New Patient Information

Name_____ Date____/____/____

Address_____City_____State _____ Zip_____

Home Phone _____ DOB ____/____/____ S.S.#_____

Cell Phone _____ Email Address _____

Marital Status _____ Emergency Contact _____ Phone _____

Employment Information

Employer_____Address_____

Occupation_____ Work Phone _____

Referral Information

Referring Physician_____Phone _____

Diagnosis_____ Date of Onset_____

Describe the problem(s) for which you seek physical therapy.

_____

What happened?_____

What are your goals for physical therapy?_____

Are you seeing anyone else for your condition(s)?

☐ Acupuncturist ☐ Chiropractor ☐ Massage Therapist ☐ Osteopath
☐ Orthopedist ☐ Rheumatologist ☐ Neurologist ☐ Cardiologist
☐ OB/GYN ☐ Other(s)_____

How did you find our facility?_____

General Health Status

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes in the past year? (i.e. baby, job change, death in family) ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes, year quit_____ ☐ No

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No

How many days/week?_____ Describe exercise: _____

Height _____ Weight _____

Family History

Indicate whether you mother, father, sibling suffered from any of the following condition(s) and age of onset if known.

☐ Heart disease_____ ☐ Hypertension_____ ☐ Stroke _____ ☐ Cancer_____
☐ Diabetes_____ ☐ Psychological _____ ☐ Arthritis _____ ☐ Osteoporosis_____
☐ Other_____

Medical/ Surgical History *(Check if you have ever had any of the following.)*

☐ Arthritis	☐ Broken bones/Fractures	☐ Multiple Sclerosis	☐ Epilepsy/Seizures
☐ Vascular disease	☐ Heart problems	☐ Skin disease	☐ Prostate disease
☐ Stroke	☐ Allergies	☐ Pregnancy	☐ Growth problems
☐ Lung problems	☐ Head injury	☐ Infectious disease (Hepatitis)	☐ Recent pregnancy
☐ OB/GYN problems	☐ Muscular Dystrophy	☐ Low blood sugar	☐ Blood disorders
☐ Parkinson's	☐ Thyroid problems	☐ Ulcers/Stomach	☐ Pelvic inflammatory disease
☐ Osteoporosis	☐ Cancer	☐ Kidney problems	☐ Depression
☐ Diabetes	☐ High blood pressure	☐ Menstrual problems	☐ Complicated pregnancy

☐ Recent injury_____

Other_____

Within the past year have you had any of the following symptoms? *(Check all that apply.)*

☐ Chest pain	☐ Shortness of breath	☐ Joint pain/Swelling	☐ Loss of appetite
☐ Bowel problems	☐ Urinary problems	☐ Hearing problems	☐ Heart palpitations
☐ Loss of balance	☐ Pain at night	☐ Nausea/Vomiting	☐ Weight loss
☐ Fever/Chills	☐ Vision problems	☐ Cough	☐ Coordination problems
☐ Difficulty walking	☐ Difficulty sleeping	☐ Weight gain	☐ Headaches
☐ Weakness in arms	☐ Weakness in legs	☐ Dizziness/Vertigo	☐ Difficulty swallowing

Other_____

Have you fallen in the past year? ☐ Yes ☐ No If so, approximately how many times _____

Medications

Do you take any prescription medication? ☐ Yes ☐ No

If yes please list:_____

_____

Do you take any nonprescription medication? ☐ Yes ☐ No

Check all that apply.

☐ Advil/Aleve ☐ Aspirin ☐ Tylenol ☐ Antihistamines ☐ Decongestants

☐ Herbal supplements ☐ Antacids ☐ Other_____

Within the past year, have you had any of the following tests? (Check all that apply.)

☐ Angiogram	☐ Arthroscopy	☐ Biopsy	☐ Bone scan	☐ Blood tests	☐ CT scan
☐ EKG	☐ Myelogram	☐ Nerve conduction	☐ Stress test	☐ X-rays	☐ MRI

Other_____

CONSENT TO TREATMENT: I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

I affirm the medical problem for which I am seeking physical therapy is not related to a no-fault or Workers' Compensation event.

Signature of Patient or Legal Guardian _____ Date _____

Physical Therapist Initials _____

New Castle Physical Therapy
And Personal Training

NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and the disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - i. The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of complaint.
  - ii. The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a restriction.
  - iii. The right to inspect and copy protected health information.
  - iv. The right to amend protected health information.
  - v. The right to receive an accounting of disclosures of protected health information.
  - vi. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.
  - vii. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all the protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Policy on request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge receipt of written Notice of Privacy Practices.

_____ _____

Patient Signature **Date**

□ Patient chose not to sign acknowledgement
□ Emergency prevented obtainment of acknowledgement
□ Communication barrier prohibited
□ Other_____

OFFICE STAFF WITNESS OF PATIENT REFUSAL TO SIGN ACKNOWLEGEMENT

_____ _____

Staff Signature **Date**

NEW CASTLE Physical THERAPY & Personal TRAINING

PAYMENT POLICIES

Thank you for choosing New Castle Physical Therapy. Please familiarize yourself with our payment policies and feel free to ask us any questions you may have about your payment responsibilities.

- **COMMERCIAL INSURANCE**

  New Castle Physical Therapy does not participate with commercial insurance carriers. As a courtesy we will submit all paperwork and claims on your behalf, but please note that **many insurance carriers send payments directly to the patient**. Therefore, we offer two payment options.

  1. **Pay your co-insurance at the time of service and endorse and deliver to us all insurance check(s) you receive for your treatment at New Castle Physical Therapy.** If you choose this option, please leave a credit card number on file in our secure database and, by signing below authorize, New Castle Physical Therapy to apply any outstanding charges to your card if you fail to deliver the endorsed insurance check(s) within 30 days from the date of issue.

  2. Pay your charges at the time of service and await reimbursement from your insurance company.

  New Castle Physical Therapy may require full payment at the time of service for patients covered by commercial insurance carriers with restricted payment policies or reimbursement rates.

- **MEDICARE**

  New Castle Physical Therapy is a participating Medicare provider. Medicare patients have an annual deductible that your secondary insurance may cover. If your secondary insurance does not cover your deductible, you are responsible for the charges. Medicare reimburses New Castle Physical Therapy directly and sends the remaining balance to most secondary insurance plans. If you do not have secondary insurance or your secondary insurance does not cover the remaining balance, you are responsible for this balance.

- **WORKER'S COMPENSATION and NO FAULT CASES**

  New Castle Physical Therapy does not participate in Worker's Compensation or No Fault cases. If you neglect to advise us that your appointments involve either type of case, you will be charged in full for your visits.

- **CANCELLATION POLICY**

  We require 24 hours notice for a cancellation. There is a $100 charge for missed appointments or appointments cancelled inside of 24 hours.

- **MEDICAL RECORDS FOR INSURANCE CLAIMS**

  Your insurance carrier may request your medical records in order to process your claims. By signing below, you authorize New Castle Physical Therapy to release your medical records to process any pending medical claims.

Please sign below to indicate full understanding of the above payment policies. Thank you.

Signature of Patient or Guardian_____ Date_____