ProTailored Physical Therapy LLC

Patient Information

First Name_____ MI____ Last Name_____DOB_____/_____/_____ Sex M F (circle)

Address _____City_____State_____Zip_____

Primary Phone_____Secondary Phone _____Email _____

I would like to receive appointment reminders via ☐ text ☐ phone call (mark one)

Employer_____ Occupation_____ Work Phone_____

Emergency Contact_____Phone_____Relation _____

How did you hear about ProTailored (please be specific)?_____

Primary Insurance_____Insured Party_____

Relation to Insured_____ DOB____/___/_____Insured's Address_____

Secondary Insurance_____Insured Party_____

Relation to Insured_____ DOB___/___/_____Insured's Address_____

If Medicare is secondary state reason:

☐ working aged benefit ☐ disabled benefit ☐ veteran's admin ☐ work comp ☐ public health ☐ other

Medical Information

Seeking treatment for_____Pain Onset/Injury Date_____

Any imaging (X-Ray/MRI) relating to the area of concern? Yes No If so, where and when?_____

Are you receiving or have you recently received home health services? ☐ Yes ☐ No

Are you receiving or have you recently received other therapy services? ☐ Yes ☐ No

If "Yes", please explain_____

Do you have any allergies? ☐ Yes ☐ No

If "Yes", please list_____

Please list any surgeries or other conditions for which you have been hospitalized:

Date	Reason for Surgery/Hospitalization	Date	Reason for Surgery/Hospitalization
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Could you be, or are you, pregnant? ☐ Yes ☐ No

Please check any of the following which you have recently noticed:

☐ Weight loss/gain ☐ Nausea/vomiting ☐ Fatigue ☐ Weakness ☐ Fever/chills/sweats ☐ Numbness/tingling

Are you presently taking any medications? ☐ Yes ☐ No

If "Yes", please list (or provide a copy of medication list)_____

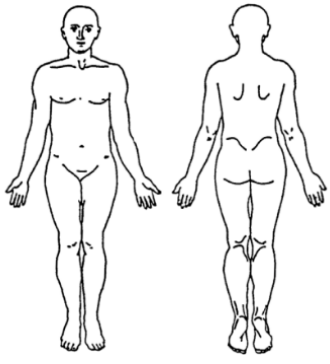
Which of the following conditions are you currently being treated or have been treated for in the past? (please circle)

- Cancer
- Other arthritic conditions
- Depression
- Anxiety
- Tuberculosis
- Kidney disease
- Epilepsy/Seizures
- High/Low blood pressure
- Asthma
- Pacemaker
- Diabetes
- Shortness of breath
- Hepatitis
- Stroke
- Anemia
- Heart problems
- Circulation problems
- Emphysema/Bronchitis
- Thyroid problems
- Multiple sclerosis
- Recent weight loss/gain
- Latex Allergy
- Rheumatoid arthritis

If you checked any of the above or have other conditions not listed, please explain:

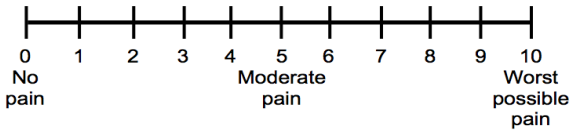
_____

Circle the parts of the body that are currently giving you discomfort:

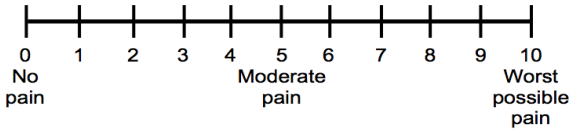


Using the scales below, indicate your pain levels by circling the appropriate number on the following scales.

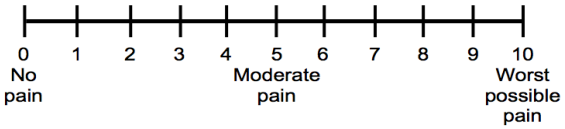
Please rate your **current** level of pain:



Please rate your **worst** level of pain in the last 24 hours:



Please rate your **best** level of pain in the last 24 hours:



Patient Authorization

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ProTailored Physical Therapy, LLC to furnish medical evaluation, care and/or treatment to me or someone I am authorized to sign and make medical decisions for. This evaluation, care, or treatment is considered medically necessary and proper in the diagnosing or treatment of his/her/my physical condition. I understand that even though I give my consent for evaluation, care, or treatment, I may refuse any of these services at any time. **Initial**_____

FINANCIAL POLICY STATEMENT

ProTailored Physical Therapy, LLC will bill your health insurance company as a courtesy to you. We require that payment of your estimated share (ie-co-pay) be made today. If your insurance company does not remit payment for any reason the balance due may be your responsibility. In the event your insurance company requests a refund of payment or denies coverage for your service, you may be responsible for the balance due. If payment is made to you for services provided by ProTailored Physical Therapy, LLC, you are obligated to promptly pay for those services. Any questions regarding your insurance coverage need to be directed to your insurance carrier. You will be responsible for all fees incurred for collections of monies owed including collection agency fees and/or court costs. A fee of $25 will be charged for any returned checks. **Initial**_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company to ProTailored Physical Therapy, LLC. I authorize ProTailored Physical Therapy, LLC to obtain medical records and/or professional information from my physician and/or other medical professional as it relates to my treatment. **Initial**_____

NOTICE OF PRIVACY PRACTICES

A Notice of Privacy (NP) has been made available to me by ProTailored Physical Therapy, LLC. The NP describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA). In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. **Initial**_____

AUTHORIZATION OF EMAIL/TEXT COMMUNICATIONS

I understand the risks associated with and agree to the use of communication via email and text messaging between the ProTailored staff and me. ProTailored's standard of email communication via the primary email account (info@protailored.com) is with encryption (secured). **Initial**_____

Communication with most other email addresses at ProTailored (including therapists) is unencrypted (unsecured). **To opt for unencrypted e-mail communications (ie-emailing with your therapist), please provide your e-mail address: _____.** By opting for unencrypted e-mail communications, you must understand that the communications will not be protected or secured and that ProTailored Physical Therapy, LLC will **NOT** be responsible for further disclosure or misuse of your information.

I certify that I have read, understood, and filled out all the information in this packet accurately to the best of my knowledge:

Patient Name_____ **Patient/Guardian Signature**_____ **Date**_____

HIPAA RELEASE OF INFORMATION

I am giving my consent for release of my health information or financial information to the following individuals/physicians/facilities:

Name	**Relationship**	**Date of birth**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****Direct Access Patients Only:** In the state of Indiana, you can receive physical therapy services for 42 days without a script from a physician. By adding your physician above you are giving our office permission to contact your doctor to request a script on your behalf. If a script is obtained you may be treated beyond the 42 days.

I understand that I have the right to change (in writing) the above-named individuals at any time and I hereby grant ProTailored Physical Therapy permission to release confidential health information about me to the physician/ person/ facility/ entity listed above.

_____ _____/_____/_____

Printed Name Date of birth

_____ _____

Signature Date