of the assessment is the physical examination. This may include observing your ability to go through a variety of movements. This may include having you walk, bend, raise your limbs through a range of motion and perform functional activities such as rising from a seat or going up and down stairs, as you are able. Additional components of the typical exam may include having the therapist move your limbs or spine through the available range of motion. The therapist will be noting the gross range available, quality of the movement and your responses. Palpation, the touching of skin and, indirectly, underlying tissue, gives therapists valuable knowledge in making a full assessment. For example, restricted motion may be from underlying scar tissue or swelling in an area. Palpation assists in determining the origin of the problem. Please note, normal tissue does not hurt when palpated. If you have pain on palpation, there may be an underlying problem to address with physical therapy.

If you are uncomfortable with the idea of being touched, share this with your therapist. Modifications of the assessment can be made and allow you to still benefit from therapy. Please let us know if you prefer a female or male therapist.

Assessment frequently includes a Manual Muscle Test. This is performed by the therapist positioning your body part, you will be asked to try holding a position and having your try to resist the therapist's manual pressure.

Types of treatment that are used in an orthopedic, manual therapy clinic, like Inniss Physical Therapy may include Passive exercises, where the therapists gently moves a body part through a range of motion, Active Assistive exercises, where the therapist and patient work together to move a body part and Resistive exercises, where the therapist grades a resistance to the patient's movement to optimize muscle recruitment and strengthening.

Massage may also be a part of treatment. There are different types of massage. These may include scar tissue mobilization for adhesions that develop after surgery or injury, soft tissue mobilization for areas of fascial binding within muscle and tendon, transverse friction which decreases scar tissue build up over tendons and effleurage to decrease swelling. There may be discomfort with each of these approaches however; some improvement range of motion or pain relief should be immediately noticeable.

I have read this statement and consent to start physical therapy.

Signature_____ Date_____

I have read the statement and wish to discuss the physical contact aspects of therapy before starting therapy.

Signature_____ Date_____

INNISS PHYSICAL THERAPY

PATIENT INFORMATION

Fill out

DATE_____ REFERRING DOCTOR_____

Last Name_____ **First**_____ **M.I.**_____ **Sex** M__ F __

Address_____ **Apt #**_____ **SS #**_____

City_____ **State**_____ **Zip Code**_____ **Date of Birth**_____

Phone #_____ **Cell Phone #**_____ **Drivers license #** _____

Emergency Contacts 1)_____ 2)_____
Name Telephone Name Telephone

Marital Status M____W ____ S____ D_____ **Email** _____

Work related injury? Y___N___ Injury Date_____**Auto accident related injury? Y___ N ___Accident date**_____

Employer's Name_____

Employer's Address_____City_____State_____Zip Code_____

Work Phone #_____Extension_____Employee ID#_____Occupation_____

Medicare Number (if applicable)_____

Primary Insurance: Is this your coverage? Y____ N____ If no, coverage is in whose name?_____

Your relationship to the insured_____Policy/Certificate #_____Group #_____

Insurance Company Name_____Phone #_____

Address_____City_____State_____Zip Code_____

Secondary Insurance: Name of Insured_____Relationship_____

Insurance Policy Number_____Group Number_____

Insurance Company Name_____Phone #_____

Address_____City_____State_____Zip_____

AUTHORIZATION TO PAY INNISS PHYSICAL THERAPY

Assignment of Benefits

Sign

I hereby authorize my insurance benefits to be paid directly to INNISS PHYSICAL THERAPY and I am financially responsible for non-covered services. I also authorize INNISS PHYSICAL THERAPY to release any information to process this claim.

SIGNED_____DATE_____

BOTH SIDES PLEASE