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
REGISTRATION FORM

** Please Print **

TODAY'S DATE:	**PRIMARY MD.**				**REFERRING MD.**	
PATIENT INFORMATION						
LAST NAME: **FIRST NAME:** **MIDDLE:**			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	**MARITAL STATUS (Circle One)** Single / Mar / Div / Sep / Wid	
IS THIS YOUR LEGAL NAME? ☐ Yes ☐ No	**IF NOT, WHAT IS YOUR LEGAL NAME?**	**(FORMER NAME):**	**DATE OF BIRTH:** / /	**AGE:**	**Sex:** ☐ M ☐ F	
MAILING ADRESS:		**SOCIAL SECURITY NO:**			**HOME: # ( )** **CELL:# ( )**	
CITY:	**STATE:**	**ZIP CODE:**	**EMAIL ADRESS:**			
OCCUPATION:		**EMPLOYER:**		**EMPLOYERS #:** ( )		

***** Are you currently receiving or have you received Home Health within the past 60 days?***
***** If yes, indicate your company name:*** ***** Dates of service/discharge:***

INSURANCE INFORMATION

**** Please give your insurance card and photo ID to the receptionist ****

PERSON RESPONSIBLE FOR BILL:	**DATE OF BIRTH:** / /	**ADDRESS (IF DIFFERENT):**	**HOME # ( )** **CELL # ( )**
OCCUPATION:	**EMPLOYER:**	**EMPLOYER ADDRESS:**	**EMPLOYER PHONE #:** ( )

Is the patient covered by insurance? ☐ Yes ☐ No

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

NAME OF PRIMARY INSURANCE:			**NAME OF SECONDARY INSURANCE:**		
SUBSCRIBERS NAME:	**SUBSCRIBERS SSN:**		**SUBSCRIBERS NAME:**	**SUBSCRIBERS SSN:**	
DATE OF BIRTH: / /	**POLICY #:**	**GROUP #:**	**DATE OF BIRTH:** / /	**POLICY #:**	**GROUP #:**

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE:	**RELATIONSHIP TO PATIENT:**	**HOME/CELL #:** ( )	**WORK #:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize EUFAULA PHYSICAL THERAPY + WELLNESS or insurance company to release any information required to process my claims.

_____ _____

Patient Signature **Date**

_____ _____

Guardian Signature (if under 18 years of age) **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? _____

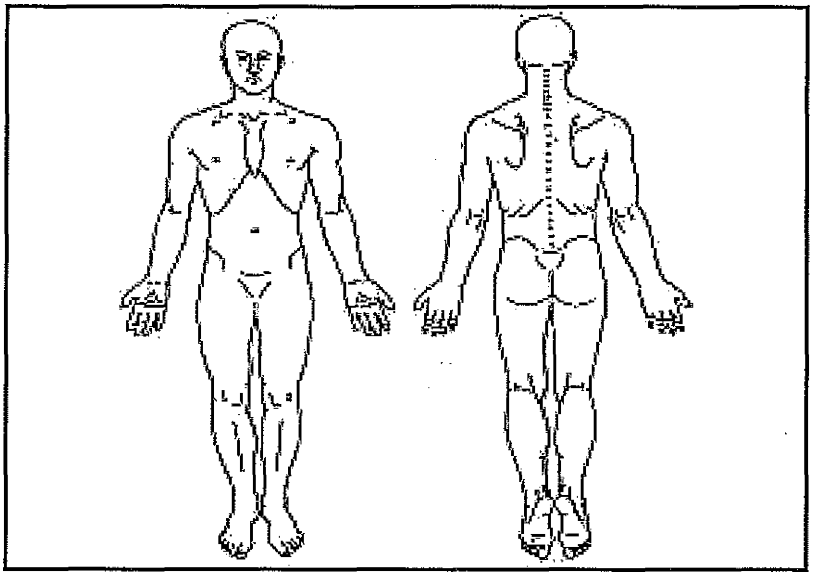
_____

How often do you experience your symptoms?

- ❑ Constantly (76%400% 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

EUFAULA PHYSICAL THERAPY +WELLNESS
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:

❑High blood pressure	❑Osteoarthritis	❑Seizure Disorder
❑Angina	❑Diabetes	❑Kidney Disease
❑Heart attack	❑Rheumatoid Arthritis	❑Headaches
❑ Stroke	❑Arthritis	❑Allergies
❑Asthma	❑Pregnancy	❑Heat/Ice sensitivity
❑ HIV/AIDS	❑Pacemaker	
❑Tumor	❑Tobacco Use packs/day _____	
❑Systemic Lupus	❑Drug or Alcohol Dependence	
❑ Hepatitis	❑Dizziness/Balance Problems	
❑ Cancer	❑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) _____

Eufaula Physical Therapy

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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

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
(0) I can look after myself normally without extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting
(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it gives me extra pain.
(2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
(3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Headache
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come infrequently.
(5) I have headaches almost all the time.

5. Recreation
(0) I am able engage in all my recreational activities without pain.
(1) I am able to engage in my recreational activities with some pain.
(2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
(3) I am able to engage in a few of my usual recreational activities with some neck pain.
(4) I can hardly do any recreational activities because of neck pain.
(5) I can't do any recreational activities at all.

6. Reading
(0) I can read as much as I want with no pain in my neck.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I can't read as much as I want because of moderate neck pain.
(4) I can hardly read at all because of severe neck pain.
(5) I cannot read at all because of neck pain.

7. Work
(0) I can do as much as I want to.
(1) I can only do my usual work but no more.
(2) I can do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any usual work at all.
(5) I can't do any work at all.

8. Sleeping
(0) Pain does not prevent me from sleeping well.
(1) My sleep is slightly disturbed (<1 hr sleep loss).
(2) My sleep is mildly disturbed (1-2 hr sleep loss).
(3) My sleep is moderately disturbed (2-3 hr sleep loss).
(4) My sleep is greatly disturbed (3-4 hr sleep loss).
(5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have great difficulty concentrating when I want.
(5) I cannot concentrate at all.

10. Driving
(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I can't drive my car as long as I want because of moderate pain.
(4) I can hardly drive my car at all because of severe neck pain.
(5) I can't drive my car at all.

Therapist Use Only

Comorbidities:
☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____