NEW PATIENT INFORMATION

(**PLEASE PRINT**) DATE: _____

Patient's Name: _____ SS# _____

Sex ____ Age ____ Date of Birth_____ Marital Status: S M W D

Address: _____

_____ Phone:_____

(City) (State) (Zip)

E-mail address:_____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____ Bus Phone:_____

Spouse Name: _____ SS # _____

Spouse Employer: _____ Occupation:_____

Date of onset of illness or injury:_____ Date of related surgeries_____

Illness or Injury related to: Work _____ Auto Accident _____ Other_____

Your Primary Care Physician_____Address/phone# of PCP_____

_____

How did you learn about our Physical Therapy office? (please check your answer)

□ Doctor's referral □ Friend or relative referral □ Insurance listing □ Phone book □ Newspaper

□ Drive by □ Other _____

HEALTH INSURANCE INFORMATION:

Primary Insurance Company_____Phone:_____

Insured Name_____Patient Relation to Insured: Self Spouse Child

ID#_____Policy?Group#_____

Secondary Insurance Company_____Phone:_____

Insured Name_____Patient Relation to Insured: Self Spouse Child

ID#_____Policy?Group#_____

FOR OFFICE USE ONLY:

Medical Diagnosis:_____ Treatment Diagnosis:_____

Referring Physician:_____ NPI #_____

# of Treatments Prescribed:_____Date last seen by physician_____

Pre-authorization required? □ Yes □ No Referrral #_____

Authorization #_____ # of visits approved _____

Co-payment due per visit_____

RELEASE OF INFORMATION

I hereby authorize the office of **Professional Physical Therapy and Balance** to release any information acquired in the course of my treatment to my insurance company, adjuster or attorney involved in this case.

MEDICARE PATIENTS: I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

DIRECTION TO PAY

I hereby instruct and direct the insurance company to pay above named office/specialist/doctor directly and mail it to the address above.
If my current policy prohibits direct payment to the physical therapist, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

FINANCIAL RESPONSIBILITY

I understand that I am directly responsible to above named office/doctor for all bills for physical therapy services received by me or my child. I agree to pay the co-payment fees and percentage of responsibility assigned to me or my family by my health insurance carrier. If my health insurance company requires specific insurance forms, I will furnish the office these forms necessary to complete the billing. I will promptly notify the office of changes in my insurance policy.

If my insurance company disputes or rejects the claim for physical therapy services, unless the services and claims were inappropriately provided and submitted, it will be my responsibility to pay the charges and pursue reimbursement from the insurance company.

A photocopy of this Assignment shall be considered as effective and valid as the original.

DATE: _____ SIGNATURE: _____

General Health Review

Patient Name:_____**Date**_____

What is your weight: _____ lbs.; What is your height: ___ft. ___in. How many level(s) are in your home?____; List Stair Steps in home & which side your handrail(s)is on; be detailed: _____

_____

Do you use an assistive device to walk with? *(Circle)* **Y or N. What device are you using?**

Front wheel walker__; 4 wheel walker__; Standard cane __; Wide Base Quad Cane __; Pyramid Cane __; Crutches __; Other: __ **What assistive device?** _____

Whom do you live with in your home? _____

Do you currently have or have recently had:

	YES	NO		YES	NO
Unexplained weight loss/gain			Are you continent of feces		
Fever, chills, night sweats			(go regularly)?		
Pain that wakes you at night			Numbness		
Malaise/lethargy			Fainting		
Shortness of breath			Dizziness/lightheadedness		
Weakness			Headache		
Nausea/vomiting			Smoking		
Bowel changes/altered bowel habits			If yes, how much each day?_____week?_____		
Problems/pain with urination			Alcohol consumption		
Are you continent of urine			If yes, how many drinks each day?_____week?		
(go regularly)?			Drug abuse		

Medical/Surgical History

Do you have personal history of

	YES	NO
Cancer		
Diabetes		
Heart disease		
Stroke		
High blood pressure		
For women, are you pregnant,		
or think you may be pregnant?		

Immediate family medical history

	YES	NO
Cancer		
Diabetes		
Heart disease		
Stroke		
High blood pressure		

List any surgeries and dates:

List all medications, including over the counter drugs, you are currently taking or have recently stopped.

650 Townbank Rd., Suite 203, North Cape May, NJ ♦ 609-884-9800

NOTICE OF PRIVACY PRACTICES

Professional PT& Balance must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of *Professional PT & Balance* to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care, and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within *Pro PT & Balance* as well as reasons why your health information could be sent to other service providers outside of this office.

This *Notice* describes your rights in regards to the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures *Pro PT & Balance* uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Client Acknowledgement

I have received *Notice of Privacy Practices*, which describes this office's methods for protecting the privacy of my health information that is used in providing health care services to me.

_____/_____

Patient (or Personal Representative/Parent of Minor) Date

Name of the Patient:_____

Date of Birth:_____

Address:_____

_____

PROPT &Balance

Name: _____

Date: _____

Client Needs Screen (CNS)

1. Would you like to find out about a product that boosts your Nitric Oxide Levels (NOL). NOL diminish as we get older and can play a very important role in cardiovascular health.	□ Yes □ No **my blood pressure and heart are fine**
2. Have you had a fall in the past year?	□ Yes □ No
3. Do you have a fear of falling?	□ Yes □ No
4. Would you like your balance to be assessed?	□ Yes □ No
5. Do you experience dizziness or imbalance?	□ Yes □ No
6. Do you lose your balance when stepping up/down curbs or stairs/steps?	□ Yes □ No
7. Do you have a difficult time walking in the dark?	□ Yes □ No
8. Do you have difficulty hearing?	□ Yes □ No

9. Do you have osteoporosis, osteoarthritis and/or joint pain?	□ Yes □ No
10. Do you take bone and/or joint supplements?	□ Yes □ No
11. Do you experience muscle aches, pains and/or muscle cramping?	□ Yes □ No
12. Do you use cold, heat or compression therapy at home?	□ Yes □ No
13. Are you interested in learning how compression clothing with ice could help your condition?	□ Yes □ No
14. Are you interested in learning how home heat and/or cold therapy could help your condition?	□ Yes □ No

15. Do you have foot and/or ankle pain/discomfort?	□ Yes □ No
16. Do you currently wear shoe inserts?	□ Yes □ No
17. Are you interested in learning about how a shoe insert could help your condition?	□ Yes □ No
18. Do you have pain and/or physical challenges other than what you are being seen for today?	□ Yes □ No
19. Would you like to get more information about your whole body health?	□ Yes □ No
20. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	□ Yes □ No

21. Do you have a hard time falling asleep or staying asleep?	□ Yes □ No
22. Do you wake up with pain, stiffness, and/or soreness?	□ Yes □ No
23. Are you tired when you wake up?	□ Yes □ No
24. Do you experience sleep disruption from being too hot?	□ Yes □ No
25. Are you interested in learning how the right mattress can improve your recovery and total body health?	□ Yes □ No