Point Forward Physical Therapy

2901 Hoover Rd., Stevens Point, WI 54481 Phone: (715) 254-3978 Fax: (715) 254-3936

Patient Name: _____ Sex: M F

Date of First Visit: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Marital Status: S M W D

Work Phone #:_____ Employer: _____

Cell Phone #: _____ SSN #: _____

Would you like text message reminders for your appointments? yes no

Email address: _____

Would you like email reminders for your appointments? yes no

Would you like quarterly updates from Point Forward? yes no

How did you hear about our office?

Returning Patient Doctor's office Facebook Friend/Family

Advertisement Google Word of mouth

CONSENT TO TREATMENT:

I consent to and authorize the customary rehabilitative services, evaluation and treatment as provided by Point Forward Physical Therapy Ltd. members, assistants, or designees determined necessary and appropriate. I recognize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations administered at and by Point Forward Physical Therapy Ltd. I understand that I may be discharged from treatment by Point Forward Physical Therapy Ltd. before all of my medical problems are known or treated, and that it is my responsibility to make arrangements, if necessary, for follow-up care.

FINANCIAL AGREEMENT:

I hereby certify that the information provided by me in applying for payment under Medicare, Medicaid, or any other insurance is correct. I hereby authorize direct payment to Point Forward Physical Therapy Ltd. of authorized benefits for this treatment. I hereby assign benefits payable for services to Point Forward Physical Therapy Ltd. and authorize Point Forward Physical Therapy Ltd. to submit a claim to Medicare, Medicaid or my insurance. I understand that Point Forward Physical Therapy Ltd. cannot determine in advance the total charges and/or cost for my treatment. The clinic's charges for my treatment shall be in accordance with the clinics current usual and customary charges for each specific service, test, or supply the clinic or my therapist considers necessary for my treatment. I understand the charges have been determined based on Point Forward Physical Therapy Ltd. cost of the entire operation and not on the individual cost of any item. I further understand that any determination by Medicare, Medicaid, or other insurance as to what charges will be covered by them or their reason for their determination shall not affect my responsibility to Point Forward Physical Therapy Ltd. and that I am financially responsible to the clinic for any charges not covered by Medicare, Medicaid, or my insurance. If any excess funds remain after payment in full of the charges for services rendered for this clinical visit, the undersigned hereby authorizes the clinic to apply such funds towards any other outstanding account(s) which the patient may have had with Point Forward Physical Therapy Ltd. for any prior services rendered and for which the undersigned is responsible. If my account with Point Forward Physical Therapy Ltd. is referred to an attorney for enforcement of my obligation to pay, I agree to pay Point Forward Physical Therapy Ltd. reasonable attorneys fees and collection expense that may incur until the obligation is paid in full. I also understand that a specific time has been set aside for my appointment at Point Forward Physical Therapy Ltd. By failing to show up for my scheduled appointment, I understand that I am hurting my own recovery, as well as the recovery of other patients who may have benefited from my appointment time. If I fail to cancel an appointment within 24 hours of its scheduled time or if I fail to show up for an appointment, I understand that my account may be charged a fee. I also understand that this fee will be charged directly to my account, and will not be sent to my insurance company for reimbursement. The application of this fee is to be determined at the sole discretion of Point Forward Physical Therapy Ltd. Returned checks for insufficient funds will also be subject to a minimum $50 fee.

CONSENT FOR RELEASE OF INFORMATION:

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing our consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting Point Forward Physical Therapy Ltd. at 2901 Hoover Road, Stevens Point, WI 54481 or by phone at (715) 254-3978.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to the use and disclosure of protected health information about you for treatment, payment, or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

You (or another person holding a written statement of informed consent signed by you) may review and copy your medical records (including x-ray reports), upon payment of reasonable cost, at any time during regular business hours, upon reasonable notice.

DATE RECEIVED copy of the "Notice of Privacy Practices" _____

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ THIS ENTIRE AGREEMENT, UNDERSTANDS ITS CONTENTS AND SIGNIFICANCE, ACCEPTS RESPONSIBILITY FOR PAYMENT, AND IS COMPETENT TO EXECUTE IT, OR AUTHORIZED TO EXECUTE IT, OR AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Patient Signature:_____Witness_____

Date: _____

If the patient is a minor or unable to consent, complete and sign the following:

Patient is unable to sign because _____

Signature_____ Relationship to patient_____

Witness_____

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Due to the inconsistency of benefit verification and therefore insurance payment for services rendered for your rehabilitation, any expenses incurred that are not covered by your insurance company will be your responsibility. You will be notified via letter if your insurance company fails to make payment. Upon reception of the letter, the payment for your balance is due in full and is your responsibility.

_____

Patient signature

___/___/_____

Date

Point Forward Physical Therapy

GENERAL HEALTH QUESTIONNAIRE

To ensure you receive a complete and thorough evaluation, please provide us with the following health history information. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name:_____ DOB: _____ Date: _____

Allergies (include medications) _____

Have you declared the Advance Healthcare Directive of DO NOT RESUSCITATE? YES NO

Are you latex sensitive? YES NO

GENERAL INFORMATION

- What is your occupation?_____
- Work restrictions (if any):_____

MEDICAL/HEALTHCARE

- Family Doctor _____
- Height _____
- Weight _____

SOCIAL/HEALTH HABITS

Do you currently smoke tobacco? YES NO

PAST MEDICAL HISTORY

- Have you ever been diagnosed with any of the following conditions?

  Please circle all that apply.

Osteoarthritis	Rheumatoid Arthritis	Broken bones/fractures_____
Osteoporosis	Heart Problems	High Blood Pressure (onset date)
Circulation disorder	Blood Disorder	Anemia
Stroke	Fibromyalgia	Diabetes Type I (Onset Date)
Parkinson's Disease	Thyroid Problems	Diabetes Type II (Onset Date)
Muscular Dystrophy	Kidney Disease	Cancer (type/status)
Multiple Sclerosis	Seizures/Epilepsy	Skin Diseases_____
Ulcers	Stomach Problems	Blood Clots
Infectious Diseases (HIV, Tuberculosis, Hepatitis)		Asthma
Scoliosis	Ehlers-Danlos	Depression
Anxiety		

Other _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things:	0	1	2	3
Feeling down, depressed or hopeless:	0	1	2	3

Have you recently noticed any of the following: (Please circle all that apply)

Chest pain	Dizziness or blackouts	Weight loss/Gain
Numbness/Tingling	Joint pain/swelling	Shortness of breath
Nausea/vomiting	Fever/Chills/Sweats	Bowel/Bladder changes
Weakness		

Have you had any falls in the last 6 months? YES NO

- If yes, how many? _____

Please list any SURGERIES, HOSPITALIZATIONS OR SIGNIFICANT INJURIES:

1._____ Date_____

2._____ Date_____

3._____ Date_____

4._____ Date_____

MEDICATIONS

Please list any prescription medication you are currently taking (including pills, injections, and/or skin patches): _____

Please list any nonprescription medications you take on a regular basis (aspirin, vitamins, herbal supplements, etc.): _____

CURRENT CONDITION/CHIEF COMPLAINT

A. Describe the current problem(s) for which you are seeking physical therapy:

_____

B. When did the pain/problem(s) begin? _____

C. What caused the pain/problem?_____

D. Have you had any testing for THIS problem? (please circle) x-ray MRI CT EMG other

- Please describe the results: _____

E. Have you had any treatment for THIS problem? YES NO

- If so, what kind? _____

F. Has your pain/problem changed your level of functioning or everyday activities? YES NO

- If yes, how are you limited? _____

G. What makes your pain/problem worse? _____

H. What relieves your pain?_____

I. What are you limited from now that you want to return to?

_____

_____

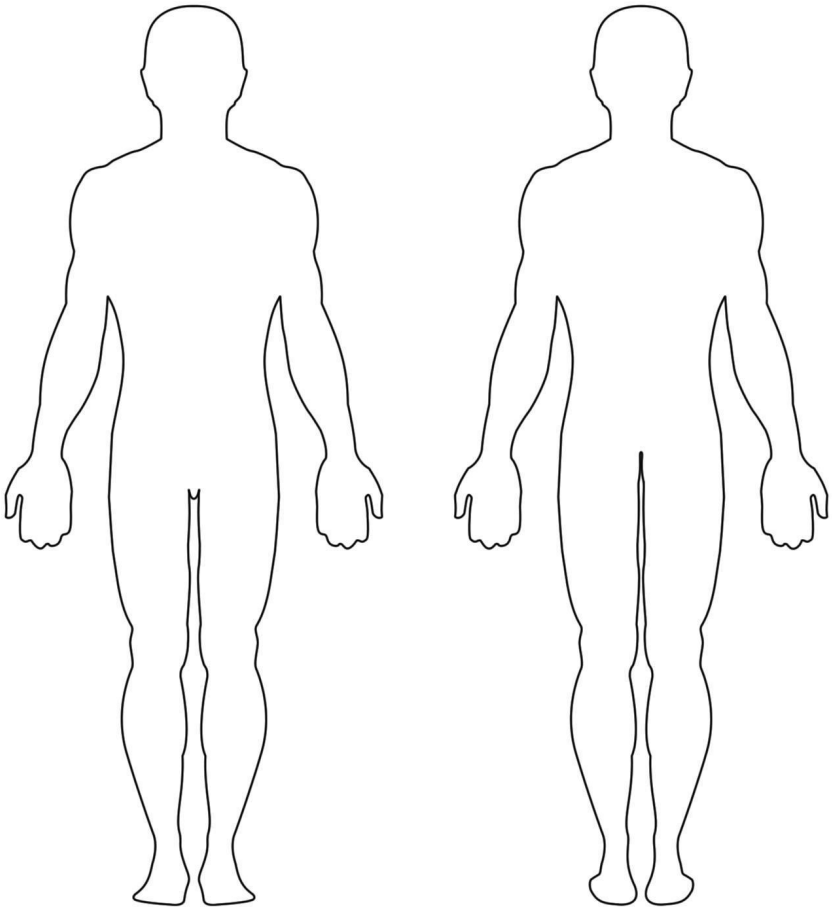
_____

Please circle your **pain level** on the scale below.

Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

Is there an attorney involved with your injury? YES NO

On the diagram below, please indicate the painful/problem area(s).



Front Back

_____ _____

Signature Date