



PATIENT MEDICAL HISTORY

Name (PRINTED) _____ Referring Physician _____

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

Date of Injury or onset of symptoms: _____ NA Date returned to work after this injury _____

Is injury due to Auto Accident or Workers Comp claim? YES NO

List all previous surgeries _____ Year of surgery _____

Have you had ANY other surgeries in the YES NO
past?

Please enter your – HEIGHT _____ WEIGHT _____ AGE _____

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

	YES	NO		YES	NO
Chiropractor	_____	_____	EMG/NCV	_____	_____
Neurologist	_____	_____	Myelogram	_____	_____
Orthopedist	_____	_____	Emergency Room Care	_____	_____
General Practitioner	_____	_____	CT Scan	_____	_____
Occupational Therapy	_____	_____	MRI	_____	_____
Physical Therapy	_____	_____	X-Rays	_____	_____

Do you now have or have you ever had ANY of the following?

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Asthma			Severe/Frequent Headaches		
Shortness of breath/chest pain			Vision/hearing difficulties		
Coronary heart disease or angina			Dizziness or Fainting		
Heart attack or surgery			Weight loss/Energy loss		
Do you have a Pacemaker			Hernia		
High blood pressure			Allergies		
Stroke/TIA			Joint replacement		
Blood clot/Emboli			Any joint/metal implants		
Epilepsy/seizures			Shoulder injury/surgery		
Anemia			Elbow/hand injury/surgery		
Infectious disease			Neck/Back injury/surgery		
Diabetes			Knee injury/surgery		
Cancer or chemotherapy/radiation			Leg./ankle injury/surgery		
Arthritis/swollen joints			Are you pregnant		
Osteoporosis			Do you smoke/How long		
Sleeping problems/difficulties			Difficulty/Frequent urinating		
Anxiety			Depression		
Alzheimer's			Dementia		
Thyroid Condition			Night Pain		

List any other information that would assist us in your care: _____

Patient or responsible party signature _____ Date: _____

I have reviewed this information with the patient

Therapist (PRINTED) _____ Therapist (SIGNATURE) _____ Date: _____



Last Name: _____ First Name: _____ Middle Initial: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security #: ____ - ____ - ____ Circle One: M F

Spouse Name: _____ Email Address: _____

Spouse Date of Birth: ____/____/____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Insurance Information: (The following section must be filled out COMPLETELY.)

I hereby instruct the insurance company listed below to make payment directly to A&M Therapy, Inc.

Primary Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Relationship: _____ DOB: _____

Co-Pay per Visit _____ Plan coverage % _____ Visits per Year _____ Deductible _____

As a courtesy to you, A&M Therapy, Inc. verifies insurance benefits. However, A&M Therapy, Inc. does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefits plans.

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify A&M Therapy, Inc. of any changes in my status or the above information. I hereby authorize any treatment (s) agreed upon with the Physical Therapist and my referring physician which are deemed medically necessary.

**I authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case. I also authorize A&M Therapy, Inc. and its staff to call my home and leave messages regarding appointments with my spouse and/or on the answering machine. Furthermore, I authorize the use of facsimile transmission, email transmission, internet transmission, and electronic transmission of my personal health information for the purpose of treatment, payment, and healthcare operations.*

**For the purpose of education and research, I hereby consent to the use of multimedia, including but not limited to photos or video taken by A&M Therapy, Inc during Physical Therapy sessions.*

Patient or Responsible Party Signature: _____ Date: _____



DETERMINATION OF PRIMARY PAYOR:

- Have you received **OUTPATIENT PHYSICAL THERAPY SERVICES** this calendar year? YES NO
If yes, where? _____

- Is Medicare your secondary? If yes, please indicate the type by circling below. YES NO
Working Age Beneficiary End Stage Renal Disease No Fault Insurance Black Lung

PHC or Other Federal Veteran's Administration Disabled Beneficiary Other: _____

- Are you currently receiving, or plan to receive, any type of home health care including nursing/home healthaide? YES NO

- Are you currently receiving or plan on receiving any type of chiropractic care? YES NO

- Is this injury due to an automobile accident? YES NO
If "YES", what was the date of the accident? _____ State of Accident? _____

- Is this injury work related? YES NO
If "YES", what was the date of injury? _____

- Is your injury the result of any other type of accident? YES NO
If "YES", please provide us with the details: _____

I understand that if payment of services by Medicare or other insurance payer is denied due to false information I will be held responsible for these charges.

Patient or Responsible Party Signature: _____ Date: _____

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our practice;
- Leave appointment reminders via text or voicemail;

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

I give permission to share appointment, billing, or medical information with the person (s) named here:

Patient or Responsible Party Signature: _____ Date: _____



Medications List

Name: _____

Date: ___/___/___

Medication	Dosage	Frequency	Reason for Medication



Patient Name: _____

Is there a lawyer involved in this current medical case?

Yes. No.

Lawyer Information:

Bureau: _____

Lawyer: _____

Phone: _____

Email: _____

Signature: _____ Date: ____/____/____



To: All Patients

From: A&M Therapy Inc.

Re: Missed Visit Policy

Missed visits hurt everyone. This office, you and other patients are hurt when appointments are missed and/or not cancelled properly.

Our Office requires notice of a cancellation at least 24 hours prior to your scheduled appointment.

Any patient who misses an appointment will be subject to a service fee of \$25.00 unless proper notification is given.

I have read and understand the above. I agree to abide by this policy.

Signature: _____ Date: ___ / ___ / ___