



Eufaula Physical Therapy

+ Wellness

Ph: 334-687-4007 | Fax: 334-687-7050

General Information

Welcome and Thank you for choosing **Eufaula Physical Therapy + Wellness**. It is our goal to provide you with a high quality rehabilitation treatment plan individualized to meet your specific needs. So that we have a mutual understanding concerning your treatment, we ask that you review the following information prior to starting your program.

Appointments: Typically, appointments will be scheduled with your therapist 1 to 3 times per week. We ask that you make every effort to keep appointments and to arrive by your scheduled time. **Paperwork must be completed by your appointment time or we will need to reschedule.** If you arrive more than fifteen minutes late for an appointment, we cannot guarantee that you will be seen that day. Please help us to serve you (and all of our patients) better by keeping scheduled appointments.

Workers' Compensation Patients: In consideration of other patients, we need to firmly adhere to our 24-hour cancellation policy. If you miss or cancel any appointments, we will notify your referring physician, WC insurance company and nurse case manager in writing of missed appointments. If you miss and/or cancel at least 3 appointments at our discretion, we may put your physical therapy treatment on HOLD until you follow up with your referring physician and obtain a new written physical therapy treatment order to resume with your treatment.

Clothing: Please wear loose and comfortable clothing for each session, we have changing rooms and lockers for your convenience.

Fees: \$25 nonsufficient funds return check fee.

Payment: You are responsible for all payments of service rendered by **Eufaula Physical Therapy + Wellness LLC**, whether your insurance company pays or not. Although we will do our utmost to assist in gathering information regarding claims payment, it is your responsibility to know your benefit and coverage limits as well as which services require authorization. Please note your insurance contract is between you and the insurance company. Our relationship is with you and not your insurance company. **Payment is due at the time of service for copays, deductibles, services deemed non-covered by your insurer and any other items addressed herein.** Budget payments are available on an individual consideration basis. We accept cash, check, all major credit cards, and money orders. If your account becomes delinquent, collection proceedings will occur and you will be 100% liable for any collection fees, attorneys and court cases incurred by Eufaula Physical Therapy to collect said fees from the Responsible Party.

Rules for Plans of Nonparticipation: We will provide the service of submitting claims to your insurer if we are nonparticipating; however, if payment is not received within 90 days from the date of service, the bill then becomes your financial responsibility. You are responsible for our entire charge less any payment from your insurer. If we do not participate with your secondary (or any non-primary) insurer, you are responsible for that portion of your bill at the time of service. If at any time you have any questions about your treatment program, please bring your concerns to the attention of your therapist. Also, our office staff is available to answer any questions regarding insurance, scheduling and to assist you in any way that will make your participation in your program here more convenient and worthwhile.

Cell Phone Policy: Cell phone usage is **strictly prohibited** in the gym area during your treatment time due to HIPPA regulations.

Patient or Guardian Signature: _____

Date: _____

EUFAULA PHYSICAL THERAPY + WELLNESS
PATIENT HEALTH QUESTIONNAIRE
****All Questions Must Be Answered****

Patient Name _____ **Date** _____

When did your symptoms start? ___ / ___ / ___

Describe your symptoms _____

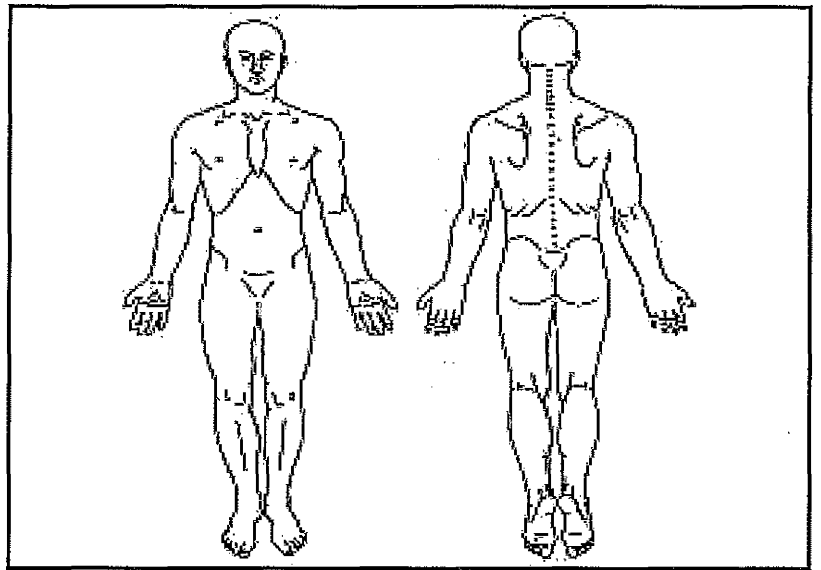
What is your goal for therapy? _____

How often do you experience your symptoms?

- Constantly (76%-100% of the day)
- Frequently (51%-75% of the day)
- Occasionally (26%-50% of the day)
- Intermittently (0%-25% of the day)

Indicate where you have pain or other symptoms:

(MARK PICTURE WHERE YOU HAVE PAIN)



What describes the nature of your symptoms?

(Check all that apply)

- Sharp Shooting
- Dull Ache Burning
- Numb Tingling

How are your symptoms changing?

(Check one below)

- Getting better
- Not changing
- Getting worse

Your symptoms are worse in the:

- Morning Increased during the day
- Afternoon Night Same all day

What movement causes the pain to increase? _____

During the past 4 weeks: (Circle to indicate)

Indicate the intensity of pain at rest: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Indicate the intensity of pain with movement: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How much has it interfered with your normal work (including home and housework)? (Check one below)

- None of the time A little bit Moderately Quite a bit Extremely

What makes your problem better?

(Check all that apply)

- Nothing Standing Movement/Exercise
- Lying Down Sitting Inactivity

What makes your problem worse?

(Check all that apply)

- Nothing Standing Movement/Exercise
- Lying Down Sitting Inactivity

HEALTH QUESTIONNAIRE -2-

Patient Name _____

Date _____

During the past 4 weeks how much of the time has your condition interfered with your social activities? (Example: visiting with friends, relatives, etc.) (Check one below)

- All the time Most of the time Some of the time A little of the time None of the time

In general, would you say your overall health right now is... (Check one below) Excellent Very Good

- Good Fair Poor

Who have you seen for your symptoms? (Check one below)

- No One Chiropractor Medical Doctor Physical Therapist Other _____

What treatment did you receive and when? _____

What tests have you had for your symptoms and when were they performed? (Check one below)

- X-rays date: _____ CT Scan date: _____ MRI: _____

Did you have surgery? Yes No

Date of Surgery if applicable: ____/____/____

Work Status: Full Time Part Time Self Employed Unemployed Not Currently Working

Please check below if any of the following conditions apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Heat/Ice sensitivity |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Tobacco Use packs/day _____ | |
| <input type="checkbox"/> Systemic Lupus | <input type="checkbox"/> Drug or Alcohol Dependence | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Dizziness/Balance Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Metal Implants | |

Hospitalization/Surgical Procedures (list if not described elsewhere): _____

Medications (Dosage): _____

****ATTACH LIST IF NEEDED****

Patient Signature _____ **Date** _____

Parent or Legal Guardian's Signature (if under 18 years of age) _____

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Acknowledgement of Privacy Policy

IN SIGNING THIS POLICY...

You assign your insurance benefits directly to **Eufaula Physical Therapy + Wellness LLC**, you authorize Eufaula Physical Therapy to release any medical information necessary for clinical or claims payment purposes, you certify all information given is correct to the best of your knowledge, you agree to release all treatment records upon request. Your signature on this document serves as a "signature on file" for all claims submitted to your insurance company for services rendered.

Circle one

Yes No The practice has my permission to call my home number to confirm appointments and may leave a message on my answering machine or with the person answering the phone.

Yes No The practice may contact me at work to reschedule appointments or confirm existing appointments.

Notice of Privacy Practices and Patient Acknowledgment Form

Eufaula Physical Therapy + Wellness LLC is required by a federal law known as "The Health Insurance Portability and Accountability Act" (**FHP AA**) to maintain the privacy of your medical and health information; also referred to as "Protected Health Information" (PHI).

Our notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the notice (or any other Notice in effect at the time of the use of the disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree with this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your signature below constitutes your acknowledgement that you have received a copy of our Notice of Privacy Rights and Practices, and your consent under federal and state laws to the kinds of uses and disclosures of Protected Health Information mentioned in our Notice.

Authorization for Patient Release of Information

I the undersigned, hereby authorize **Eufaula Physical Therapy + Wellness, LLC** and my attending physician to release my Protected Health Information (PHI). I have received and reviewed a copy of the Eufaula Physical Therapy's Notice of Privacy Rights and Practices and I understand that **Eufaula Physical Therapy + Wellness LLC**

- will only disclose the minimum information necessary for my treatment and payment of my services according to the Health Insurance Portability and Accountability Act (HIPPA/US. Department of Justice 5 U.S. C 552a (b) regulating protected health information (PHI).

Continued....



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Authorization for Patient Release of Information

I understand that I have the right to limit the kind of information released. I further understand that I have the right to revoke this consent at any time by written request to my provider.

"The Undersigned" hereby acknowledges that he/she has reviewed all the terms and conditions on both pages of this form and agree to the same.

Patient Signature

Date

Legal Guardian or Authorized Representative Signature Date

****If under the age of 18, parent or legal guardian must sign****



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***In order for our staff to determine whether medical services should be covered by Medicare or another insurance, federal law requires the following questions be asked. Thank you for your cooperation.*

Medicare Secondary Payer Questionnaire

Name of Patient: _____

Date: _____

Is the patient 65 years or age or older?

Yes ___

No ___

Is the patient retired?

Yes ___

No ___

If yes, what is your retirement date? _____

If no, is the patient actively employed?

by an employer of 20 or more employees?

Yes ___

No ___

Name of employer _____

Address of employer _____

Is the patient's spouse retired?

If yes, what is the retirement date? _____

If no, is the patient's spouse actively employed by

An employer of 20 or more employees?

Yes ___

No ___

If yes, name of employer. _____

Full legal name of spouse. _____

Name of spouse's insurance company. _____

Spouse's Policy Number _____

Is the patient less than 65 years of age and entitled to Medicare benefits based on disability?

Yes ___

No ___

If yes, is the patient or patient's spouse employed by an employer of 100 or more employees?

Yes ___

No ___

Is the illness or injury related to an automobile accident?

Yes ___

No ___

If yes, Name of the responsible party _____

Name of the liability insurance _____

Address of the liability insurance _____

Phone number of liability insurance _____

Insurance claim number _____



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Is the patient receiving Medicare benefits based on Black Lung Disease?

Yes ___ No ___

Is the patient receiving Medicare benefits based on {ESRD} End-Stage Renal Disease?

Yes ___ No ___

Is the illness/injury work related?

Yes ___ No ___

If yes, Date of injury

Name of employer

Address of employer

Phone number of employer

Is the patient covered by the Veteran's Administration {VA}?

Yes ___ No ___

Name of the person who supplied the above Information.

Relationship to the patient

Phone number

Signature: _____

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

- (0) I can take care of myself normally without causing increased pain.
- (1) I can take care of myself normally, but it increases my pain.
- (2) It is painful to take care of myself, and I am slow and careful.
- (3) I need help, but I am able to manage most of my personal care.
- (4) I need help every day in most aspects of my care.
- (5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

- (0) I can lift heavy weights without increased pain.
- (1) I can lift heavy weights, but it causes increased pain.
- (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- (3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Walking

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 1/2 mile.
- (3) Pain prevents me from walking more than 1/4 mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can only sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting more than 1 hour.
- (3) Pain prevents me from sitting more than 1/2 hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

6. Standing

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

7. Sleeping

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

8. Social Life

- (0) My social life is normal and does not increase my pain.
- (1) My social life is normal, but it increases my level of pain.
- (2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- (3) Pain prevents me from going out very often.
- (4) Pain has restricted my social life to my home.
- (5) I have hardly any social life because of my pain.

9. Traveling

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

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Therapist Use Only	
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas
	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
	ICD Code: _____