DATE:_____/______/______

NAME:____AGE:___________ GENDER: □ M / □ F

ADDRESS:______________________________________CITY/STATE:_______________________ZIP:___________

HOME PHONE:(_____)____________________ CELL PHONE:(_____)_________________________

EMAIL:____ DATE OF BIRTH:___/___/____ SSN:_________________________

MARITIAL STATUS:_____________ SPOUSE'S NAME:_______________________________ PHONE #:____________________

EMER. CONTACT:_______________________________ RELATIONSHIP:________________ PHONE#:____________________

EMPLOYER:____ □ FULL-TIME / □ PART-TIME

ADDRESS:___________________________________ CITY/STATE:________________________ ZIP:______________

OCCUPATION:_________________________________

STUDENT: □ YES / □ NO □ FULL-TIME / □ PART-TIME

REFERRING PHYSICIAN:____LAST DR'S VISIT:_________________

FAMILY PHYSICIAN:____________________________________

HAVE YOU HAD HOME HEALTH CARE: □ YES / □ NO IF YES, DATE OF DISCHARGE: ____/____/______

HOW DID YOU HEAR OF LYCOMING PHYSICAL THERAPY?

□ FRIEND □ PHYSICIAN □ YELLOW PAGES □ RADIO □ NEWSPAPER □ WEBSITE/FACEBOOK

PLEASE PRESENT ALL INSURANCE CARDS FOR PHOTOCOPY

MEDICAL INSURANCE:____

NAME OF POLICY HOLDER:_____________________________ DATE OF BIRTH:___/___/____

RELATIONSHIP TO PATIENT:______________

SECONDARY MEDICAL INSURANCE:____

NAME OF POLICY HOLDER:_____________________________DATE OF BIRTH:___/___/____

RELATIONSHIP TO PATIENT:_______________

WAS YOUR INJURY DUE TO AN ACCIDENT? □ YES / □ NO

IF YES: □ AUTO □ WORK RELATED □ LIABILITY □ OTHER DATE OF ACCIDENT:___/___/___

PLEASE DESCRIBE ACCIDENT:____

____

____

AUTO OR WORK INJURY CLAIM

PRESENT INSURANCE CARD FOR PHOTOCOPY

INSURANCE COMPANY:_______________________________________ CLAIM#:___________________________

CLAIM REP:_____________________________________ PHONE#:_________________________

IS THERE AN ATTORNEY INVOLVED: □ YES / □ NO

IF YES, NAME OF FIRM AND ATTORNEY'S NAME:____

ADDRESS:__________________________________CITY/STATE:_______________________ ______ZIP:__________

MEDICAL CONDITIONS (PLEASE CIRCLE ALL THAT APPLY)		
NEUROMUSCULAR	**CARDIOVASCULAR**	**GASTROINTESTINAL**
□ STROKE OR TIA	□ HYPERTENSION	□ REFLUX/GERD/HEARTBURN
□ PARKINSON'S DISEASE	□ HEART ATTACK	□ CHRON'S DISEASE
□ DEMENTIA/MEMORY LOSS	□ ARRHYTHMIA/PALPITATIONS	□ GI BLEEDING
□ NEUROPATHY	□ PERIPHERAL VASCULAR DISEASE	□ CONSTIPATION
□ MUSCLE DISEASE	□ CONGESTIVE HEART FAILURE	□ ULCERS
□ RESTLESS LEG SYNDROME	**ENDOCRINE**	**RHEUMATOLOGY**
□ MULTIPLE SCLEROSIS	□ THYROID DISEASE	□ RHEUMATOID ARTHRITIS
□ EPILEPSY	□ DIABETES	□ LUPUS
□ HEARING/VISUAL LOSS	□ KIDNEY DISEASE	□ SPINAL STENOSIS
□ FIBROMYALGIA	□ EXCESSIVE FATIGUE	□ OSTEOPOROSIS
□ SLURRED SPEECH	□ EXCESSIVE THIRST/HUNGER	**RESPIRATORY**
□ VERTIGO/DIZZINESS	**PSYCHIATRIC**	□ ASTHMA
CANCER	□ ANXIETY/DEPRESSION	□ EMPHYSEMA
LOCATION:___________________	□ BIPOLAR DISEASE	□ COPD
TREATMENT:____________________	□ SCHIZOPHRENIA	□ SHORTNESS OF BREATH
	□ PANIC ATTACKS	□ PERSISTANT COUGH

OTHER MEDICAL CONDITIONS:____

____

ALLERGIES:____

LIST ALL SURGIERIES AND DATES THEY OCCURRED

____ DATE:____/____/________

____ DATE:____/____/________

____ DATE:____/____/________

____ DATE:____/____/________

____ DATE:____/____/________

____ DATE:____/____/________

LIST CURRENT PRESCRIPTION MEDICATIONS AND DOSAGES YOU ARE TAKING OR PROVIDE A LIST FOR PHOTOCOPY

MED:____ DOSAGE:_______________________

MED:____ DOSAGE:_______________________

MED:____ DOSAGE:_______________________

MED:____ DOSAGE:_______________________

MED:____ DOSAGE:_______________________

HAVE YOU HAD ANY **FALLS** IN THE PAST YEAR: □ YES / □ NO HOW MANY:______ WITH INJURY:________

BRIEFLY DESCRIBE YOUR REASON FOR COMING TO PHYSICAL THERAPY:____

____

WHEN DID THIS CONDITION BEGIN: ____

HOW DID SYMPTOMS START:____

HAVE YOU HAD OTHER TREATMENT FOR THIS CONDITION: □ YES / □ NO

IF YES, PLEASE SPECIFY: _____SURGERY _____MEDICATIONS ____CHIROPRACTIC ____INJECTIONS ____OTHER

HAVE YOU HAD PHYSICAL THERAPY FOR ANY CONDITION IN THE LAST YEAR: □ YES / □ NO

IF YES, PLEASE PROVIDE DATES AND CAUSE FOR THERAPY:____

____

ARE YOU CURRENTLY INVOLVED IN A REGULAR EXERCISE PROGRAM OR SPORT: □ YES / □ NO

IF YES PLEASE DESCRIBE:____

DO YOU SMOKE: □ YES / □ NO _____PACK(S) PER DAY ARE YOU PREGNANT: □ YES / □ NO

DO YOU DRINK ALCOHOL: □ YES / □ NO _____DAYS PER WEEK

HEIGHT:_______' _______" WEIGHT:__________LBS

IN GENERAL, WOULD YOU SAY YOU ARE IN: □ GREAT / □ GOOD / □ FAIR / □ POOR (CIRCLE ONE) HEALTH?

TODAY I AM FEELING: □ GOOD / □ FAIR / □ POOR (CIRCLE ONE)?

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____ Birth Date:________________________

I authorize ____ to release information from my medical records to LYCOMING PHYSICAL THERAPY:

SPECIFIC INFORMATION TO RELEASE		
□ MRI/X-Ray	□ History/Clinical Notes	□ Discharge Summary
□ Operative Reports	□ Emergency Room Notes	□ Lab/Pathology Reports
□ Itemized Bills	□ Attendance History	
□ Other: All records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expenses		
□ Other (Specify):		
□ Other (Specify):		

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization A copy of this authorization shall have the same force and effect as the original. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practies for my ease of reference. I also understand that this consent will expire 12 months after the date of signature or automatically with the records request requested on this authorization has been released. I understand that the information released may be re-released by the recipient and may no longer be protected by the HIPAA (Federal regulations). I understand that providing authorization for the requested use of disclosure is not a condition of my treatment, payment, enrollment in a health plan or eligibility for benefit except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The above Authorization applies to the release of written documents and permits oral conversation(s) with the entity(ies) indicated above with regard to the release of information from my medical records.

AUTHORIZATION SIGNATURES:

Date: _______________________ Patient Signature:____

If patient is unable to sign authorization form because of physical condition of age, complete the following. Patient is a minor or patient is unable to sign authorization because: ____

____

Date: _________________ Signature: _______________________________ Relationship: ____________________________

NOTE: IF PATIENT IS UNDER 18 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR, THE PARENT OR GUARDIAN MUST SIGN.

******* COPY OF COMPLETED AUTHORIZATION PROVIDED TO PARENTS *******

6/04/2014

AGREEMENT TO PAY FOR SERVICES

The financial policies of Lycoming Physical Therapy, Ltd. Are as follows:

1) We will offer the most effective physical therapy treatment for our patients; in accordance with APTA Code of Ethics, these services are reimbursable.

2) It is the patient's responsibility to be aware of and knowledgeable of their insurance coverage.

3) Any concerns that the patient may have regarding payment for physical therapy service rendered in our facility should be discussed and settled with the patient prior to discharge.

4) Should the patient be a legal minor, the patient's parent/guardian shall be held responsible for the payment of said physical therapy services – any financial matters will be discussed with the parent/guardian as noted above.

5) Payment for physical therapy services rendered in our facility is payable upon receipt of patient statement.

6) Payment schedules may be established at the discretion of Lycoming Physical Therapy, Ltd. And agreed to be by the responsible party.

In consideration of the above policies and procedures, I acknowledge and agree to the above terms and conditions. I hereby agree to consent to treatment and agree that I am responsible for payment of such services, regardless of insurance coverage. I assign all payments and/or medical benefits for physical therapy services including Medicare, Major Medical, Workers' Compensation, Private Insurance and/or other health insurance coverage to Lycoming Physical Therapy, Ltd. Further, I authorize Lycoming Physical Therapy, Ltd. To release and/or provide all pertinent and necessary information and records as may be required to secure payment and/or notify physician(s), attorneys and insurers of my status.

____ ____

Patient Signature Date Patient/Guardian Date