Summit Strength Physical Therapy, LLC

PATIENT PERSONAL INFORMATION

Today's Date_____

Name_____Birthdate_____

Home Address_____
(Street) (City) (State) (Zip)

Home Phone #_____Y / N Cell Phone #_____Y / N
Message OK? Message OK?

Social Security #_____ (Male Female)

Email Address_____

(Married Single Divorced Widowed Minor)

Employer_____Occupation_____

Employer Address_____ Phone #_____Y / N
Message OK?

_____
EMERGENCY CONTACT (Relationship) (Phone)

INJURY? *No* _____ *-or YES-date* _____ *Auto* _____ *Work*_____ *Other* _____

How did you hear about us? Prior Patient ___ Doctor ___ Friend (Name) _____ Other _____

PERSON RESPONSIBLE FOR ACCOUNT **CHECK BOX IF SAME AS ABOVE** ☐

Name_____Address_____

Relationship to client_____Birthdate_____

Social Security #_____ Phone #_____

Employer_____ Address_____Phone #_____

Spouse's Name_____ Birthdate_____ Social Security #_____

Address_____ Phone #_____

Spouse's
Employer_____Phone#_____

Address_____

Summit Strength Physical Therapy, LLC

CONFIDENTIAL HEALTH HISTORY

Patient Name:_____ **Referring Physician**: _____**Primary Care Physician**:_____

Are you aware of your diagnosis?_____

Have you had any other orthopedic injuries or surgeries? If yes explain_____

Have you had any prior physical or speech therapy visits this year? If yes how many visits?_____

At the present time, would you Rate your Overall General Health as: Excellent ____ Good ____ Fair ____ Poor_____

Please circle all conditions that you have or have had in the past

MUSCULOSKELTAL
Osteoarthritis
Osteopenia
Osteoporosis
Rheumatoid Arthritis
Lupus/SLE
Fibromyalgia
Headaches/Migraines
Bulging Disk
Leg Cramps/Restless Legs
Jaw Pain/TMJ
History of Falling
Use of Cane/Walker
Gout
Other:_____

CIRCULATION/RESPIRATORY
Heart Disease
Heart Surgery
Heart Arrhythmia
Pacemaker
Myocardial Infarction
Angina/Chest Pain
Mitral Valve Prolapse
Aneurysm
High/Low Blood Pressure
High Cholesterol–On Statin Meds
Anemia
Blood Clots/Phlebitis
Asthma/SOB
COPD
Other:_____

ENDOCRINE/DIGESTION
Diabetes
Low Blood Sugar
Kidney Dysfunction
Irritable Bowel Syndrome
Crohn's Disease
Bladder Dysfunction
Liver Dysfunction
Thyroid Dysfunction
Hernia
Unexplained Weight Loss/Gain
Other:_____

INFECTIOUS DISEASE
Tuberculosis
Hepatitis
Influenza
Shingles
STD
Blood Transfusion
HIV/AIDS
Other:_____

NERVOUS SYSTEM
Stroke/TIA
Polio
Parkinson's Disease
Multiple Sclerosis
Epilepsy/Seizures
Concussion
Traumatic Brain Injury
Numbness or Tingling
Other:_____

CANCER
Type Of Cancer:
_____
_____
Date of Diagnosis: _____
Treatments:
_____
_____
_____

- **Are you currently pregnant?** Yes No
- **Do You Smoke?** Yes No
- **Do You Drink Alcohol?** Yes No
- **Illicit Drug Use?** Yes No

ALLERGIES: PLEASE CIRCLE
LATEX ALLERGY
TAPE ALLERGY
OTHER ALLERGY:

Is there anything else we should know about your health?_____

TELL US ABOUT YOUR CONDITION

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates)

First episode_____ Subsequent Episodes_____ Most Recent Episode_____

How did your symptoms/injury occur?_____

Where are your symptoms located?_____

What is your main problem related to this condition?_____

What makes your symptoms better?_____ Worse?_____

Have you had any surgery for your injury/condition?_____ If yes, what kind and when?_____

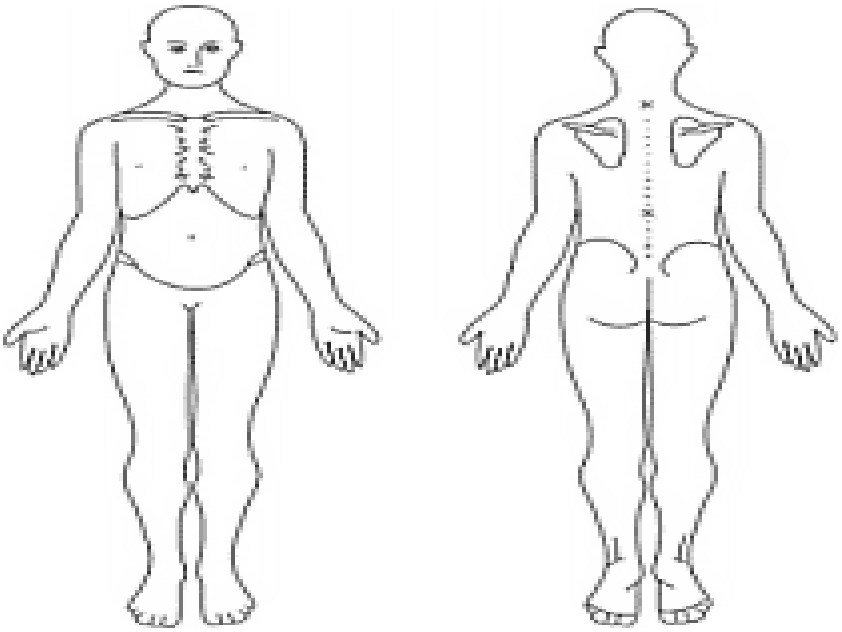
Have you received any injections for your injury/condition?_____ If yes, when?_____ Did it help?_____

Diagnostic tests performed (X-RAY, MRI, etc) _____

For your current injury or condition, have you seen any of the following? (Please circle all that apply and specify approximate dates of treatment)
Medical Doctor _____ Physical Therapist _____ Psychiatrist/Psychologist _____
Chiropractor _____ Athletic Trainer _____ Personal Trainer _____

Are you exercising? _____ Describe:_____ Problems with exercise?_____ Describe:_____

What do you hope to accomplish with physical therapy?_____



On the diagram, please indicate your current symptom location (s) using they key below:

Stabbing	//////
Burning	XXXXXX
Numbness	======
Pins & Needles	000000
Aching	SSSSSS

Pain Rating Descriptions :

0 No Pain
1-3 Achy, Sore Pain/No Restriction Of Function
4 Minor Restriction of Function
5 Moderate Restriction of Function
6 Severe Restriction of Function
7 Complete Restriction of Function
8-9 Hospital, Emergency Room Pain
10 Hot Poker In The Eye Pain

Function Rating Descriptions:

0 Unable to Function or get out of bed
10 Normal Function, The day before the injury occurred

HEIGHT_____ **WEIGHT**_____

BMI (Therapist Will Calculate)_____

How often do you experience your current symptoms? Always ☐ Frequently ☐ Occasionally ☐ Seldom ☐

Are your symptoms ? Not Changing ☐ Improving ☐ Getting Worse ☐

Using this scale (0 = no pain, 10 = emergency type pain):

My average level of pain is _____
My highest pain level in the last 30 days has been _____
My lowest pain level in the last 30 days has been _____

Using this scale (0 = no function, 10 = ability to perform normal daily activity):

My average level of function _____
My highest function level in the last 30 days has been _____
My lowest function level in the last 30 days has been _____

FOR THERAPIST USE ONLY

I have reviewed past medical history with the patient/guardian prior to evaluation and treatment. The following was identified:

- _____
- _____
- _____

I have informed the patient on our plan of treatment Y N
I have informed the patient of their outcome potential prior to treatment Y N

Therapist Signature: _____Date:_____

I, _____ understand and accept the plan of care.
Patient/Guardian Signature

Patient/Guardian signature: _____Date:_____

Summit Strength Physical Therapy, LLC

MEDICATION LIST

Patient Name:**____**

Food/Drug Allergies:**____**

Reaction:**____**

Name of Medication:	*Strength:*	*How Often Taken:*	*Comments:*

SUMMIT STRENGTH PHYSICALTHERAPY, LLC

SIGNED AUTHORIZATIONS

Phone # 816-524-7040 Fax# 816-524-7057
800 NW Main Street Ste. 100 Lee's Summit MO 64086
1300 N 7 Highway Blue Springs MO 64014

AUTHORIZATION FOR CARE

I/we hereby authorize to receive care at Summit Strength Physical Therapy, LLC. I/we understand that receiving physical therapy or strength and conditioning may involve stress of musculoskeletal tissue that may cause soreness (like one might feel for a few days after starting a workout program such as running or lifting weights.) Furthermore, I/we understand that the provider may need to perform mobilization technique, massage technique, manual traction, distraction, ultrasound, electrical stimulation, taping, bracing, orthotic fitting, weight training and other movement modalities that may produce brief (several days) soreness and discomfort. It is my/our responsibility to communicate any difficulties that I/we are having during treatment to my/our provider. It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions.

_____ _____

Signature Date

ASSIGNMENT & RELEASE

I, the undersigned, assign directly to Summit Strength Physical Therapy, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I herby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I also understand that if I have a co-pay it will be due at the time of service.

_____ _____

Signature Date

PAYMENT POLICY

I/we understand we are responsible to pay all co-pays, coinsurance and fees that are provided by Summit Strength Physical Therapy, LLC. I/we understand that it is our responsibility to understand the percentage of coverage allowed by our insurance program and understand the coinsurance payments required. I/we understand that should Summit Strength Physical Therapy deem it necessary to proceed to collections to obtain money owed them, there may be additional court fees and attorney fees that I/we will have to pay. Interest of 9% APR is charged on accounts over 30 days past due.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICE/HIPAA (Health Insurance Portability and Accountability Act)

I acknowledge that I have received Summit Strength Physical Therapy, LLC's notice of Privacy Practices (HIPAA)

_____ _____

Signature Date

MEDICARE AUTHORIZATION (For Medicare Patients Only)

I request that payment of authorized Medicare or Medigap benefits be made on my behalf to Summit Strength Physical Therapy, LLC for any services furnished to me by a physical therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" or "Medigap" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

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CANCELLATION POLICY

Due to the nature of our business, good communication between our staff at Summit Strength Physical Therapy and the patient is important for efficient scheduling for our clients. Our office greatly appreciates as much advance notice as possible for any reason you may need to cancel. Our staff has significant flexibility and understanding for last minute illness and issues that causes changes in the schedule. We appreciate advance notice so we can promptly call people on a waiting list and allow them to fill the spots that you have canceled. Our policy will be that if on any situation that you do not show for an appointment you will be charged $50.00 on your account for that visit. Cancellations made 48 hours in advance will not be charged. Cancellation of appointments not within 48 hours will be charged $50.00 after 3 cancellations and thereafter. You will also lose any prior scheduling arrangements (Preferred Continuous Time Slots) that are made.

I understand the cancellation policy for Summit Strength Physical Therapy, LLC.

_____ _____

Patient Name *Date*

CREDIT CARD AUTHORIZATION

I hereby agree to payment with the credit card listed below for the following reasons (Please circle all that apply):

copays of $ _____

Balance due on my account after insurance payment, maximum of $ _____

Recurring payments of $_____ Number: _____

Weekly ___ Bi-weekly ___ Monthly ___ Date to begin: _____

Other: _____ $_____

Email for receipts: _____

My credit card Number: _____

Expiration MM/YY: _____/_____

This authorization remains in place until: _____ or until I notify Summit Strength in writing that this authorization is no longer valid. I understand that I must notify Summit Strength at least two business days ahead of a scheduled payment to change this authorization.

_____ _____

Signature Date