CAM
Physical Therapy and
Wellness Services LLC.
"Where Wellness Is Our Function"

PATIENT REGISTRATION (PLEASE PRINT)

Date ____________________

Name (Last, First, M.I.) ____ e-Mail ________________________________

Home Phone # (___)________________Cell Phone # (___) ________________ Other Phone # (___) ______________

Address ___________________________________ City _____________________ State _____ ZIP ____________

SSN _______-_______-________ Sex _____ Marital Status _______ DOB ______________ Age _______

Employer _____________________________ Occupation ___________________ Phone # (___) __________________

Address ___________________________________ City ____________________ State _____ ZIP _______________

Date of Injury/Illness: ____________ Referring Doctor ______________________ Phone (__) ___________________

In case of emergency please contact:

Name ____ Relationship _____________________________

Home Phone (____) __________________ Cell Phone (____) ________________ Other Phone # (____) ____________

Primary Insurance Information

Name __________________________________

Address ________________________________

ID/Policy # _____________________________

Group Name/# ___________________________

Subscriber ______________________________

Subscriber SSN ___________________________

Relationship to Patient _____________________

Secondary Insurance Information

Name _____________________________________

Address ___________________________________

ID/Policy # ________________________________

Group Name/# ______________________________

Subscriber _________________________________

Subscriber SSN _____________________________

Relationship to Patient ______________________

Worker's Compensation Information

Date of Injury ___________________________

W/C Carrier _____________________________

Address ________________________________

Claim # _________________________________

Adjuster ________________________________

Phone # (____) ___________________________

MVA Information

Date of Accident __________________________

Driver (Yes) _______ (No) _______

Auto Insurance ___________________________

Policy # _________________________________

Claim # _________________________________

Insurance Agent ___________________________

Phone # (____) ____________________________

Attorney Information

Name ___________________________________ Address____

Phone # (_____) __________________________ Fax # (_____) _________________________

PATIENT QUESTIONNAIRE / HEALTH HISTORY **Name:** ______________________________ **Date:**______________

To insure you receive a complete and thorough evaluation, please provide us with background information on the following form. If you do not understand a question, ask for assistance. Thank you.

HISTORY OF PRESENT CONDITION

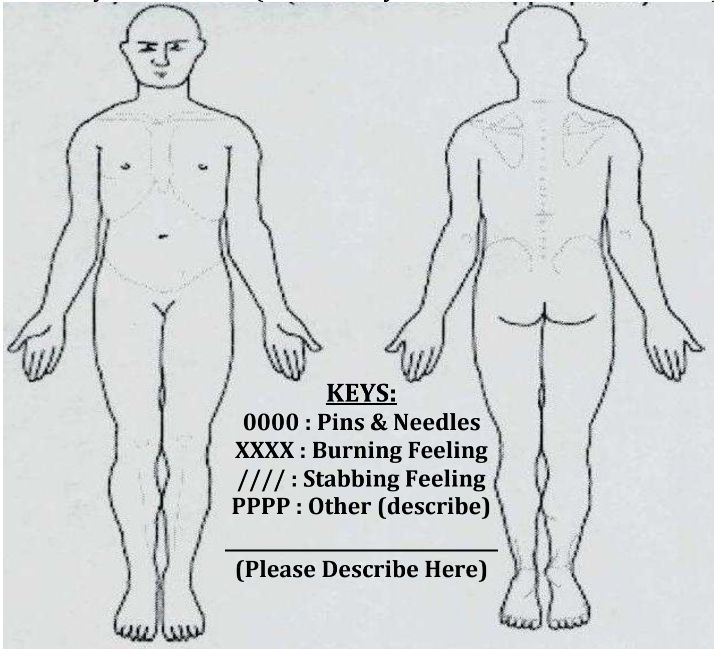
1. What are your symptoms?

____

____

____

2. Localize areas of **pain** or **abnormal** sensation on the body chart below (Use the Keys to mark the affected areas)



INCOMING PAIN SYMPTOM SCALE (Circle One)

NO PAIN	MINIMAL	MODERATE	INTENSE	EMERGENCY
0	1 2 3	4 5 6	7 8 9	10

3. When did you symptoms begin?
(Please indicate a specific date if possible) ________________

4. Was the **onset** of this episode gradual or sudden? (Check on)
☐ GRADUAL ☐ SUDDEN

5. Which of the following **best describe** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)
- ☐ Lifting
- ☐ MVA (car accident)
- ☐ Accident at Work
- ☐ Overuse (Cumulative Trauma)
- ☐ Throwing
- ☐ Other ________________________
- ☐ Trauma
- ☐ Degenerative Process
- ☐ During Recreation/Sports
- ☐ Running
- ☐ Unknown

6. Since onset, are your symptoms getting: (Check One)
☐ BETTER ☐ WORSE ☐ NOT CHANGING

7. Have you had similar symptoms in the past? ☐ YES ☐ NO
More than one episode? ☐ YES ☐ NO

8. Nature of pain/symptoms (Check all that apply)
☐ SHARP ☐ ACHING ☐ CONSTANT
☐ DULL ☐ PERIODIC ☐ THROBBING
☐ OCCASIONAL ☐ OTHER ______________________

9. As the day progresses, do your symptoms: (Check One)
☐ INCREASE ☐ DECREASE ☐ STAY THE SAME

10. Does the pain wake you at night? ☐ YES ☐ NO
If yes, is it present: ☐ While lying still
☐ Only when changing positions
☐ Both

11. Do you have pain/stiffness upon getting out of bed in the Morning? ☐ YES ☐ NO

12. In what position do you sleep? (Check all that apply)
☐ Right side ☐ Back ☐ Back, Sides, Stomach
☐ Left Side ☐ Chair/Recliner ☐ Stomach
☐ Other

13. Since the onset of your current symptoms have you had:
- ☐ Any difficulty with control of bowel or bladder function
- ☐ Fever/Chills
- ☐ Any numbness in the genital or anal area
- ☐ Numbness
- ☐ Any dizziness or fainting attacks
- ☐ Weakness
- ☐ Unexplained weight changes
- ☐ Night pain/Sweats
- ☐ Malaise (vague feeling of bodily discomfort)
- ☐ Problems with vision/hearing
- ☐ None of the above

14. What aggravates your symptoms? (Check all that apply)
- ☐ Sitting
- ☐ Lying Down
- ☐ Up/Down stairs
- ☐ Reaching overhead
- ☐ Reaching behind back
- ☐ Squatting
- ☐ Coughing/Sneezing
- ☐ Looking overhead
- ☐ Stress
- ☐ Going to/Raising from sitting
- ☐ Walking
- ☐ Standing
- ☐ Reaching in front of body
- ☐ Reaching across body
- ☐ Sleeping
- ☐ Taking a deep breath
- ☐ Swallowing
- ☐ Sustained bending
- ☐ Recreational Sports including:______________________
- ☐ Other: ______________________________

15. What relieves your symptoms? (Check all that apply)
☐ Sitting ☐ Rest ☐ Massage
☐ Heat ☐ Standing ☐ Medication
☐ Cold ☐ Walking ☐ Stretching
☐ Exercise ☐ Lying Down ☐ Wearing a splint/Orthosis

☐ Other: ______________________________

List Medications: ______________________________

____

MEDICAL HISTORY: (Check all that Apply)

- ☐ Numbness / Tingling
- ☐ Stroke / Blood Clot
- ☐ HIV Positive / AIDS
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Balance Problems
- ☐ Cancer
- ☐ Tuberculosis / Persistent Cough
- ☐ Convulsions
- ☐ Memory Loss
- ☐ Fainting / Dizzy Spells
- ☐ High Blood
- ☐ Pregnancy
- ☐ Pacemaker

CONSENT TO PATIENT INTERVENTION

Instructions: Initial inside the box beside each policy, then sign and date at the bottom.

☐ **CONSENT TO TREATMENT OR FUNCTIONAL CAPACITY EVALUATION:** I hereby authorize the healthcare providers of ***CAM Physical Therapy & Wellness Services LLC.*** to administer such treatments, as they deem necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

☐ **FINANCIAL RESPONSIBILITY:** I agree that I am financially responsible for all charges relating to services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I also understand I am responsible for knowing my policy and any dispute over the Insurance Company's decision or coverage is my responsibility to resolve. Balance of bill payment is due within 30 days of final payment by insurance company.

☐ **CO-PAYMENTS AND CO-INSURANCES ARE DUE AND PAYABLE ON THE DATE OF SERVICE:** We accept cash, checks and all credit cards. ***A $25.00 charge will be applied for EVERY returned checks***. I agree to pay the portion that I am responsible for, as indicate here:

Deductible $ ___________ Co-Insurance % _______ / Pay Per Visit $___________ Copayment Per Visit $__________

☐ **CANCELLATION POLICY AND FEE:** In order to maintain ***CAM Physical Therapy & Wellness Services LLC.*** high standard of care we ask that you give us a 24-hour notice if canceling an appointment. This allows us ample time to schedule and provide care to another patient. I understand that if I cancel on the same day of service or I do not show up for a scheduled appointment, ***I will be charged $25.00 for which I am personally responsible.***

☐ **LATE POLICY "15 MINUTES":** Being late by more than 15 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **CHILDREN REQUIRING SUPERVISION ARE NOT ALLOWED TO ATTEND SESSIONS WITH YOU:** If your child does not require supervision and is capable of waiting for you quietly in the waiting area, then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child. Children's are **NOT ALLOWED** in the gym area while you or other patients are using the equipments.

☐ **SPOUSE, FRIENDS OR PARTNERS:** due to liability issues, friends, spouses or domestic partners are not allowed in the treatment areas while you are been treated or examined.

☐ **ASSIGNMENT OF BENEFITS:** I hereby assign to ***CAM Physical Therapy & Wellness Services LLC.*** all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to ***CAM Physical Therapy & Wellness Services LLC.***

☐ **RELEASE OF INFORMATION:** I authorize ***CAM Physical Therapy & Wellness Services LLC.*** to release all medical information, via mail, facsimile or electronic mail required by my insurance company or Worker's Compensation carrier or designee to file for medical benefits. Additionally, ***CAM Physical Therapy & Wellness Services LLC.*** may release information, via facsimile or email, to any hospital or physician I may be referred from, or referred to, by ***CAM Physical Therapy & Wellness Services LLC.***

☐ **MEDICARE WAIVER STATEMENT (IF APPLICABLE):** Anyone who misrepresents or falsifies essential information requested by this form may, upon conviction, be subject to fine and imprisonment under Federal Law. Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a) (1) of the Medicare Law.

I, the undersigned agree to be responsible, whether through another insurance or otherwise for payments of therapy services. I acknowledge that no Medicare limiting charge limits will apply and that other supplemental insurance may elect not to make payments for such services.

____ ____________________

(**PRINT**)Patient's Name / Responsibility Party Date

____ ____________________

(SIGNATURE) Patient/Responsibility Party Signature Date

NOTICE OF PRIVACY PRACTICES
HEALTH INFORMATION PRIVACY UNDER HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMATION. THESE RULES REQUIRE US TO PROVIDE YOU WITH THIS DOCUMENT. WE RESERVE THE RIGHT TO UPDATE THIS NOTICE IF REQUIRED BY LAW. PLEASE REVIEW IT CAREFULLY.

TO PROTECT YOUR INFORMATION, WE ARE REQUIRED TO:

- Have contracts in place with our contractors and others ensuring that we use, disclose and safeguard your health information properly.
- Have procedures in place to limit who can view and access your health information.
- Implement training programs for employees about how to protect your health information.
- Reasonably Limit use and disclosure to the minimum necessary to accomplish their intended purpose.
- Not provide any information related to your treatment at ***CAM Physical Therapy and Wellness Services LLC.*** this includes; family members, friends, spouses or domestic partners. If you wish to authorize someone to have access to your treatment care records provided at ***CAM Physical Therapy & Wellness Services LLC.*** i.e., medical records and appointment history, please provide us with their name and their relationship to you below.
  I consent to authorize ________________________________, related to me as __________________ to have access to my medical records, make changes on my appointments dates and time or get any information on relation to my appointments or medical treatment.

UNDER THE PRIVACY RULE, WE MUST COMPLY WITH YOUR RIGHT TO:

- **Restrictions**: you have the right to request restrictions on how your information is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.
- **Confidential Communication and Access to Records**: You have the right to request confidential communication from us as well as copy of your medical records. You must make these requests in writing and we may charge a fee to cover the cost of copying and mailing.
- **Amendments**: You have the right to request an amendment be made to your records, if you disagree with what is says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend pats of your medical record that we did not create.
- **Complaints**: If you feel that your privacy rights have been violated, you have the right to make a complaint. Your complaint should contain specific information so that we may adequately investigate and respond to your concern. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services. To find additional information about filing a complaint go to http://hhs.gov or by calling 866-627-7748

WE ARE ALLOWED TO SHARE YOUR INFORMATION IF IT IS NECESSARY:

- **Treatment**: disclosure of health information to other providers who have referred you for services or are involved in your care. This may include nurses, technicians, attorneys, adjusters and any other provider involved in your treatment case.
- **Payment**: disclosure of the health information to your insurance company, including Medicare and Medicaid, so payment can be obtained by services rendered.
- **Health Care Operations**: utilization of your records to monitor the quality of care being given at our facility or for business planning activities.
- **Auto Insurance:** disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to auto insurance or other similar programs established by law.
- **Worker's Compensation:** disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's comp or other similar programs established by law.
- **Other Special Uses:** our practice may use your information to send you an appointment reminder, to inform you of our other health-related products and services.

USES AND DISCLOSURES REQUIRED BY LAW: The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

Source: American Physical Therapy Association

____________________________________ ________________

(**PRINT**) Patient/Responsibility Party Name Date

____________________________________ ________________

(**SIGNATURE**) Patient/Responsibility Party Signature Date