

Date \_\_\_\_\_

Name (Last, First, M.I.) \_\_\_\_\_ e-Mail \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_ Other Phone # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_ Referring Doctor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**In case of emergency please contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Other Phone # (\_\_\_\_) \_\_\_\_\_

**Primary Insurance Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

ID/Policy # \_\_\_\_\_

Group Name/# \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Secondary Insurance Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

ID/Policy # \_\_\_\_\_

Group Name/# \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Worker's Compensation Information**

Date of Injury \_\_\_\_\_

W/C Carrier \_\_\_\_\_

Address \_\_\_\_\_

Claim # \_\_\_\_\_

Adjuster \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

**MVA Information**

Date of Accident \_\_\_\_\_

Driver (Yes) \_\_\_\_\_ (No) \_\_\_\_\_

Auto Insurance \_\_\_\_\_

Policy # \_\_\_\_\_

Claim # \_\_\_\_\_

Insurance Agent \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

**Attorney Information**

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

To insure you receive a complete and thorough evaluation, please provide us with background information on the following form. If you do not understand a question, ask for assistance. Thank you.

**HISTORY OF PRESENT CONDITION**

1. What are your symptoms?

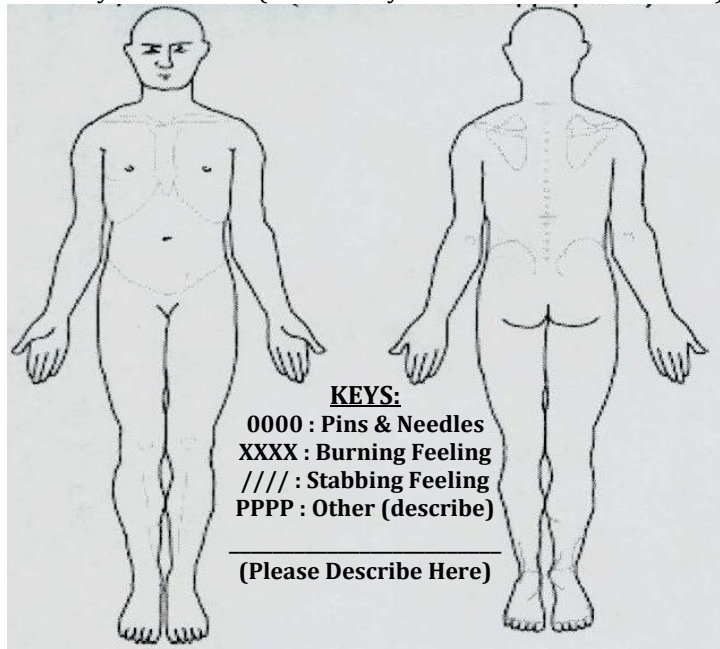
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Localize areas of **pain** or **abnormal** sensation on

the body chart below (Use the Keys to mark the affected areas)



**INCOMING PAIN SYMPTOM SCALE (Circle One)**

NO PAIN	MINIMAL	MODERATE	INTENSE	EMERGENCY
0	1 2 3	4 5 6	7 8 9	10

3. When did you symptoms begin?

(Please indicate a specific date if possible) \_\_\_\_\_

4. Was the **onset** of this episode gradual or sudden? (Check on)

- GRADUAL       SUDDEN

5. Which of the following **best describe** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)

- |  |   |
|--|---|
| <input type="checkbox"/> Lifting                     | <input type="checkbox"/> Trauma                   |
| <input type="checkbox"/> MVA (car accident)          | <input type="checkbox"/> Degenerative Process     |
| <input type="checkbox"/> Accident at Work            | <input type="checkbox"/> During Recreation/Sports |
| <input type="checkbox"/> Overuse (Cumulative Trauma) | <input type="checkbox"/> Running                  |
| <input type="checkbox"/> Throwing                    | <input type="checkbox"/> Unknown                  |
| <input type="checkbox"/> Other _____                 |   |

6. Since onset, are your symptoms getting: (Check One)

- BETTER     WORSE     NOT CHANGING

7. Have you had similar symptoms in the past?  YES     NO

More than one episode?  YES     NO

8. Nature of pain/symptoms (Check all that apply)

- |                                     |                                      |                                    |
|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> SHARP      | <input type="checkbox"/> ACHING      | <input type="checkbox"/> CONSTANT  |
| <input type="checkbox"/> DULL       | <input type="checkbox"/> PERIODIC    | <input type="checkbox"/> THROBBING |
| <input type="checkbox"/> OCCASIONAL | <input type="checkbox"/> OTHER _____ |                                    |

9. As the day progresses, do your symptoms: (Check One)

- INCREASE     DECREASE     STAY THE SAME

10. Does the pain wake you at night?  YES     NO

- If yes, is it present:  While lying still  
 Only when changing positions  
 Both

11. Do you have pain/stiffness upon getting out of bed in the Morning?  YES     NO

12. In what position do you sleep? (Check all that apply)

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Right side | <input type="checkbox"/> Back           | <input type="checkbox"/> Back, Sides, Stomach |
| <input type="checkbox"/> Left Side  | <input type="checkbox"/> Chair/Recliner | <input type="checkbox"/> Stomach              |
|                                     |   | <input type="checkbox"/> Other _____          |

13. Since the onset of your current symptoms have you had:

- Any difficulty with control of bowel or bladder function
- Fever/Chills
- Any numbness in the genital or anal area
- Numbness
- Any dizziness or fainting attacks
- Weakness
- Unexplained weight changes
- Night pain/Sweats
- Malaise (vague feeling of bodily discomfort)
- Problems with vision/hearing
- None of the above

14. What aggravates your symptoms? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Sitting                              | <input type="checkbox"/> Going to/Raising from sitting |
| <input type="checkbox"/> Lying Down                           | <input type="checkbox"/> Walking                       |
| <input type="checkbox"/> Up/Down stairs                       | <input type="checkbox"/> Standing                      |
| <input type="checkbox"/> Reaching overhead                    | <input type="checkbox"/> Reaching in front of body     |
| <input type="checkbox"/> Reaching behind back                 | <input type="checkbox"/> Reaching across body          |
| <input type="checkbox"/> Squatting                            | <input type="checkbox"/> Sleeping                      |
| <input type="checkbox"/> Coughing/Sneezing                    | <input type="checkbox"/> Taking a deep breath          |
| <input type="checkbox"/> Looking overhead                     | <input type="checkbox"/> Swallowing                    |
| <input type="checkbox"/> Stress                               | <input type="checkbox"/> Sustained bending             |
| <input type="checkbox"/> Recreational Sports including: _____ |  |
| <input type="checkbox"/> Other: _____                         |  |

15. What relieves your symptoms? (Check all that apply)

- |                                       |                                     |  |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Sitting      | <input type="checkbox"/> Rest       | <input type="checkbox"/> Massage                   |
| <input type="checkbox"/> Heat         | <input type="checkbox"/> Standing   | <input type="checkbox"/> Medication                |
| <input type="checkbox"/> Cold         | <input type="checkbox"/> Walking    | <input type="checkbox"/> Stretching                |
| <input type="checkbox"/> Exercise     | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Wearing a splint/Orthosis |
| <input type="checkbox"/> Other: _____ |                                     |  |

List Medications: \_\_\_\_\_

**MEDICAL HISTORY: (Check all that Apply)**

- |  |  |  |                                     |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Convulsions             | <input type="checkbox"/> High Blood |
| <input type="checkbox"/> Stroke / Blood Clot | <input type="checkbox"/> Balance Problems                | <input type="checkbox"/> Memory Loss             | <input type="checkbox"/> Pregnancy  |
| <input type="checkbox"/> HIV Positive / AIDS | <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Fainting / Dizzy Spells | <input type="checkbox"/> Pacemaker  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Tuberculosis / Persistent Cough |  |                                     |

**CONSENT TO PATIENT INTERVENTION**

Instructions: Initial inside the box beside each policy, then sign and date at the bottom.

**CONSENT TO TREATMENT OR FUNCTIONAL CAPACITY EVALUATION:** I hereby authorize the healthcare providers of ***CAM Physical Therapy & Wellness Services LLC.*** to administer such treatments, as they deem necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

**FINANCIAL RESPONSIBILITY:** I agree that I am financially responsible for all charges relating to services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I also understand I am responsible for knowing my policy and any dispute over the Insurance Company's decision or coverage is my responsibility to resolve. Balance of bill payment is due within 30 days of final payment by insurance company.

**CO-PAYMENTS AND CO-INSURANCES ARE DUE AND PAYABLE ON THE DATE OF SERVICE:** We accept cash, checks and all credit cards. ***A \$25.00 charge will be applied for EVERY returned checks.*** I agree to pay the portion that I am responsible for, as indicate here:

Deductible \$ \_\_\_\_\_ Co-Insurance % \_\_\_\_\_ / Pay Per Visit \$ \_\_\_\_\_ Copayment Per Visit \$ \_\_\_\_\_

**CANCELLATION POLICY AND FEE:** In order to maintain ***CAM Physical Therapy & Wellness Services LLC.*** high standard of care we ask that you give us a 24-hour notice if canceling an appointment. This allows us ample time to schedule and provide care to another patient. I understand that if I cancel on the same day of service or I do not show up for a scheduled appointment, ***I will be charged \$25.00 for which I am personally responsible.***

**LATE POLICY "15 MINUTES":** Being late by more than 15 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

**CHILDREN REQUIRING SUPERVISION ARE NOT ALLOWED TO ATTEND SESSIONS WITH YOU:** If your child does not require supervision and is capable of waiting for you quietly in the waiting area, then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child. Children's are **NOT ALLOWED** in the gym area while you or other patients are using the equipments.

**SPOUSE, FRIENDS OR PARTNERS:** due to liability issues, friends, spouses or domestic partners are not allowed in the treatment areas while you are been treated or examined.

**ASSIGNMENT OF BENEFITS:** I hereby assign to ***CAM Physical Therapy & Wellness Services LLC.*** all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to ***CAM Physical Therapy & Wellness Services LLC.***

**RELEASE OF INFORMATION:** I authorize ***CAM Physical Therapy & Wellness Services LLC.*** to release all medical information, via mail, facsimile or electronic mail required by my insurance company or Worker's Compensation carrier or designee to file for medical benefits. Additionally, ***CAM Physical Therapy & Wellness Services LLC.*** may release information, via facsimile or email, to any hospital or physician I may be referred from, or referred to, by ***CAM Physical Therapy & Wellness Services LLC.***

**MEDICARE WAIVER STATEMENT (IF APPLICABLE):** Anyone who misrepresents or falsifies essential information requested by this form may, upon conviction, be subject to fine and imprisonment under Federal Law. Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a) (1) of the Medicare Law.

I, the undersigned agree to be responsible, whether through another insurance or otherwise for payments of therapy services. I acknowledge that no Medicare limiting charge limits will apply and that other supplemental insurance may elect not to make payments for such services.

\_\_\_\_\_  
(PRINT) Patient's Name / Responsibility Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
(SIGNATURE) Patient/Responsibility Party Signature

\_\_\_\_\_  
Date

**NOTICE OF PRIVACY PRACTICES**  
**HEALTH INFORMATION PRIVACY UNDER HIPAA**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THESE RULES REQUIRE US TO PROVIDE YOU WITH THIS DOCUMENT. WE RESERVE THE RIGHT TO UPDATE THIS NOTICE IF REQUIRED BY LAW. PLEASE REVIEW IT CAREFULLY.

**TO PROTECT YOUR INFORMATION, WE ARE REQUIRED TO:**

- Have contracts in place with our contractors and others ensuring that we use, disclose and safeguard your health information properly.
- Have procedures in place to limit who can view and access your health information.
- Implement training programs for employees about how to protect your health information.
- Reasonably Limit use and disclosure to the minimum necessary to accomplish their intended purpose.
- Not provide any information related to your treatment at **CAM Physical Therapy and Wellness Services LLC**. this includes; family members, friends, spouses or domestic partners. If you wish to authorize someone to have access to your treatment care records provided at **CAM Physical Therapy & Wellness Services LLC**. i.e., medical records and appointment history, please provide us with their name and their relationship to you below.

*I consent to authorize \_\_\_\_\_, related to me as \_\_\_\_\_ to have access to my medical records, make changes on my appointments dates and time or get any information on relation to my appointments or medical treatment.*

**UNDER THE PRIVACY RULE, WE MUST COMPLY WITH YOUR RIGHT TO:**

- **Restrictions:** you have the right to request restrictions on how your information is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.
- **Confidential Communication and Access to Records:** You have the right to request confidential communication from us as well as copy of your medical records. You must make these requests in writing and we may charge a fee to cover the cost of copying and mailing.
- **Amendments:** You have the right to request an amendment be made to your records, if you disagree with what is says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.
- **Complaints:** If you feel that your privacy rights have been violated, you have the right to make a complaint. Your complaint should contain specific information so that we may adequately investigate and respond to your concern. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services. To find additional information about filing a complaint go to <http://hhs.gov> or by calling 866-627-7748

**WE ARE ALLOWED TO SHARE YOUR INFORMATION IF IT IS NECESSARY:**

- **Treatment:** disclosure of health information to other providers who have referred you for services or are involved in your care. This may include nurses, technicians, attorneys, adjusters and any other provider involved in your treatment case.
- **Payment:** disclosure of the health information to your insurance company, including Medicare and Medicaid, so payment can be obtained by services rendered.
- **Health Care Operations:** utilization of your records to monitor the quality of care being given at our facility or for business planning activities.
- **Auto Insurance:** disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to auto insurance or other similar programs established by law.
- **Worker's Compensation:** disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's comp or other similar programs established by law.
- **Other Special Uses:** our practice may use your information to send you an appointment reminder, to inform you of our other health-related products and services.

**USES AND DISCLOSURES REQUIRED BY LAW:** The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

Source: American Physical Therapy Association

\_\_\_\_\_  
**(PRINT)** Patient/Responsibility Party Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
**(SIGNATURE)** Patient/Responsibility Party Signature

\_\_\_\_\_  
Date