CAMPUS COMMONS
PHYSICAL THERAPY

Today's Date: **Staff Initials:** **Start Date:** **Therapist:**

NAME: (Last) _____ (First) _____ (M.I.) _____

ADDRESS: _____ CITY:_____ STATE: ZIP: _____-_____

BIRTHDATE: _____/_____/_____ AGE: _____ SSN: _____ SEX: ☐F ☐M

PHONE#: Home (_____) _____ Work (_____) _____ Cell (_____) _____

EMAIL ADDRESS: _____MAY WE SEND EMAILS TO THIS ADDRESS? ☐Y ☐N

EMPLOYER: _____ OCCUPATION:_____

IS THIS A WORK INJURY? ☐Y ☐N IS THIS THE RESULT OF AN AUTO ACCIDENT? ☐Y ☐ N

EMERGENCY CONTACT : _____PHONE: (_____) _____

How did you hear about us? MD Returning Patient Family/Friend_____ Other_____

HAVE YOU RECEIVED HOME HEALTH SERVICES WITHIN THE LAST 2 MONTHS? _____Y _____N

WHEN WAS THE LAST DATE OF HOME HEALTH TREATMENT? _____

ARE YOU RECEIVING ANY TYPE OF THERAPY AT ANOTHER FACILITY OR HOSPITAL? _____Y _____N

MEDICAL INFORMATION

DIAGNOSIS: _____ ICD-10#: _____

REFERRING DOCTOR: _____ DATE OF REFERRAL: _____

DATE OF INJURY: _____

INSURANCE INFORMATION: PRIVATE MEDICARE

PRIVATE INSURANCE:_____ ID #: _____

EFFECTIVE DATE:_____ DEDUCTIBLE: $_____ MET: $_____ COPAY:

COVERED AT_____% PLAN LIMITATIONS:_____

CONFIRMED BY: _____ DATE:_____

SECONDARY INSURANCE: _____ ID#_____

Coinsurance _____%

_____***PATIENT IS AWARE OF DEDUCTIBLE AND WILL PAY $75 PER VISIT. PATIENT WILL BE BILLED ANY DIFFERENCE THAT IS APPLIED TO THE DEDUCTIBLE, AS THIS IS AN ESTIMATE OF CHARGE**

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees, I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

_____ _____ _____

Patient Name Patient Signature Date

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FINANCIAL RESPONSIBILITY

Health insurance is designed to help meet the cost of medical services, but basic responsibility for payment is yours. Your insurance contract defines to what extent the services are covered. A mutually agreeable, realistic plan for payment will always be considered if you discuss it with us.

POLICIES AND PROCEDURES

You are responsible for all co-payments, deductibles, percentages, and any other portion your insurance does not pay. Co-payments, co-insurance, and deductibles are due at time of service. It is your responsibility to call your insurance company and find out your coverage.

If your policy or insurance company changes and you fail to inform us, any visits that may not be authorized or your new insurance company does not cover charges that are incurred, you will be responsible for those charges.

PATIENT PRIVACY NOTICE

We are required by law to maintain the privacy of your healthcare information, provide you with the attached notice of our legal duties and healthcare information privacy practices, and abide by the terms of this notice.

Please sign below indicating you have read and understand these policies.

_____	_____	_____
Patient Name	Patient Signature	Date

CAMPUS COMMONS
PHYSICAL THERAPY

Missed Visit Policy

At Campus Commons Physical Therapy, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure that you understand that it is extremely important that you attend all of appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled and if that occurs, you will incur a missed visit charge. Chronically late patients will be asked to change their appointment times.
5. Our schedule is very full and certain time slots are not always available for patients who need them. If you need to cancel or change a scheduled appointment, for any reason, we require a day's notice – **we need you to contact our office by 4:00pm the day before so we have enough time to help someone else who needs an appointment time.**
6. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
7. Same-day cancellations and appointment no-shows are not permitted as they keep other patients from getting the care they need.
8. There is a **$50.00 fee if you do not provide at least a day's notice of your appointment change or cancellation. This is non-negotiable and it's your responsibility as insurance will not cover it.**
9. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment. We need you to contact our office the day before by 4:00pm.
10. **To avoid our missed visit fee, call our office during business hours – by 4:00pm the day before, for any illness, appointment changes or cancellations.**
11. Patients who have multiple same-day cancellations or no-shows, will be removed from the schedule. We will also notify your physician of your non-compliance.
12. If you're worker's comp, we are required to notify your claims adjuster if you cancel or no-show.

We look forward to working with you to meet your physical therapy goals.
Mark Eddy, Owner

I have read this policy and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date

Staff Initials_____/ Date_____

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Medical History

Name: _____ Date: _____ Height: _____ Weight: _____

What is the reason for your visit today?_____

Describe any previous treatment for the condition we are seeing you for today. _____

Have you had any tests for this current problem? (**please circle**): X-Ray MRI CT Scan Lab Work Other:_____

Do you have a previous injury or condition that may affect your treatment? _____

Have you fallen two times or more in the last year, or had any fall resulting in an injury? YES NO
YES, Explain: _____

Currently, I am experiencing the following? (Circle all that apply)

Unexplained Weight Loss/Gain	Falls/Loss of Balance	Headaches	Shortness of Breath
Loss of Consciousness/Fainting	Changes in appetite	Numbness / Tingling	Dizziness
Changes in bowel/bladder function	Nausea / Vomiting	Fever / Chills	Night Sweats

Please list past surgeries and dates: _____

_____

Do you exercise?	YES / NO	Do you wear glasses/contacts?	YES / NO
Do you use alcohol?	YES / NO	Are you pregnant?	YES / NO
Do you smoke?	YES / NO	Do you have difficulty hearing?	YES / NO

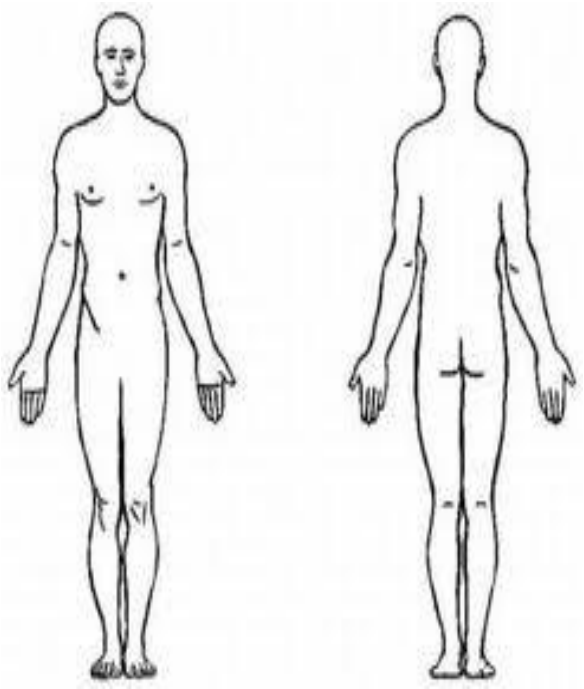
Please indicate (**X**) if you have or have ever had any of the following:

_____ Cancer(type):_____
_____ Pacemaker/Heart disease
_____ Blood Pressure Problems
_____ Circulation Problems
_____ Asthma/Lung Disease
_____ Stroke
_____ Nervous Disorder
_____ Seizures
_____ Diabetes
_____ Osteoporosis
_____ Kidney Disease
_____ Rheumatoid Arthritis
_____ Other Arthritic Conditions
_____ Allergies
_____ Anemia
_____ Thyroid Problems

Please explain and give approximate dates for any item indicated above: _____
_____

Please indicate on the body chart below the symptoms you are having:

Numbness/tingling: XXXX **Burning Pain: OOOO**
Dull/Aching Pain: ==== **Sharp Pain: ////**



Please circle the pain intensity when you feel the BEST, and when you feel the WORST (0 = no pain, 10 = worst pain imaginable)

Pain at best = 0 1 2 3 4 5 6 7 8 9 10
Pain at worst = 0 1 2 3 4 5 6 7 8 9 10

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Medication List

Please include prescription, over-the-counter, herbals, and supplements.

Please indicate how medication is taken if not taken orally. Thank you!

Patient Name:_____ Date: _____

Patient Signature:_____

☐ No Medications

☐ See attached list

	Medication:	Dose:	Frequency:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____