HealthActions PHYSICAL THERAPY

Patient Information / Subjective Information

Patient Name: _____
Mailing Address: _____
_____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
SSN: _____ Sex: _____
Date of Birth: _____ Age: _____
Email : _____

Spouse/Parent Name: _____
Mailing Address: _____
_____
City/State/Zip: _____
Home Phone: _____
SSN: _____ Sex: _____
Date of Birth: _____ Age: _____
Spouse's Employer: _____
Job Title: _____ Job Phone: _____

Patient's Employer: _____
Job Title: _____ Job Phone: _____
Is your condition accident related?
Auto ☐ Work ☐ Other ☐
How did the accident happen? _____
_____
Date of Accident: _____ Date problem started: _____
# of work days missed: _____
Date of last Doctor's appointment: _____
Date of next Doctor's appointment: _____

In case of emergency call: _____
Emergency phone number: _____

***** FOR WORKER'S COMP PATIENTS ONLY *****
Worker's Comp Carrier: _____
Address: _____
City/State/Zip: _____
Adjuster: _____
Adjuster's phone: _____
Claim # : _____
Referring Physician: _____
Case Manager:

Primary Insurance Company: _____ **Secondary:** _____

What do you want to achieve with therapy? (your goal) _____
What type of problem has brought you to therapy? _____
When did the problem begin? (date) _____
Have you ever had this problem before? ☐ Yes ☐ No If yes, when? _____
What type of treatment did you receive? _____
Have you received Physical Therapy this year? _____ If Yes, # of visits_____ Location: _____
Have you received Home Health this year? _____ If Yes, # of visits_____ Location: _____
List the Physicians you have seen for this for problem: _____
Have you had any injections for your injury/condition? Yes☐ No☐ When? _____ Did it help? Yes☐ No☐
Have you had any surgery? Yes☐ No☐ Explain: _____
Have you had any hospital stays related to this problem? ☐ Yes ☐ No Explain: _____
Are you ☐ employed ☐ Unemployed ☐ Retired ☐ Disabled?
If disabled, as of when? _____ Have you received a settlement? Yes ☐ No ☐
Has your doctor diagnosed you with Stage One or Stage Two Diabetes? ☐ Yes No ☐

Date: _____ **Patient's Signature:** _____

For Patients returning to Healthactions: I have reviewed all of the above information and made any appropriate changes
Date: _____ Patient's Signature: _____

HealthActions
PHYSICAL THERAPY

Consent to Treat and Privacy Notification and Acknowledgement

Patient: _____ Date: _____ DOB: _____
PLEASE PRINT

Consent to Treatment

Consent is hereby given for patient to receive treatment from HealthActions Physical Therapy and Wellness. I understand that risk may be associated with certain procedures, including but not limited to the risks associated with the use of the pool during aquatic therapy.

_____
Initial

I certify that the billing information I have provided is correct. I authorize my insurance carrier to pay all benefits I may be due directly to HealthActions Physical Therapy and Wellness. Authorization is hereby given to release any information that may be necessary to process my insurance claims.

_____
Initial

Rights and Responsibilities

I have received a copy of my patient rights and responsibilities. _____
Initial

Release of Medical Information

I authorize the following persons to have access to my medical information and treatment.

Spouse: _____
Family: _____
Other: _____

Privacy Notice

I have received the privacy notice for HealthActions _____
Initial

I agree that during the course of treatment my case may be discussed during weekly professional staff meetings for quality of care purposes. I agree to notifications and appointment reminders at my home address and phone number or this alternate phone number: _____ _____
Initial

I have read, initialed, and understand the content of this form.

_____ _____ _____ _____
Patient Signature Date Witness Date

To be completed by HealthActions Physical Therapy and Wellness employee only if acknowledgement is refused.

After a good faith attempt to obtain this Acknowledgement, the patient or his/her representative refused or was unable to acknowledge receipt of our Privacy Notice for the following reason(s):

_____

_____

_____ _____
Signature of Employee Date

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PHYSICAL THERAPY

24hr Cancellation/No show policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24hrs notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.

- There is a $20 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patients documentation of any missed appointments will be forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: A) you're feeling worse and think the treatment is not working or, B) you're feeling better and it's a great day for hunting or fishing. Neither of these conditions is legitimate as a reason not to come: A) if you're in pain, come in and get it fixed. B) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient, who could have been scheduled for treatment if you had given proper notice.

Please note: Multiple cancellations (more than 3) may prevent us from being able to schedule you and may result in the need to treat you on a work-in basis.

Please cooperate with us in this regard. We're looking forward to working with you.

_____ _____

Patient Signature Date

_____ _____

HealthActions Employee Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

I hereby authorize and request:

_____(Releasor)
Name of Facility/Hospital

_____
Address

_____

To release to: **Health*Actions* Physical Therapy and Wellness** (Releasee)

(circle your location)

JACKSON P: 251-246-5761 F: 251-246-3779	DOTHAN-EAST P: 334-500-1150 F: 334-828-7125	THOMASVILLE P: 334-636-1461 F: 334-636-1463	MONROEVILLE P: 251-575-1933 F: 251-575-2807	TROY P: 334-670-5435 F: 334-670-5234
DOTHAN-FLOWERS P: 334-758-8288 F: 334-758-6988	DOTHAN-RCC P: 334-305-0222 F: 334-305-0223	DAPHNE P: 251-410-0620 F: 251-410-0621	ATMORE P: 251-491-0200 F: 251-491-0201	ENTERPRISE P: 334-828-7591 F: 334-828-7298

A copy of the medical records on the above named patient pertaining to:

_____Outpatient care, date _____

_____ Hospitalization, date(s) _____

I acknowledge that data to be released may include material that is protected by Federal Law such as mental, drug and/or alcohol, HIV information. My signature below authorizes release to same. I understand this authorization is valid for 90 days and may be revoked by me at any time.

_____ _____
Signature (Patient) Date

_____ _____
Witness Date

Releasor, its agents and employees are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

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Date:

Name: _____DOB:_____Age:_____ Height/Weight:_____

Please fill in the blanks and check any box that applies to you.

Coronary Artery Disease Risk Factors:

- ☐ Male > 45 yrs of age
- ☐ Female > 55 yrs of age
- ☐ Diabetes Mellitus
- ☐ Obesity
- ☐ Sedentary lifestyle & job
- ☐ Smoking
- ☐ High Blood Pressure (>140/90 or on meds)
- ☐ High cholesterol (>200mg/dl)
- ☐ Family Hx of Coronary Artery Disease (father/brother had a heart attack by age 55, mother/sister had a heart attack by age 65)

Major Signs/Symptoms:

- ☐ Pain/discomfort in chest, neck, jaw or arms
- ☐ Shortness of breath at rest or mild exertion
- ☐ Dizziness, light-headed, or fainting
- ☐ Known heart murmur
- ☐ Ankle swelling
- ☐ Rapid or skipped heart beat
- ☐ UNUSUAL fatigue w/ USUAL activities
- ☐ Orthopnea/Nocturnal Dyspnea (difficulty breathing at night or when lying down)
- ☐ Orthopedic limitations (foot, back, neck, knee, hip, hand, wrist, shoulder problems, broken bones, limited range of motion in joints, arthritis,bursitis)
- ☐ Intermittent Claudication (pain in calf with walking/activity)

Cardiopulmonary/Metabolic Disease:

- ☐ Heart Attack
- ☐ Diabetes Mellitus
- ☐ Hospitalized within past 6 mos? _____
- ☐ Angioplasty
- ☐ Stable Angina
- ☐ Coronary Artery Bypass Grafting
- ☐ Congestive Heart Failure
- ☐ COPD (Lung Disease)
- ☐ Peripheral vascular disease
- ☐ Pacemaker

Other: Please check if currently or previously diagnosed with the following.

- ☐ Phlebitis or emboli _____
- ☐ Rheumatic fever _____
- ☐ Fibromyalgia _____
- ☐ Low Blood Pressure _____
- ☐ Trouble Sleeping _____
- ☐ Migraine/Recurrent Headaches _____
- ☐ Epilepsy or Seizures _____
- ☐ Anemia _____
- ☐ Cancer _____
- ☐ Hernia _____
- ☐ Tuberculosis _____
- ☐ Allergies _____
- ☐ Asthma _____
- ☐ Emphysema _____
- ☐ Bronchitis _____
- ☐ Pneumonia _____
- ☐ ↑ anxiety or depression _____
- ☐ Emotional disorders _____
- ☐ Ulcers _____
- ☐ Stomach or intestinal problems _____
- ☐ Hepatitis _____
- ☐ Eating Disorder _____
- ☐ Osteoporosis: _____
- ☐ Other: _____

MEDICATIONS WITH DOSAGE

(include all Prescriptions/vitamins/herbs/over-the counter)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you had any surgery? ☐ Yes ☐ No

What type of surgery did you have?_____

_____

Have you had any hospital stays? ☐ Yes ☐ No

When?_____

Signature:_____ **Date**

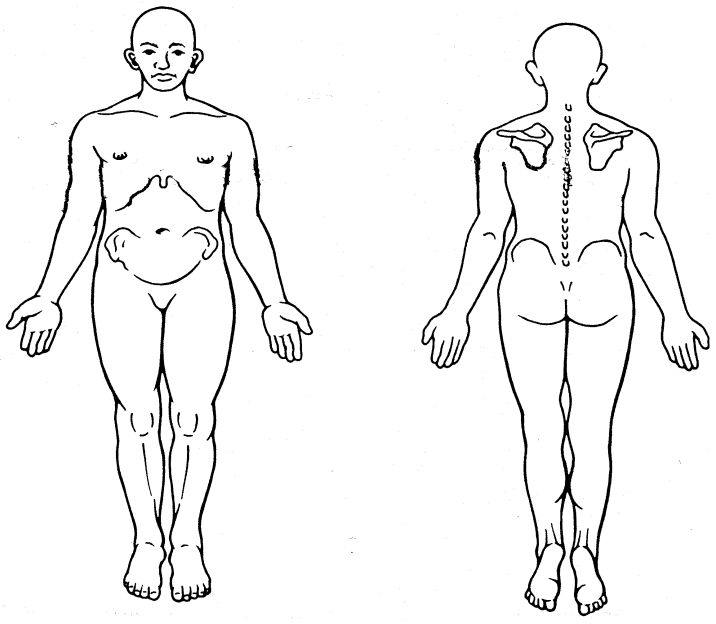
Signature of Parent/Guardian:_____ **(if under 19)** **Date**

Witness: _____ **Date**

PAIN INFORMATION

Name:_____

Please mark the areas where you have pain, numbness, or tingling. *P = Pain N = Numbness T = Tingling*



Pain level today. Select #:

1 2 3 4 5 6 7 8 9 10

(least pain ----------greatest pain)

What makes your pain less?

_____

What makes your pain worse?

_____

Is pain ☐ better or ☐ worse in the morning?

Is pain ☐ better or ☐ worse in the afternoon?

WHO is your employer? _____

WHAT is your job title/responsibility?_____

ARE you currently working? ☐ **Yes** ☐ **No** **If yes, how much?** ☐ **Full Duty** ☐ **Restricted Duty**

Hours for typical work week? _____ **How many TOTAL work days have you missed?** _____

What work duties/tasks have been stopped/limited by your injury/condition? _____

How did you hear about us? (Please Select one)

- ◯ **1. Doctor Referral**
- ◯ **2. Website**
- ◯ **3. Online Search**
- ◯ **4. Radio**
- ◯ **5. TV**
- ◯ **6. Social Media (Facebook Twitter)**
- ◯ **7. Newspaper**
- ◯ **8. Mailer**
- ◯ **9. Free Screen Card**
- ◯ **10. Community Event**
- ◯ **11. Family/Friend**

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Telemedicine Services Consent Form

Patient: _____

Informed Consent for Telemedicine Services

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

- I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider. My provider may record the visit if deemed necessary.

- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.

- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without effecting my right to future care or treatment.

- I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Patient Signature: _____

Printed Name: _____

Signature Date: _____