Central
Physical Therapy
& Rehabilitation

Today's date: _____

PATIENT INFORMATION

Name: _____ DOB: _____ Sex: _____

SSN: _____Occupation: _____ Marital Status: _____

Mailing address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Emergency contact: _____ Tel: _____

Primary care physician: _____ Tel: _____

Referring physician: _____ Tel: _____

How did you hear about us? _____

MEDICAL HISTORY

Please check (☒) if you have been **diagnosed** with the following…

1	Asthma		***14***	Dementia		***27***	Hearing Impairment	
2	Allergies		***15***	Back and/or Neck Problems		***28***	Vision Impairment	
3	Diabetes		***16***	Kidney or Liver Problems		***29***	Fibromyalgia	
4	COPD		***17***	Bladder Problems		***30***	Osteoarthritis	
5	ARDS		***18***	Urination Problems		***31***	Rheumatoid Arthritis	
6	Glaucoma		***19***	Prostate Problems		***32***	Gastrointestinal Disease	
7	Emphysema		***20***	Thyroid Problems		***33***	Prosthesis	
8	Headaches		***21***	Sleep Problems		***34***	Implants	
9	Cancer		***22***	Circulation Problems		***34***	AIDS or HIV	
10	Stroke		***23***	Gynecological Problems		***36***	Hepatitis	
11	TIA		***24***	Osteoporosis or Osteopenia		***37***	Multiple Sclerosis	
12	Seizures		***25***	High/Low Blood Pressure		***38***	Parkinson's Disease	
13	Heart Problems		***26***	Low or High Blood Sugar		CIRCLE: Right or Left-handed		

Other relevant medical history: _____

_____

If you checked any of the above questions, please indicate the number and explain.

No. _____ , _____

No. _____ , _____

No. _____ , _____

No. _____ , _____

Previous surgery/hospitalization: _____ Date: _____

Previous surgery/hospitalization: _____ Date: _____

Do you smoke? _____. Do you drink alcohol? _____. *If yes, how much per day* _____

RECENT EXPERIENCE (PAST MONTH) … Please check if necessary:

Unexplained Weight Changes		Shortness of Breath		Nausea / Vomiting	
Changes in Appetite		Fevers / Chills / Sweats		Dizziness / Fainting	
Changes in Bowel Function		Illness / Flu / Virus		Unsteadiness / Falls	

If yes to dizziness/fainting, please indicate when they usually occur: _____

If yes to falls, please indicate the amount in the past year: _____

MEDICATIONS (including over the counter)

Name of drug	Dosage	Frequency

MEDICAL TESTING

Name of test (MRI, X-RAY…)	Date performed	Result

CURRENT EXPERIENCE

Describe how your injury/condition occurred: _____

_____

Describe your symptoms: _____

_____

When did your injury/condition occur?

☐ Past Week ☐ 2-3 Weeks ago ☐ 1-3 Months ago ☐ 3-6 Months ago ☐ Over 6 Months ago

How did your injury/condition occur?

☐ Suddenly ☐ Gradually Caused by: _____

Currently, has your condition … ☐ IMPROVED ☐ WORSENED or ☐ STAYED SAME?

Before the occurrence, did you have any issues with the same area? **Y** **N** *If yes, explain*: _____

_____

PAIN AND LOCATION

Pain level **right now** *(circle one)*

No pain **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** *Extreme pain*

*In the **past few weeks**…*

Lowest rating of pain _____/10 Highest rating of pain _____/10

What word(s) best describe your pain? ☐ Ache ☐ Sharp ☐ Tingling ☐ Numbness ☐ Burning ☐ Cramping

☐ Tender ☐ Discomfort ☐ Other: _____

What makes your pain better? _____

What makes your pain worse? _____

Does coughing or sneezing cause discomfort?		Does the pain wake you up at night?	
Have you had physical therapy somewhere else?		*If so*, can you return to sleep?	

Did symptoms start in one place and later spread? If so, to where: _____

_____

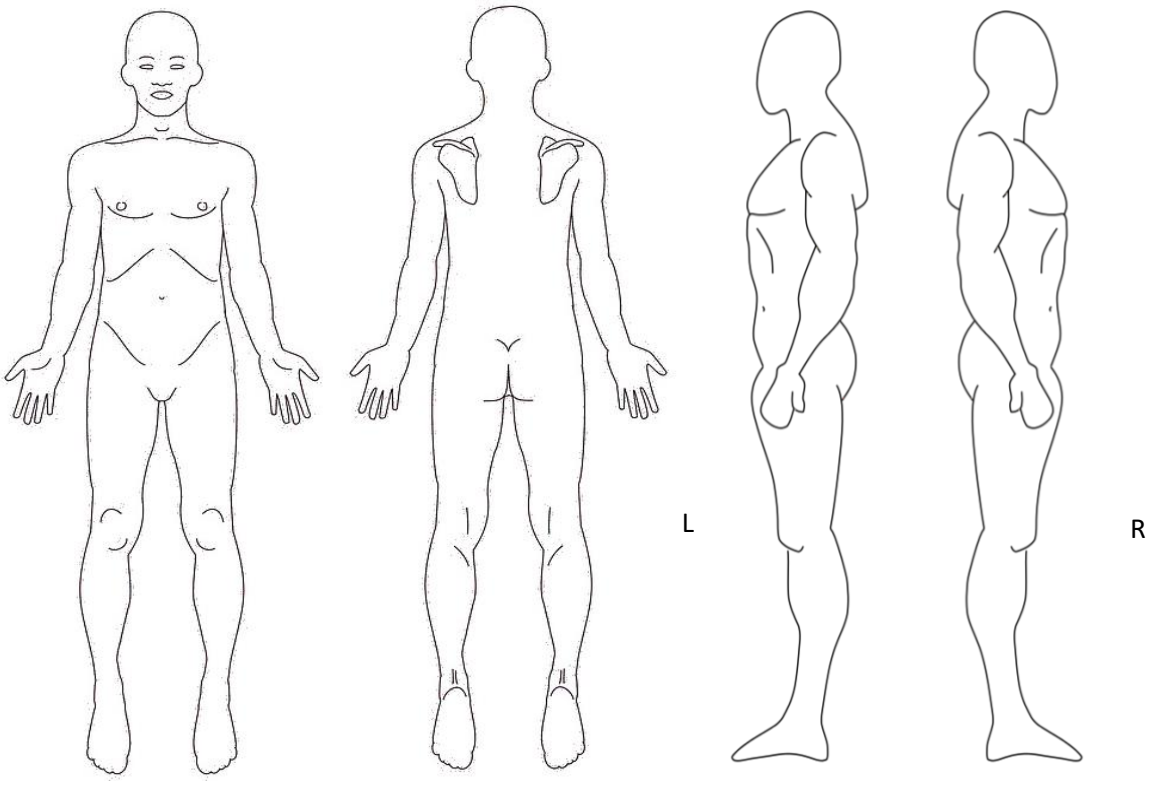
Please mark:

▲ Numbness

■ Minimal Pain

◍ Moderate Pain

✕ Severe Pain



For office use only:

Blood Pressure _____ O2 _____ Heart Rate _____ Height _____ Weight _____

Central
Physical Therapy
& Rehabilitation

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Reading PA, 19601
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Fax: 484-987-2695

Acknowledgement of Policies and Private Practices

Please read this notice carefully regarding our policies and practices.

Attendance and Scheduling

Physical therapy is a process, although you may start to feel better sooner than expected, it is always recommended that you continue therapy until you are **officially discharged**. Although certain injuries/conditions may take longer than expected, please do not discontinue physical therapy. Lapses in treatment often delay the recovery time and may lead to periods of discomfort and/or pain You are encouraged to talk to us about modifying your plan of care or communicating with your primary care physician for other options.

In addition, it is important to us that we treat all patients with the same type of care and attention. So, if you are unable to make your appointment, we kindly ask you to contact us in advance. We ask all our patients to come to their scheduled appointments **ON TIME**. Patients that come early may be asked to wait until their scheduled appointment time to be seen. Or, if you arrive more than 15 minutes late, you may be asked to schedule another appointment. Also, if you miss more than three (3) appointments, we may contact your doctor/lawyer/etc. to notify them of you are not compliant with therapy.

Physical Therapy Referrals

Please be aware that the prescription you bring from your referring physician has an expiration date. Unless otherwise explicitly written, the referral will expire in **six** (6) months from the date written by your provider. It is important to have a prescription that is up to date, so that your insurance will continue to cover physical therapy services. In addition, Pennsylvania law requires a prescription to receive physical therapy services. Our office will try to remind you to continue brining un updated referral, but it is not our responsibility to do so. Whenever you follow-up with your primary care physician or referring doctor, we advise you to request an updated physical therapy prescription, if needed. If your referral is not up to date, we will unfortunately not be able to provide you with therapy services.

Consent of Treatment

I, the undersigned, do hereby authorize Central Physical Therapy & Rehabilitation, LLC to evaluate and treat my injury/condition. I also understand no guarantee or promise concerning the results of treatment. Oftentimes the first few sessions of treatment may cause more discomfort or pain, which I understand is normal, due to increased activity. Although not common, I understand that my condition may worsen even with the course of recommended treatment. This consent is intended as a waiver of liability for such treatment expecting acts of negligence.

Our Legal Duty

Central Physical Therapy & Rehabilitation, LLC is required by law to protect your personal and health information, maintain confidentiality, provide notice about our management policies, and follow the protocols described below.

Release of Information

We use your personal and health information to treat, secure payment, conduct internal administrative activities, and assess quality of care. In addition, we may use your information without prior authorization for public health purposes, appointment reminders, audit tracking, and if required by law. If at any point we change our policies, they will be available to view at any time and you may request a copy at any time. Our compliance officer is Claudia Salgado; she can be reached by contacting our office at (484) 987-2738.

I, hereby assign all medical benefits that I am entitled to, included Medicare, Medicaid, private insurance and third-party payers to: Central Physical Therapy & Rehabilitation, LLC. A photocopy of benefits is needed in order to verify eligibility of benefits. I, hereby authorize said assignee to release all necessary information, including medical records to secure payment of said benefits, additionally, said assignee may represent me to secure payment.

Financial Policy

It is required that we have your most up to date insurance information at the time of your first visit, if not handed in today, you must do so on your second visit. If you change insurance, you **MUST** notify us ASAP. If you fail to notify us, you will be responsible for balances due.

Central Physical Therapy & Rehabilitation, LLC will contact your insurance company to verify coverage and benefits. This does not mean a pre-authorization of treatment. When a pre-authorization is required by your insurance, we will wait to treat you until you have been approved for treatment by your insurance company.

Certain private insurances may require your consent of treatment, in this case we will represent you in order to receive approval of physical therapy services and/or file on your behalf.

We will bill your primary and secondary insurance as a courtesy to you. In most cases, **Medicare** will pay 80% of allowable charges, if you do not have a secondary insurance the balance will be billed to you.

For **self-pay,** the balance must be paid at the time of service. In the event you are unable to pay at the time of service, we are willing to make payment arrangements. Please be advised, we are not a credit grantor, therefore, failure to maintain said arrangements will result in the placement of your account to a collections agency or an attorney for collection.

I understand that I am responsible for whatever fees my insurance company does not pay on my claim, typically a co-payment, deductible, and/or co-insurance. In the event my account becomes delinquent and is in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt.

If your insurance coverage is through **Blue Cross Major Medical (Capital Blue Cross)**, your insurance company will reimburse you directly for physical therapy services billed by us. In this case, when you receive payment, you should recognize an obligation to promptly remit and pay to Central Physical Therapy & Rehabilitation, LLC so that we can credit your account.

If you are receiving therapy due to an **auto accident**, the following is needed: your automotive company's name and address, claim number, adjuster's name and phone number, private health insurance name and claim forms, and if you have an attorney, their name, telephone, and address.

If you are receiving **Worker's Compensation** benefits, the following is needed: W/C company name and address, claim number, adjuster's name and phone number, employer's name, address, and phone number, and if you have an attorney, their name, telephone, and address. Please be advised, if you have W/C claim benefits and are subsequently denied such benefits, you may be held responsible for the total amount charged and services rendered to you.

Your individual rights include:

The right to request to receive confidential communications of our protected health information by alternative means or allocations.

The right to access, inspect and copy your protected health information.

The right to request an amendment to your protected health information.

The right to receive a report on the disclosure of protected health information outside of treatment, payment and operations.

The right to obtain a paper copy of this notice from us after receiving the request.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to close relatives, other family members, personal friends, or any other person identified by you. However, we are not required to accept a restraining request. If we accept a restriction, we must comply with it unless you agree in writing to remove it.

You have the right to file a formal written complaint with us, or at the Department of Health and Human Services, Office of Civil Rights, if you feel that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

I, _____ reviewed and understand the Notice of Policies and Private Practices.

X

Patient Signature *(if under 18, parent/legal guardian signature)* **Date**