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| **PATIENT INFORMATION SHEET** |

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_\_

 Last First MI

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 No. Street Apt.# (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_/\_\_\_/\_\_\_

 City State Zip

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_ Internet \_\_\_Doctor \_\_\_Family/Friends \_\_\_ others

**Employment Status: Marital Status: Student Status**

 O Fulltime O Single O Full-Time

 O Part-Time O Married O Part-Time

 O Retired / Unemployed O Other

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT INFORMATION REGARDING**

 **MISSED APPOINTMENTS**

**(Cancellations/ No-Shows)**

 You play the biggest role in the success or failure of your treatment. We found that the following is crucial in ensuring a positive outcome:

* Attending your scheduled appointments
* Following and performing home programs (if applicable)
* Following Physician and PT recommendations and instructions
* Contacting your therapist if a difficulty arises with your treatment

We take cancellations and no-shows seriously at this clinic as it can affect the success of your treatment.

* We require 24 hours’ notice for all cancellations. It is your responsibility when you call to have an alternate time in mind to reschedule.

**Failure to provide 24 hour notice may result in a $10 cancellation fee.**

This charge WILL NOT be covered by insurance, and will have to be paid by you personally.

 (24 hours means 24 business day hours, weekend cancellations for Monday appointments will be charged)

**No-shows will incur a $10 charge**

“No-shows” are when patient is not here of has not contacted us before the appointment start time.

**Rescheduling**

A late cancel or missed appointment may be rescheduled TO AVOID THE CANCELLATION FEE if the appointment is rescheduled within the same week. Not keeping a rescheduled appointment will result in a cancellation fee.

* For Worker’s Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Care Physician, which could jeopardized your claim.
* Please understand that your pain may increase and decrease as your course of treatment progresses. Either example can seem to be a reason not to keep your appointment:
1. You’re feeling worse and think the treatment is not working or making your worse
2. You’re feeling better and think the you don’t need to come anymore

**Neither of these are legitimate reasons not to come.**

When you do not come to your scheduled appointment three people are hurt:

1. YOU because you don’t get the treatment you need as prescribed by the doctor;
2. The THERAPIST who now has a space in their schedule since the time was reserved for you personally; and
3. ANOTHER PATIENT who could have been scheduled for treatment if you had given proper notice.

We ask for your cooperation regarding this issue and we look forward to working with you.

I have read and understand this policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature Date

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| **ASSIGNMENT OF BENEFITS FORM** |

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME

 I irrevocably assign to **ACE Physical Therapy and Wellness Center, Inc.** all my rights and benefits under any insurance contracts for payment for services rendered to me by **ACE Physical Therapy.** I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by **ACE Physical Therapy** to be released to **ACE Physical Therapy.** I irrevocably authorize **ACE Physical Therapy** to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to **ACE Physical Therapy.** I irrevocably authorize **ACE Physical Therapy** to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. I understand that whatever amounts you do not collect from insurance company proceeds, whether it is be all part of what is due, I will personally owe you.

 This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **RECORDS RELEASE AUTHORITY** |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby request that you release to:

 (PATIENT NAME)

**ACE PHYSICAL THERAPY, Inc.**

520 Westfield Ave. Suite 204

Elizabeth, NJ 07208

Fax: (908) 820-0601

A report of my diagnosis, treatment, prognosis, recommendations, any diagnostic test results, MRI, radiographic reports as well as other data pertinent to your treatment of me from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient’s Name Patient’s Signature Date

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| **MEDICAL INTAKE FORM** |

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ALLERGIES:** List any medication(s) you are allergic to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you latex sensitive? Yes NoList any allergies we should know about:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please check any of the following whose care you’re under:

\_\_\_\_ Medical Doctor (MD) \_\_\_\_ Psychiatrist/Psychologist Other: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Osteopath \_\_\_\_ Physical Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Dentist \_\_\_\_ Chiropractor

If you have seen any of the above during the last three months, please describe for what reason (illness, medical condition, physical, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you EVER been diagnosed as having any of the following conditions?

YES NO Alzheimer’s YES NO Traumatic Brain Injury

YES NO Cardiovascular Disease YES NO High Blood Pressure

YES NO Cauda Equina Sundrome YES NO History of Cancer

YES NO Cerebral Vascular Accident YES NO Huntington’s

YES NO Current Infection YES NO Immunosuppression

YES NO Diabetes Mellitus Type 1 YES NO Lupus

YES NO Diabetes Mellitus Type 2 YES NO Muscular Dystrophy

YES NO Fibromyalgia YES NO Obesity

YES NO Fracture or Suspected Fracture YES NO Osteoarthritis

 YES NO Rheumatoid Arthritis

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_

During the past month have you been feeling down, depressed, or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

 DATE REASON FOR SURGERY/HOSPITALIZATION

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any significant injuries for which you have been treated (including fractures, dislocations, and sprains) and the approximate date of injury.

 DATE INJURY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes YES NO Cancer

YES NO Tuberculosis YES NO Arthritis

YES NO Heart Disease YES NO Anemia

YES NO Stroke YES NO Headaches

YES NO Kidney Disease YES NO Epilepsy

YES NO Alcoholism (chemical dependency) YES NO Mental Illness

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES NO Advil/Motrin/Ibuprofen

YES NO Laxatives

YES NO Decongestants

YES NO Antihistamines

YES NO Antacid

YES NO Vitamins/Mineral Supplements

YES NO Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much caffeinated coffee or caffeine containing beverages do you think per day? \_\_\_\_\_\_\_\_\_\_\_\_\_

How many packs of cigarettes do you smoke a day? \_\_\_\_\_\_\_\_

How many days per week do you drink alcohol? \_\_\_\_\_\_\_\_

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? \_\_\_\_\_\_\_\_

Have you recently noted:

YES NO Weight loss/gain

YES NO Nausea/Vomiting

YES NO Fatigue

YES NO Weakness

YES NO Fever/Chills/Sweats

YES NO Numbness or tingling

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interviewer Signature Date

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| **PRIVACY PRACTICES ACKNOWLEDGMENT**  |

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_