Returning Patient Update

Thank you for choosing to come back to ProTailored Physical Therapy for your therapy needs! You are like family to us. We become invested in who you are and how you're doing and always look forward to the opportunity to catch up and provide you with the same great care you experienced in the past!

-From the ProTailored Family-

First Name_____MI_____Last Name_____Today's Date_____

Please write down any changes in the following:

Address_____Phone Number_____

Insurance_____

Medication_____Other (allergies, hospitalizations, etc)_____

Employer_____ Occupation_____ Work #_____

Employer Address_____ City _____ State_____ Zip_____

Emergency Contact_____Phone_____Relation _____

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_____

What prompted you to come back to ProTailored PT?_____

Please list any new (since past visit) surgeries or other conditions for which you have been hospitalized:

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

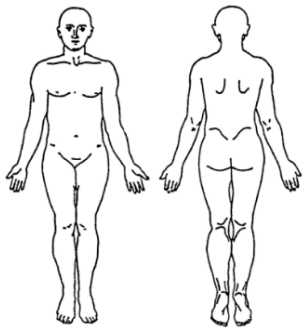
Which of the following conditions are you currently being treated or have been treated for in the past? (please circle)

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

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

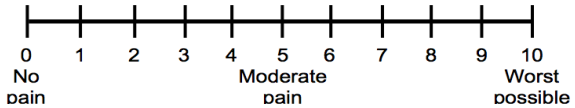
_____

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

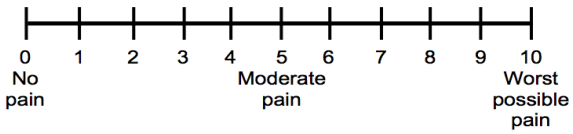


Using the scales below, indicate your pain levels by circling the appropriate number on the following scales.

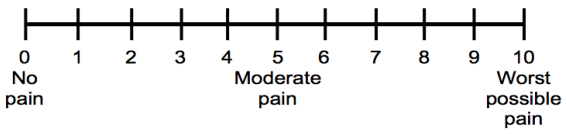
Please rate your **current** level of pain:



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



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



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**_____

PAYMENT GUARANTEE

I agree to pay ProTailored Physical Therapy, LLC for the services provided to me. If any law, such as workers' compensation or insurance contract, prohibits payment for the services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. I acknowledge and understand that payment for services may be denied by my insurance carrier, including, but not limited to, pre-existing conditions, routine, experimental, not reasonable or necessary, or work related reasons. Where the law or an insurance contract does not prohibit payments by me, I acknowledge responsibility for any and all account balances. If my insurance pays me directly, I agree to forward the payment to this office within 10 days of my receipt of payment. I further understand that failure to comply with this policy will result in ProTailored Physical Therapy, LLC taking appropriate legal action to collect this amount. I acknowledge that I am financially responsible for all fees incurred for services rendered regardless of insurance. Once a balance goes unpaid past 100 days, the account may be turned over to an attorney for collections. You agree that you will pay interest that can be added at the current legal rate as well as all collection fees, returned check fees ($25 each), attorney fees, and court costs incurred for the collection of all sums due. I understand the benefits quote given to me today is an estimate of what my insurance has quoted and not a guarantee of coverage. If the information provided by my insurance company is not accurate or if the insurance changes coverage, I will be responsible for payment. I understand that this agreement is binding regardless of any legal transaction in progress or initiated after the course of my treatments unless agreed to in writing by myself and a representative of ProTailored Physical Therapy, LLC. **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. 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**_____

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**_____

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

Printed Patient/Guardian Name_____**Date**_____

Patient/Guardian Signature_____

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