

WELCOME TO GOLD MEDAL PHYSICAL THERAPY, LLC

Please provide the necessary information below as accurately as possible so that we may correctly process insurance billing. Please ask our office staff if there are any questions or concerns. Thanks you for choosing Gold Medal Physical, LLC.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH _____

STREET _____ CITY _____ STATE _____ ZIP _____

TELEPHONE (HOME) () _____ WORK () _____

CELL PHONE () _____ SOCIAL SECURITY NO: _____

EMAIL: _____

SEX: F _____ M _____ MARITAL STATUSES: M _____ S _____ D _____ W _____

EMERGENCY CONTACT: _____ CONTACT PHONE () _____

RELATIONSHIP TO PATIENT: _____

WHO MAY WE THANK FOR REFERRING YOU? (Please provide name & address) _____

REFERRING PHYSICIAN _____ OFFICE PHONE () _____

PRIMARY CARE DR _____ OFFICE PHONE () _____

DATE OF INJURY ____/____/____ TYPE OF INJURY _____

IS THIS INJURY WORKMANS COMP. OR AUTO RELATED? YES ___ NO ___ (If Yes Please See Additional Form)

EMPLOYER NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

INS. CARRIER _____ ID# _____ GROUP _____

ADDRESS _____ PHONE () _____

INSURED NAME _____ SSN# _____ DOB _____

INSURED'S EMPLOYER _____ RELATIONSHIP _____

ADDRESS _____

SECONDARY INSURANCE INFORMATION

INS. CARRIER _____ ID# _____ GROUP _____

ADDRESS _____ PHONE () _____

INSURED NAME _____ SSN# _____ DOB _____

INSURED'S EMPLOYER _____ RELATIONSHIP: _____

ADDRESS _____

I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM. I ALSO AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO GOLD MEDAL PHYSICAL THERAPY, LLC FOR SERVICES RENDERED TO THE ABOVE NAMED PATIENT. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL CHARGES INCURRED FOR TREATMENT RENDERED TO THE ABOVE NAMED PATIENT.

SIGNATURE _____ DATE _____

GOLD MEDAL PHYSICAL THERAPY – PHYSICAL THERAPY MEDICAL HISTORY FORM

Name: _____ Age: _____ Hand Dominance: _____
 Occupation: _____ Sports: _____
 Currently Working? Yes/No _____ hours/week School: _____
 What do you hope to achieve by coming to physical therapy? _____

Date of onset/injury: _____ Date of surgery? _____

Next appointment with practitioner who referred you to physical therapy? _____

Have you had any similar symptoms in the past? _____ If so, explain: _____

Have you been treated for this in the past? _____ If so, explain: _____

What tests have you had for this problem? X-ray bone scan MRI EMG CT Scan _____

Where were tests done? _____

What were the results? _____

Are you currently receiving any other medical/health services? _____

Have you been given exercises or other instructions? _____

Do you have any tingling, numbness or loss of skin sensation: _____ If so, where? _____

What increases this? _____

What decreases this? _____

Check any activities you have difficulty with due to the problem for which you are seeking treatment:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> sleeping | <input type="checkbox"/> rising from a chair | <input type="checkbox"/> bathing | <input type="checkbox"/> job functions: _____ |
| <input type="checkbox"/> getting in/out of bed | <input type="checkbox"/> prolonged sitting (45 min+) | <input type="checkbox"/> dressing | _____ |
| <input type="checkbox"/> driving | <input type="checkbox"/> prolonged standing | <input type="checkbox"/> self care | <input type="checkbox"/> leisure activities/sports: _____ |
| <input type="checkbox"/> getting in/out of vehicle | <input type="checkbox"/> walking | <input type="checkbox"/> eating | _____ |
| <input type="checkbox"/> meal preparation | <input type="checkbox"/> using stairs | <input type="checkbox"/> reaching to shelves | <input type="checkbox"/> other: _____ |

Have you been discharged from a hospital or skilled nursing facility in the last 30 days? _____

If yes, explain: _____

How many times have you fallen in the past year? _____

If so, what happened? _____

Are there cultural/religious practices that may affect your healthcare? _____ Explain: _____

Allergies: none latex tape/adhesives bee stings other: _____

How would you rate your current health? excellent very good good fair poor

Please check yes or no if you have any of the following conditions:

	Yes / No			Yes / No			Yes / No	
Smoke/Chew Tobacco	Y	N	Diabetes	Y	N	Sexually Transmitted Disease	Y	N
Packs per day: _____			Heart Attack	Y	N	Osteoarthritis	Y	N
Use of Illegal Substances	Y	N	Cardiac Bypass	Y	N	Rheumatoid Arthritis	Y	N
Drink Alcoholic Beverages	Y	N	Cardiac Stents	Y	N	Osteoporosis or Osteopenia	Y	N
Amount per day: _____	Y	N	Angina/Chest Pain	Y	N	Metal/Plastic Implants	Y	N
High Blood Pressure	Y	N	Pacemaker	Y	N	Headaches or Migraines	Y	N
High Cholesterol	Y	N	Emphysema	Y	N	Dizziness or Fainting	Y	N
Bowel Bladder	Y	N	COPD	Y	N	Cancer (site: _____)	Y	N
Acid Reflux or Ulcers	Y	N	Asthma	Y	N	Recent Infection	Y	N
Thyroid Disorder	Y	N	Kidney Disease	Y	N	Recent Anticoagulant Medicine Use	Y	N
Bleeding Disorder	Y	N	Stroke	Y	N	Recent Antibacterial Medicine Use	Y	N
Seizures/Epilepsy	Y	N	Depression	Y	N	Consistent Steroidal Medicine Use	Y	N

Do you have a problem with:

Hearing	Y	N
Vision	Y	N
Communication	Y	N

Are you currently:

pregnant Y N # of weeks: _____

Please check yes or no if in the past 3 months have you experienced:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Persistent pain at night	Y	N	change in or problems with bladder/bowel function	Y	N
Fevers, chills or night sweats	Y	N	changes in hearing	Y	N
Unexplained weight loss	Y	N	changes in mental abilities	Y	N
Unwarranted fatigue	Y	N	frequent or severe headaches with no history of injury	Y	N
Unusual lumps or growths	Y	N	problems with swallowing or changes in speech	Y	N
Pulsating pain anywhere in your body	Y	N	changes in vision (blurriness or loss of sight)	Y	N
Constant and severe pain in leg or arm	Y	N	problems with balance, coordination or falling	Y	N
Swelling without a history of injury	Y	N	fainting spells	Y	N
Shortness of breath	Y	N	sudden weakness	Y	N
Frequent or severe abdominal pain	Y	N	pain, tingling or numbness in and around your face	Y	N
Frequent nausea or vomiting	Y	N	tingling or numbness in both of your arms or both legs	Y	N

List all previous surgeries and dates: _____

To the best of my ability, I have given and included all pertinent medical information.

Patient/Guardian signature: _____ Date: _____

Medical history reviewed by physical therapy and used in determining the plan of care.

PT signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

GOLD MEDAL PHYSICAL THERAPY, LLC.

Dear Parent, Guardian or Patient,

“This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.”

Due to recent changes in State and Federal regulations governing privacy practices, and in order to update our records, please complete the attached registration for you or your family. Please provide the current information regarding your telephone numbers (home and work) and home address. This will allow us to make the correct contact when trying to reach you.

The practice has implemented policies and procedures so that the confidentiality of your personal and/or medical information remains confidential. Your physician(s) as well as all other employees working in the practice will keep any information related to you or your child (medical and/or non-medical) in a confidential manner.

So that we may provide you or your child with appropriate medical care, for general practice operations and/or for the purpose of obtaining payment, we will, at our discretion, provide information regarding the treatment you or your child received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health related entities such as:

- Physician/Non-Physician Providers (i.e. Physical Therapists, Nutritional Counselors, etc.) who work outside of this practice;
- Medical Facilities (i.e. hospitals and outpatient centers);
- Laboratories for the purpose of running medical tests;
- Other health care providers such as pharmacies, durable medical equipment suppliers, and ambulance services;
- School Health Departments;
- Insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity and/or general case management;
- State or Federal agencies that require the submission of specific health related information.

This information will be submitted by means of the U.S. Postal Service, fax, internet, voice mail and/or personal communications.

We may need to contact you by telephone to discuss your appointments, test results, treatment, and referrals, account balance and/or return your telephone call. We will first attempt to contact you at home; however, if you are not available and you provide us with your work telephone number, we may attempt to contact you at work. If you are not available, we may leave a message for you to either call the office or we may leave information to remind you of an appointment time.

In the event that you do not pay all of your charges at the time of your visit, we will mail a statement to your home. Also, depending upon your situation, we may mail other correspondence to your home noting that we are trying to contact you regarding a scheduled appointment, to schedule an appointment, to mail test result information or other medical and/or non-medical information that you may have requested or information regarding your account in order to collect a debt.

We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirement.

When you arrive at our practice for your appointment, we will ask you to sign in. If you would like information sent to another physician or medical facility, you must authorize the release of this information, in writing (we

will provide the necessary form to complete) upon registration. Also, you must provide written authorization for the release of information to your life, disability, or future health insurance carrier.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. This may not include psychotherapy notes.

You must submit your request in writing to the Practice Manager in order to inspect and/or obtain a copy of your PHI. Our practice charges a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another health care professional chosen by us will conduct reviews.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by providing a written request to the practice at any time.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, for example, if we think the information is correct, or was not created by our practice, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Practice Manager to determine if you have questions about amending your medical record. To file an amendment, your request must be in writing and must be submitted to the Practice Manager.

When necessary, these policies will be modified to ensure compliance with the practice operations and with State and Federal privacy regulations.

If you have any questions or concerns with the policies and/or procedures noted above, please contact the Practice Manager to discuss them. We trust that you are comfortable with our efforts to maintain confidentiality of the information related to you or your child’s medical care.

Sincerely,

Gold Medal Physical Therapy, LLC

PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGMENT FORM

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

Print Name: _____

Birth Date: _____

Signature: _____

Date: _____