Rehab Practice Management

Patient Health History

Patient Name: ____________________ **Date of Birth:** ____________________

CURRENT INJURY/CONDITION

Date of Injury or Date of onset of symptoms:____________________ Injury: ____________________

Check All That Apply:

____Work Related Injury ____Motor Vehicle Accident ____Injury Recurrence ____Aggravation of Pre-existing Injury

____Sports Related Injury ____Lifting Injury ____Fall ____Causes Unknown

Current Symptoms: ____________________

Have you had these symptoms before? NO / YES If yes, when? ____________________

Have you had any care for the current injury or condition: NO / YES (physical therapy/occupational/massage/________________)

What tests have you had related to your current injury: X-ray MRI CT Scan EMG NCV Bone Scan Other: ______________

Are your symptoms any different now since the initial injury? Worse / Better / Same

Check any activities you have difficulty with due to your current condition or injury:

___ Getting Dressed ___ Sit to Stand ___ Driving ___ Climbing Stairs ___ Reaching ___ Bending

___ Sleeping ___ Exercising ___ Daily Activities ___ Walking ___ Running ___ Other ____________________

PAIN LEVEL/PAIN MANAGEMENT:

Pain Rating (at rest): 0 1 2 3 4 5 6 7 8 9 10 Frequency of pain (at rest): Constant / Intermittent

Pain Rating (with activity): 0 1 2 3 4 5 6 7 8 9 10 Frequency of pain (with activity): Constant / Intermittent

What are you doing to reduce your pain: ____________________

SURGERY HISTORY:

Did you have surgery for your current injury/ condition? NO / YES

Date of Surgery: __________________ Surgical Procedure: ______________________ Date of re-check with DR: ____________

List any other surgeries you have had that we should be aware of: ____________________

____

Medical History:

What medications are you currently taking? ____________________

Are you allergic or sensitive to: (circle) medications, latex, adhesives or hot/cold?

Do you currently have or ever had any of the following:

___ AIDS/HIV ___ Artificial Joint ___ Diabetes ___ Hepatitis ___ Metal Implants ___ Skin Allergies

___ Allergies ___ Arthritis RA/OA ___ Heart Disease ___ High Blood Pressure ___ Pacemaker ___ Stroke

___ Asthma ___ Cancer ___ Heart Murmur ___ Hypoglycemia ___ Seizures ___ Other ____________

Patient Signature: ____________________ **Date** ____________________

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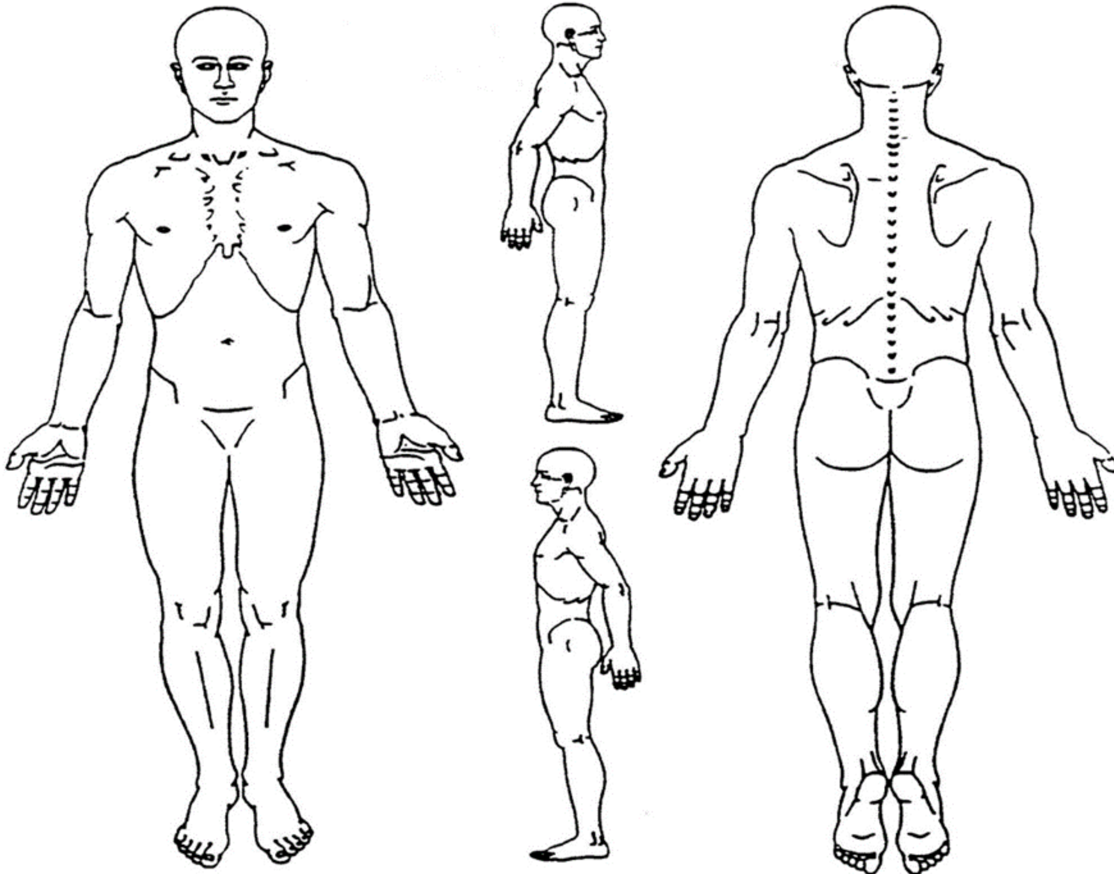
Pain Diagram

Patient Name: ______________________________ **DOB:** ______________ **Date:** ______________

Please mark these drawings according to where you hurt.

Please indicate which sensations you feel by referring to the key (symbols) below.

KEY:	Stabbing	Burning	Pins & Needles	Numbness	Aching
	///////	xxxxxx	000000	=======	+++++++



Please rate your pain over the last week on the following 10 point scale with 0 representing no pain at all and 10 representing a need for emergency care and a trip to the hospital. You will give three scores, one for least amount of pain in the past week, one for your greatest pain in the past week, and one for your typical pain daily.

												What % of the time do you experience
Least	0	1	2	3	4	5	6	7	8	9	10	_______
Worst	0	1	2	3	4	5	6	7	8	9	10	_______
Usual	0	1	2	3	4	5	6	7	8	9	10	_______

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Patient Name: ______________________________ **DOB:** ____________

PATIENT CONSIDERATIONS

- If you are unable to attend your scheduled appointment(s) please call 24 hours in advance to reschedule. If you do not show up for your scheduled appointment, a "no show", and do not cancel 24 hours before the scheduled appointment time, and/or repeatedly arrives late without prior notification to your scheduled appointment, a $**25 fee** may be charged directly to you. This charge is not payable by your insurance.
- In order for you to reach your rehabilitation goals, it is imperative that you keep your scheduled appointments. Please arrive on time. If you are more than 10 minutes late, you may be asked to wait or reschedule. If you are late, your treatment time may be shortened, so as not to impose on other patients' treatment time.
- **Medicare / Railroad Medicare patient** – please **DO NOT** schedule your Physical Therapy appointments on the same day as other Doctor appointments, where you are being treated for the same condition. Medicare will only pay for one (1) visit per day.
- Cell Phone use in the gym area is prohibited and only allowed when you are on heat or ice.
- Appointments are made for your convenience, however there may be times where your appointment may be rescheduled or cancelled due to our clinicians covering other locations. We will try to contact you as soon as possible; however there may be occasions where advance notice is not permissible. We apologize in advance for any inconvenience this may cause.

PATIENT FINANCIAL RESPONSIBILITY

As a courtesy to our patients, insurance claims (primary and secondary) are filed directly with the Insurance carriers. Our office will normally assist you by contacting, and verifying, your eligibility for medical benefits. Verification of eligibility, and benefits, does not guarantee payment for all services provided. **Ultimately you are responsible for knowing/understanding your benefits, policy coverage, limitations, exclusions, and for paying the balance on your account.**

You are responsible for all out-of-pocket expenses (co-pays, co-insurance, deductibles, no show fees and any non -covered services that have been provided) **at the time of service***. We will estimate the co-insurance percentages, based on what we expect the insurance company to pay. Because this is an estimate, and not an exact figure, there is a possibility that you will still be responsible for an additional balance when we receive the Explanation of Benefits, from your insurance carrier, and your claim has been processed.

*if you are a part of Regence, or any other insurance that does not allow us to collect a portion of your co-insurance, you will be asked to pay for any outstanding balance on claims that have been processed by your insurance company when you return for your follow-up visits.

The purchase of supply items (*Superfeet Insoles, icepacks, braces, sole lifts, shoulder pulley's, etc.)* are expected at the time of delivery.

The responsible party listed below is fully responsible for payment of all charges incurred. By signing below, you understand that you are financial responsible for any deductibles, co-pays, co-insurances and any non-covered services or supplies. You also authorize RPM Rehab Inc., d.b.a. Cascade Summit Physical Therapy bill your insurance and to release any information requested by the insurance company with regards to payment of benefits for all your appointments. I have read all of the above and understand/agree to all provisions stated.

Responsible Party Signature: ______________________________ **Date:** ____________________

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Patient Name: ______________________________ **DOB:** ______________

NOTICE OF PRIVACY PRACTICES

You are entitled to full confidentiality of your records as maintained by RPM Rehab Inc. DBA: Cascade Summit Physical Therapy under Federal and State guidelines (42 CFR 2.22). In most cases this means that your records cannot be released unless you specifically authorize that release in writing. Please be aware that Cascade Summit Physical Therapy personnel may exchange information freely within the clinic, but that neither Cascade Summit Physical Therapy nor its employees may disclose to an outside individual or agency that you are a patient receiving services, the nature of those services or the condition for which you are seeking treatment.

Your confidential information may only be released if:

a) You consent in writing on an approved Release of Information form, or
b) The disclosure is forced by legitimate court, or
c) The minimal information necessary is disclosed to medical personnel in a medical emergency.

You have a right to inspect and obtain a copy of your records, with the understanding that portions of the record may be withheld if they are determined to be detrimental to your physical and/or emotional health. If you would like a copy of your records, there will be a copy fee. Copy fees vary depending on current WAC 246-08-400.

ACKNOWLDEGEMENT AND CONSENT TO TREAT

I understand there are certain risks inherent to any physical endeavor. Every effort will be made to minimize these risks by providing me adequate instruction and supervision. I understand clear and direct communication between my therapist and me is necessary to ensure my safety and well-being. Nonetheless, in rare instances, injury may occur.

I have read, understand and agree to the above rights and responsibilities for patients of Cascade Summit Physical Therapy. In signing, I consent to be treated by the therapists and staff of Cascade Summit Physical Therapy (RPM Rehab Inc.).

Patient Signature: ______________________________ **Date:** ______________