Circuit PHYSICAL THERAPY

2210 Robb Street, Trinity TX 75862
Tel / Fax: 936.594.9224 | Cell: 318.243.9196 / 318.243.9319
email: team.circuitpt@gmail.com | www.gocircuitpt.com

PATIENT INTAKE QUESTIONNAIRE FOR REHABILITATION CLINIC

Name: _____
(First) *(Last)*

Email:_____ Phone Number:_____

Address:_____

Why are you seeking therapy? _____

_____

_____

Describe your injury. How and When it started? _____

_____

_____

Are you currently working? ☐ Yes ☐ No

Employment: ☐ Full Time ☐ Part Time ☐ Student ☐ Retire ☐ Disabled ☐ Other _____

Occupation: _____ Employer: _____ Length of Employment: _____

HOME STATUS / FUNCTIONAL LEVEL:

Live with ☐ Alone ☐ Spouse / Partner ☐ Family _____ ☐ Friends ☐ Other _____

Home ☐ 1-story with/without basement ☐ 2-story home with/without basement

☐ Apartment with/without elevator ☐ Mobile home ☐ Other _____

Maximum number of stairs to walk at any one time in home ____ Are there any handrails? ☐ Yes ☐ No

HEALTH HISTORY

Currently receiving any Home Health or Hospice services: ☐ Yes ☐ No

Previous therapy for this injury or ailment: ☐ Yes ☐ No If yes, how many visits? _____ When? _____

Number of falls in the last month: _____ In the last year? _____

Do you? Smoke ☐ Yes ☐ No if yes, how much _____

Drink Alcohol ☐ Yes ☐ No if yes, how much _____

Check each condi Caffeine ☐ Yes ☐ No if yes, how much _____

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☐ Pacemaker/Defibrillator ☐ Heart Disease/Attack ☐ Skin Disease ☐ Circulation Problems
☐ Osteoporosis/Osteopenia ☐ Stomach Disorders ☐ HIV (+) ☐ Blood Clots
☐ Arthritis (OA, RA) ☐ Liver Disorder ☐ Mental Health Issues ☐ Metal Implants _____
☐ Bleeding tendencies ☐ Kidney Disease ☐ Lung Disease/Asthma ☐ Stroke
☐ Cancer (_____) ☐ Bowel/Bladder Issue ☐ Seizure Disorder ☐ Pregnant (#of Mos) _____
☐ High Blood Pressure ☐ Thyroid Disease ☐ Unexplained weight ☐ Neurological Disorder
☐ Diabetes (Type _____) ☐ Allergies _____ ☐ Unexpected weight gain/loss
☐ Frequent Nausea / Vomiting ☐ Tape / Latex Allergy ☐ Other: _____

ADAPTIVE / ASSISTIVE EQUIPMENT OWNED

None Crutches Wheeled walker Transfer tub bench Bedside Commode Hospital Bed
Cane Walker Wheelchair Grab bars Lift Chair Other _____

List any surgeries that may be associated with your condition (include date):

_____

_____

List all current medications including over the counter types (If you have a list, we will photocopy it)

_____

_____

How frequently are you using pain medications for this condition?

Every 3-4hours Daily Weekly Intermittently / As needed Do Not Use

What are you using for pain? _____

Area/s of Pain

Rate your pain on a scale of 0-10 (0=No Pain, 10=Worst Pain)
Current _____ At Best _____ At Worst _____

_____
_____
_____
_____

Are your symptoms getting? ☐ Better ☐ Worse
Are your symptoms generally? (Check box and circle word)
☐ Better / Worse in the morning ☐ Better / Worse in the afternoon
☐ Better/Worse While Sleeping ☐ Better then worsens as the day goes on

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Area/s of Numbness/Tingling

_____

_____

_____

_____

Pain Behavior:

☐ Constant ☐ Intermittent ☐ Dull
☐ Burning ☐ Stabbing ☐ Throbbing
☐ Aching ☐ Sharp
☐ Radiating _____

Have you had any of the following for this condition? If yes, state results

None CT scan _____ EMG _____
X-ray _____ Bone scan _____ Diagnostic / Arthroscopy _____
MRI _____ Arthrogram _____ Doppler/Ultrasound _____

Previous treatment(s) for this condition: Check all that apply. (Circle helpful treatments)

☐ None ☐ Massage Therapy ☐ TENS Unit ☐ Bracing
☐ Medication: ☐ Exercise ☐ Traction ☐ Pain Clinic
☐ PT/OT ☐ Injections ☐ Surgery ☐ Other _____
☐ Chiropractic ☐ Acupuncture ☐ Splinting / Taping

Functional Limitations: Place a check to each activity that causes you pain or difficulty.

☐ Sitting ☐ Laying on back / side / stomach ☐ Putting on socks / shoes ☐ Reaching to floor
☐ Standing ☐ Bathing Tasks ☐ Going Up / Down stairs ☐ Lifting to waist level
☐ Walking ☐ Grooming Tasks ☐ Open / Close Doors ☐ Reaching Overhead
☐ Sleeping ☐ Dressing Tasks ☐ Carrying items while walking _____

What are your goals for therapy? _____

_____

_____

_____

PLEASE RETURN TO THE FRONT DESK WHEN COMPLETED. THANK YOU

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CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist and treatment by a licensed physical therapist assistant by or under contract with Circuit Physical Therapy.

The physical therapist has fully explained to me the nature and purpose of the procedures, evaluation, and course of treatment, and has witnessed my signature of this consent in his/her presence. The physical therapist has informed me of the expected benefits and possible complications and discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

The physical therapist has explained that in some cases, physical therapy treatment may not improve my condition and although unlikely, it can cause additional pain or aggravation of my condition, intervention, prognosis, expectations, and plan of care was able to answer my questions to my satisfaction.

I attest that I have fully read and understood the consent form.

Patient / Guardian Signature _____ / _____
Signature Print Name

_____ _____
Date Relationship, if signed by person other that client

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PATIENT EMERGENCY CONTACT SHEET

Name: _____
First *Last*

Relationship: _____

Address: _____
Apt / Street

_____
City *State* *Zip code*

Cell Phone: _____

Name: _____
First *Last*

Relationship: _____

Address: _____
Apt / Street

_____
City *State* *Zip code*

Cell Phone: _____

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PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL FINANCIAL RESPONSIBILIT

- I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the cost of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to CIRCUIT PHYSICAL THERAPY on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE REORDS

I hereby authorize CIRCUIT PHYSICAL THERAPY to release my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services, as well as information required for precertification, authorization, or referral to other medical provider.

4. INSURANCE REQUEST FOR PAYMENT

I request payment of authorized insurance benefits to me or on my behalf for any services furnished to me by CIRCUIT PHYSICAL THERAPY. I authorized any holder of medical or other information about me to release to insurance and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Authorized Representative or Responsible Party	Date
Print Name of Patient, Authorized Representative or Responsible Party	Date

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DICLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FORM CAREFULLY.

OUR LEGAL DUTY

CIRCUIT PHYSICAL THERPAY (CPT), is required by law to protect the privacy of your personal health and information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION

CIRCUIT PHYSICAL THERPAY, uses your personal and health information for treatment obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, CPT will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosure at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. Our HIPAA Compliance Officer is Catherine Mallari. She can be reached at the office by calling 936-594-9224.

PATIENT INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency.

CPT will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS

If you are concerned that CPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Catherine Mallari, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Circuit Physical Therapy
HIPAA Compliance Officer
Attention: Catherine Mallari
22210 S. Robb St, Trinity TX 75862
Tel / Fax: 936.594.9224 | Cell: 318.243.9196

_____
Initials

_____
Date

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CANCELLATION FEE

Circuit Physical Therapy is committed to providing you with the highest quality of care and in order to maintain that level of excellence we ask that you provide at least 24-hour notice of a cancellation.
We do realize that things come up like illness, transportation issues, hazardous driving conditions, or family emergencies that make it impossible to keep your scheduled appointment.

Cancellations without 24-hour notice will be accepted in these circumstances on a one-time basis only. Any additional instances will be subject to a $20.00 charge and must be paid at your next scheduled visit. Not showing for your appointment (no show) is unacceptable and a fee of $20.00 will be charged in every instance.

This fee will be expected to be paid at your next scheduled visit. This fee is not covered by your insurance and it will be your responsibility to pay no matter what type of coverage you have. If the fee is not paid, you will be billed and this balance is subject to collections. Please be considerate of other patients and our staff and call as soon as possible if you are unable to attend your scheduled physical therapy visit.

This Policy Will Be Enforced.

_____ _____

Initials Date