# PATIENT MEDICAL HISTORY FORM

Name: ________________________________ Date of Birth: _____________ Age:____

Treating Physician: ______________________Primary Care Physician:_________________

Date of next doctor's visit for this injury: ________________________

Have you retained an attorney as a result of your injury? YES NO

How did you hear about us? Referring physician Facebook Google

Previous Patient (Who can we thank? _________________) Other__________________

Have you had any of the following test done for this injury/ episode? (Circle all that apply)

X-rays MRI CT Scan Other testing: ______________________

Please list any past surgeries you have undergone along with the date:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
_____

Patient Height: _________ Weight: __________

**Do you now, or have you ever had, any of the following: (Check all that apply)**

- ❑ Alzheimer's
- ❑ Cardiovascular Disease
- ❑ Cerebral Vascular Accident/Stroke
- ❑ Cauda Equina Syndrome
- ❑ Current Infection
- ❑ Diabetes Mellitus (Type 1 or Type 2)
- ❑ Fibromyalgia
- ❑ Fracture or Suspected Fracture
- ❑ High Blood Pressure
- ❑ Pacemaker
- ❑ Cancer please specify:
- ❑ Latex Allergy
- ❑ Osteopenia/Osteoporosis
- ❑ Immunocompromised
- ❑ Currently Pregnant
- ❑ Muscular Dystrophy
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Parkinson's
- ❑ Asthma, Bronchitis, Emphysema
- ❑ Other:

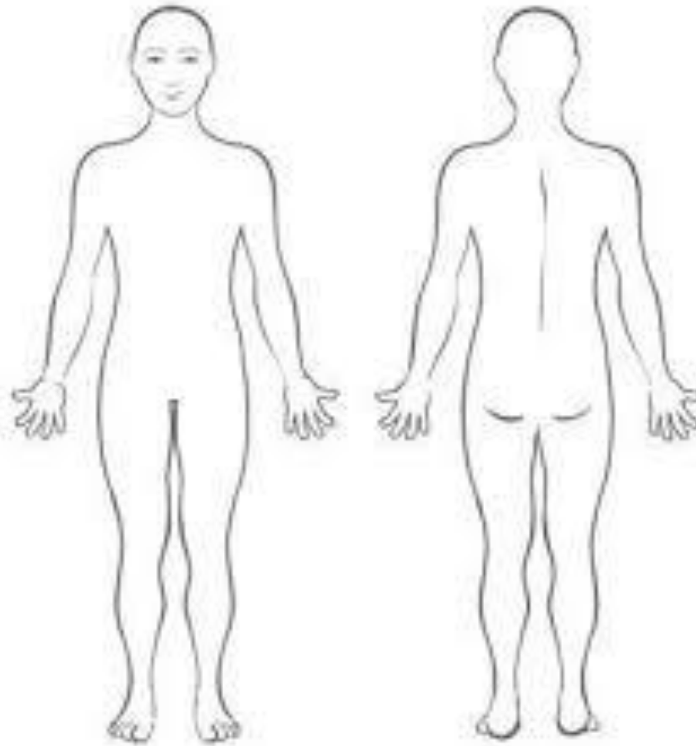
To help us better understand your symptoms, please circle all that apply.

My pain is worse: morning / night / constant / with activity / with rest

On a scale of 0 to 10 (0: no pain 5: moderate 10: severe/unbearable) please rate your pain: Current___ Best ____ Worst ___

**Pelvic Health:** If you are experiencing any of the problems listed below, please circle 'yes' and your therapist can discuss potential treatment options with you. Do you have a history of pelvic disorders (I.e., urge/stress incontinence, pelvic floor heaviness, pelvic/bladder or abdominal pain, irregular bowel movements)? Yes No

Please mark the area of injury or discomfort on the chart below in which we are treating.



Please list any additional information that would assist us in providing care:
______________________________________________________________________
______________________________________________________________________

Are you aware of your diagnosis (what you are being treated for at our clinic)? YES NO

What are your goals for therapy:
______________________________________________

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/ Legal Guardian Signature: ______________________ Date:_______________

Print Name and relationship to patient: _______________________________________

**Consent to Treat:**
The purpose of physical and occupational therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention through the use of therapeutic procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities. Response to physical and occupational therapy intervention varies from person to person; hence, I understand it is not possible to accurately predict my response to a specific modality, procedure, or exercise protocol. I further understand that it is my right to decline any part of my treatment at any time before or during treatment, should I feel any discomfort or pain or have other unresolved concerns. It is also my right to ask my physical or occupational therapist about the treatment they have planned based on my individual history, therapy diagnosis, symptoms, and examination results. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment. I have read this consent form and understand the risks involved in physical and occupational therapy and agree to fully cooperate, participate in all physical and occupational therapy procedures, and comply with the established plan of care.

**Authorization and Benefit Assignment/Financial Responsibility:**
I assign and transfer to Professional Rehabilitation Services (PRS) all insurance and other benefits and proceeds, including Medicare and Medicaid benefits and proceeds, to which I am or may become entitled as a result of PRS's charges for products and services delivered to me or the person named above for whom I am the legal guardian or authorized representative. This transfer and assignment is made and shall be re-made as of the dates on which each benefit becomes payable to me. In connection with this assignment of benefits, I hereby transfer and assign to PRS any right, title and interest that I have or may hereafter have to collect from any insurer or payer, including Medicare and Medicaid, and authorize PRS to submit a claim to such insurer or payer on my behalf. I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between PRS and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. If I receive direct payment for products and/or services provided to me by PRS from an insurer or other payer, I will hold such payment in trust for the benefit of PRS and I will promptly (a) endorse to PRS the check provider by such payer, or (b) pay PRS the full amount of such payment made to me by such payer.
The above may not apply for those patients that are considered worker's compensation beneficiaries. However, I understand that if I claim worker's compensation benefits and such benefits are subsequently denied, I may be held responsible for the total amount of charges for services rendered to me.
I understand that it is my responsibility to notify PRS of any change in my insurance. I understand that this assignment of benefits will remain in effect until revoked by me (or my legally authorized representative) in writing.

**Authorization to Release Information:**
I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid services or any other third-party payer who is responsible for my insurance benefits and their agents any information needed to determine the benefits payable for related products and services furnished by PRS.

**Disclosure of Health Information (HIPAA):**
Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care in the event of an emergency.
Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.
Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
Change of Ownership: In the event that PRS is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that PRS is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that PRS amend your protected health information. Please be advised, however, that PRS is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by PRS.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Disclosures to Specific Family Members/Friends:**
Please enter any family members or friends in which your personal health information can be released to.

Please list name and relation: ______________________________________________

**Attendance Agreement:**

I understand and acknowledge that my appointment times are scheduled in accordance with the availability of professional staff. Consistently attending my appointments will increase my success with therapy. I understand that my appointment may be rescheduled by PRS if I arrive more than 15 minutes late. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. I also acknowledge that PRS requires a 12 hour advance notice of cancellation and that PRS reserves the right to charge a *$25.00 cancellation fee to my personal account* if I fail to cancel an appointment at least 12 hours in advance.

Worker's Compensation Patients: I understand that PRS is required to inform my Worker's Compensation Adjuster and/or Case Manager of all missed or canceled appointments. I understand that any missed visits must be rescheduled.

**Electronic Communication Consent:**

By providing PRS with a telephone number for a cellular or other wireless device and/or an e-mail, I agree that authorized personnel, including my physical or occupational therapist or PRS providers, may use the provided telephone number or e-mail for scheduling/appointment reminders, billing or payment information, home exercise programs, surveys and educational/informative content as it relates to my condition. I understand and agree that PRS and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact me at the provided telephone number(s) which could result in standard data and telephone carrier charges. I expressly consent that these methods of contact may include using pre-recorded and artificial voice messages, text, email, (if an email address has been provided) and/or the use of an automatic dialing device, as applicable. This consent is not a condition of receiving services from PRS.

**Signature for Consent:**

By my signature below, I acknowledge that I have read, understand, and agree to the terms and conditions contained in the above sections.

Patient or Patient's Guardian Signature: ____________________________________________

Name Printed: ___________________________________________ Date: _______________