Patient Information

First Name _____ MI_____ Last Name _____ Date _____

Date of Birth _____ Age _____ SS# _____

Current Mailing Address _____

City _____ State_____ Zip _____ Phone (home)_____

Cell _____ Preferred # to call ☐ Home ☐ Cell ☐ Work E-mail_____

Consent to Communicate by Email

By providing my email address, I understand that authorized personnel from SOL may communicate with me regarding scheduling, treatment, health educational and promotional information.

Preferred method of contact: ☐ Phone ☐ Text/SMS ☐ Email ☐ I do not consent to email communications.

Gender ☐ Male ☐ Female ☐ Prefer not to answer **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widow

Preferred language ☐ English ☐ Spanish ☐ Other _____ ☐ Need a translator

Is this visit injury-related? ☐ Yes ☐ No If Yes, check the type: ☐ Work ☐ Car Accident ☐ Other Liability/Potential Lawsuit

If you checked yes, please complete page 7 of this packet.

How did you hear about us?

☐ Doctor ☐ Insurance ☐ Mailing ☐ Event ☐ Google ☐ Facebook ☐ Returning Patient

☐ Friend/Family (name): _____ ☐ Other: _____

Insurance Information

Primary Insurance Company _____ Policy#_____

Name of Insured Party _____ ☐ Self ☐ Other _____

Date of Birth of Primary Insured _____ Relationship to Patient _____

Secondary Insurance Company_____ Policy#_____

Name of Insured Party_____ ☐ Self ☐ Other _____

Date of birth of secondary insured _____ Relationship to patient _____

Employer Information

Policyholder Employer _____ Phone _____

Employer's Address _____

City_____ State_____ Zip _____

Emergency Contact Information

Name_____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

My signature below issues my permission for SOL to discuss my protected health information to the listed individuals, including appointment, billing and payment, and medical information (symptoms, diagnosis, treatment).

☐ I authorize permission to discuss only the following protected health information with my emergency contacts: _____

Cancellation of this authorization must be submitted in writing.

The above information is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

Patient Health Questionnaire

Patient Name _____

Referring Physician _____ Date of first doctor visit for this injury _____

Primary Care Physician (if different than referring physician) _____

Have you had surgery for this injury? ☐ Yes ☐ No Number of surgeries _____

Type of surgery _____ Height: _____ft _____ in Weight: _____lbs

Occupation

Are you currently working? ☐ Light Duty ☐ Full Duty ☐ Not working If not working, date last worked): _____

Fall History

How many falls?_____ Injury? ☐ Yes ☐ No

If Yes, most recent occurrence: ☐ Last 6 weeks ☐ Last 6 months ☐ Last 12 months ☐ More than year

Symptoms

What problem(s) are you being treated for today? (Describe type and location of symptoms)

_____

What date (roughly) did your present symptoms start?_____

How did your problem(s) begin?_____

My symptoms are currently ☐ Getting better ☐ Getting worse ☐ Staying the same

My symptoms currently ☐ Come and go ☐ Are constant ☐ Constant, but change with activity

PAIN ASSESSMENT											
Please report a pain assessment on the scale below where 0 is no pain and 10 is the worst pain imaginable.											
	N/A	1	2	3	4	5	6	7	8	9	10
Pain at Rest	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pain with Activity	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pain Range (best to worst)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

AGGRAVATING FACTORS		ALLEVIATING FACTORS	
Please list aggravating factors for pain (e.g. movement)		Please list alleviating factors for pain (e.g. laying down)	
1		1	
2		2	
3		3	

FUNCTIONAL PROBLEMS	
Please list any and all functional problems you currently have due to your diagnosis.	
1	
2	
3	

What is your goal for therapy? _____

Is there anything else we should know that is pertinent to your treatment?_____

_____

The above information is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

Patient Health Questionnaire (continued)

Have you had any of the following medical or rehabilitative services for this injury/episode?

Chiropractor	☐ Yes ☐ No	CT Scan	☐ Yes ☐ No
EMG/NCV	☐ Yes ☐ No	General Practitioner	☐ Yes ☐ No
Massage Therapy	☐ Yes ☐ No	MRI	☐ Yes ☐ No
Myelogram	☐ Yes ☐ No	Neurologist	☐ Yes ☐ No
Occupational Therapy	☐ Yes ☐ No	Orthopedist	☐ Yes ☐ No
Physical Therapy	☐ Yes ☐ No	Podiatrist	☐ Yes ☐ No
Emergency Room Care	☐ Yes ☐ No	X-Rays	☐ Yes ☐ No

Other: _____

Have you EVER HAD any of the following?

Asthma, Bronchitis, or Emphysema	☐ Yes ☐ No	Severe or Frequent Headaches	☐ Yes ☐ No
Shortness of Breath/Chest Pain	☐ Yes ☐ No	Vision or Hearing Difficulties	☐ Yes ☐ No
Coronary Heart Disease or Angina	☐ Yes ☐ No	Numbness or Tingling	☐ Yes ☐ No
Pacemaker or defibrillator	☐ Yes ☐ No	Dizziness or Fainting	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Weakness	☐ Yes ☐ No
Heart Attack or Surgery	☐ Yes ☐ No	Weight Loss/Energy Loss	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Hernia	☐ Yes ☐ No
Blood Clot/Emboli	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Thyroid Trouble/Goiter	☐ Yes ☐ No	Any Pins or Metal Implants	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Infectious Disease	☐ Yes ☐ No	Neck Injury/Surgery	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Shoulder Injury/Surgery	☐ Yes ☐ No
Cancer or Chemotherapy/Radiation	☐ Yes ☐ No	Elbow/Hand Injury/Surgery	☐ Yes ☐ No
Arthritis/Swollen Joints	☐ Yes ☐ No	Back Injury/Surgery	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Knee Injury/Surgery	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Leg/Ankle/Foot Injury/Surgery	☐ Yes ☐ No
Sleeping Problems/Difficulties	☐ Yes ☐ No	Do you smoke?	☐ Yes ☐ No
Emotional/Psychological Problems	☐ Yes ☐ No	Are you pregnant? # weeks _____	☐ Yes ☐ No

Medications

Please list any allergies (i.e. latex, adhesives) _____

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No

☐ Anti-inflammatories

☐ Muscle Relaxers

☐ Pain Medication

List Medications _____

_____

_____

_____

_____

_____

The above information is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ **Date:** _____ **Med Rec #/Account#** _____
(internal use only)

I hereby acknowledge that I have received the Notice of Privacy Practices of SOL.

Patient's Signature: _____ **Date:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name of Legal Representative: _____

Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney (attach documentation) ☐ Other

Explain and Attach Documentation: _____

Consent and Statement of Financial Responsibility

Patient Name: _____ **Date:** _____ **Med Rec #/Account#** _____
(internal use only)

I hereby consent to the use and disclosure of my health information for treatment provided to me by SOL, payment for services provided by the provider or other health care providers and the operations of SOL and others under certain circumstances. I understand that a more detailed explanation of the ways SOL may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

CONSENT FOR TREATMENT _____ *Initial Here*

It is our goal to provide the highest quality of care in a safe environment, in which patients may receive treatment, and staff may carry out their professional responsibilities to patients. In our efforts to achieve this goal, we require all patients, accompanying family members, and visitors to refrain from any disruptive behavior, which may pose a threat to the rights or safety of other patients and employees. Accordingly, our patients agree to refrain from the following actions: (1) Bringing firearms or other weapons into the clinic; (2) Inappropriate behavior involving alcohol/substance use at time of treatment; (3) Attempting to intimidate or harass in any manner therapists, staff, or fellow patients; (4) Inappropriately touching therapists, staff, or fellow patients; (5) Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality; (6) Making harassing, offensive or intimidating statements, or threats of violence through any medium of communication; (7) Making verbal threats to harm another individual or destroy property; (8) Physical assault or inflicting bodily harm; and (9) Intentionally damaging equipment or property. Violators of the abovementioned actions may be asked to leave the facility and/or be discharged from the clinic. Our patients have the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual orientation, or national origin. My signature below indicates that I will support the clinic in its efforts to provide me with quality care in a safe environment and that I understand and accept the terms of the Patient Code of Conduct.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS _____ *Initial Here*

I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to SOL for unpaid charges. I agree to pay SOL for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by SOL in collecting this account.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT _____ *Initial Here*

I consent to allow SOL to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order.

CANCELLATION AND NO SHOW POLICY _____ *Initial Here*

Patients are expected to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice or may be charged a cancellation fee of $30. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services. Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on “hold” for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE _____ *Initial Here*

In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

This Provider performs automated call, email, and text appointment reminders. The signature below also provides your consent for such reminders.

My signature below indicates that I understand the terms of treatment by SOL.

Patient/Guardian Name _____ **Signature** _____ **Date** _____

Medicare Secondary Payer *Only complete if you are enrolled with Medicare*

Patient Name: _____ **Date:** _____ **Med Rec #/Account#** _____
(internal use only)

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Worker's Compensation? ☐ Yes ☐ No
2. Is illness covered by the Black Lung Program or Veterans Administration program? ☐ Yes ☐ No
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? ☐ Yes ☐ No
4. If under age 65, disabled, and covered under an employer's Group Health Plan, does the employer have more than 100 employees? ☐ Yes ☐ No
5. If 65 and over, are you or your spouse employed by a company that has more than 100 employees and are you covered by their Group Health Plan? ☐ Yes ☐ No

INTERNAL USE:
If patient responds "no" to questions 1-5, Medicare is primary. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained. **ENSURE INSURANCE INFORMATION IS COMPLETED.**

Home Health Section-REQUIRED

Have you received / are you receiving healthcare services from one of the following:

Skilled Nursing Facility ☐ Yes ☐ No

Home Health Agency ☐ Yes ☐ No

Date Discharged: _____ Do you have a copy of your discharge letter? ☐ Yes ☐ No

Home Health Agency Name _____ Phone # _____

This statement serves as notification that if you are still receiving Skilled Nursing or Home Health services, you may be financially responsible for the treatment received in our clinic.

Protocol for Resolving Medicare Complaints from Medicare Beneficiaries

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. All complaints will be handled in a professional manner. All logged complaints will be responded to in writing or by telephone by a front office manager and investigated by the Compliance Officer within five (5) business days after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to an owner of the company.

Patient/Guardian Signature _____ **Date** _____

Third Party Coverage Questionnaire

Patient Name: _____ **Date:** _____ **Med Rec #/Account#** _____
(internal use only)

INJURY LIABILITY QUESTIONNAIRE

The nature of your injury may alert your medical insurance company to potential liability. Completing this form in its entirety allows SOL to provide a quick response to those inquiries and prevent delays in processing your claims.

Is this injury WORK-RELATED? ☐ Yes ☐ No Is this injury AUTO-RELATED? ☐ Yes ☐ No

Have you/do you intend to file a claim against a business or homeowner's insurance policy? ☐ Yes ☐ No

If you answered NO to the questions above, it is not necessary to complete the rest of this form. Please sign and date the bottom of this page.

Injury Information

Date of injury/onset of condition/recent exacerbation? _____

Describe in detail how the injury occurred _____

_____

Specific name and location where injury occurred (i.e: store, restaurant, intersection, etc.) _____

_____

Who is responsible for the accident? ☐ Self ☐ Other, describe _____

Insurance of Responsible Party _____ Claim # _____

Address _____

Adjuster Name _____ Adjuster Phone _____

Personal Insurance _____ Claim # _____

Address _____

Contact Name _____ Contact Phone _____

The above information is accurate and true to the best of my knowledge. I agree to immediately notify SOL with any change in this information.

Patient Signature: _____ **Date:** _____

When a patient is a minor or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Legal Representative Signature: _____ **Date:** _____

Printed Name (printed) _____

Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney ☐ Other _____
Explain and Attach Documentation