FLOWERTOWN
Physical Therapy

Patient Questionnaire/Medical History Form

Under Medicare and the State practice acts, we are required to obtain a complete medical history on all patients. This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Last Name: ______________________ **First Name:** ______________________ **MI:** ______ **Date:** ___/___/___

DOB: ___/___/___ **Age:** _______ **Sex:** M / F **Hand Dominance:** R / L **Height:** ___________ **Weight:** ___________

Address: __________________________________ **City:** ______________________ **Zip Code:** __________

Phone #: (H)____________________(C)____________________ **Email:** ______________________

Emergency Contact: ______________________ **Relation:** ______________ **Phone:** ______________

How did you hear about us? ____

Primary Care Doctor: ______________________________ **Referring Doctor:** ______________________________

If an accident, circle place where it occurred: Home Auto Work Sports Other **Next Doctor's Visit:** ___/___/___

Occupation: ____________________ **Work involved?** ________ **Current Work Status:** ______________________

Do you have any lifting restrictions? Y / N **Do you live alone?** Y / N **Are there stairs where you live?** Y / N

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What is the reason for your visit today? ____

Briefly describe how your problem began: ____

What goals would you like to achieve through therapy? ____

Date of onset/injury: ___/___/___ **Date of surgery:** ___/___/___ **Type of Surgery:** ______________________

Prior or ongoing treatments for your current chief complaint includes: (Circle all that apply) **No treatment received yet** _______

Physical Therapy	Chiropractic Care	Pain Management	Mechanical Traction
Massage	Injections	Aquatic Therapy	Brace/ Tape
Surgical Intervention	Personal Training	Athletic Training	Other: ______________

Have any diagnostic tests been performed for this problem? (Circle all that apply)

X-rays Bone Scan Doppler Ultrasound MRI EMG CT Scan Blood work Other: ______________

Please list body part tested and date tested: ____

Have you had similar symptoms in the past? Y / N **Have you received Home Health PT prior to coming here?** Y / N

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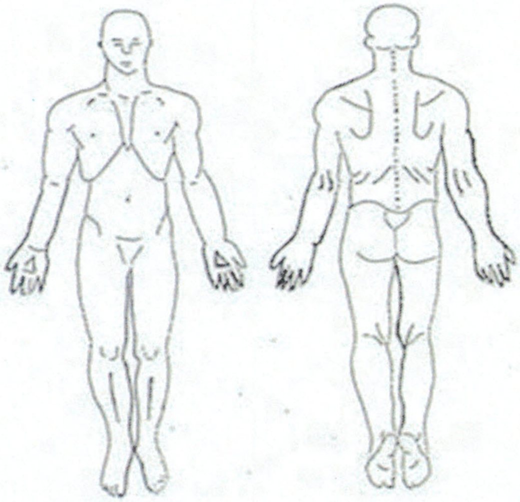
Please circle where you hurt/ have pain:



Where did your pain start? ______________________________

Since it started, pain is:

getting worse improving the same

Describe the pain:

sharp dull aching sore throbbing cramping burning

shooting stabbing squeezing constant intermittent

Other: ______________________________

What makes it worse? ______________________________

What makes it better? ______________________________

Does time of day affect pain? ______________________________

Does pain wake you from sleep? ______________________________

Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):

Least: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Present: 0 1 2 3 4 5 6 7 8 9 10

Do you have any tingling, numbness or loss of sensation? Y / N **If so, where?** _____

Do you have any weakness? Y / N **If so, for how long?** _____

Do you have any swelling? Y / N **If so, where?** _____

Have you fallen *two or more times* within the past 12 months? Y / N **If so, how many times?** _____

Do you use any of the following: Cane Walker Crutches Wheelchair

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How would you rate your current health? excellent very good good fair poor

Please circle yes or no if you have or have had any of the following conditions:

High Blood Pressure	Y / N	Diabetes	Y / N	Osteoarthritis	Y / N
High Cholesterol	Y / N	Heart Attack	Y / N	Rheumatoid Arthritis	Y / N
Bowel/ Bladder Dysfunction	Y / N	Cardiac Bypass	Y / N	Osteoporosis/ Osteopenia	Y / N
Acid Reflux/ Ulcers	Y / N	Cardiac Stents	Y / N	Scoliosis	Y / N
Thyroid Disorder	Y / N	Angina/ Chest Pain	Y / N	Headaches/ Migraines	Y / N
Bleeding Disorder	Y / N	Hepatitis	Y / N	Dizziness/ Fainting	Y / N
Seizures/ Epilepsy	Y / N	Emphysema	Y / N	Cancer (type: _____)	Y / N
Lyme Disease	Y / N	COPD	Y / N	Recent Infection	Y / N
Currently Pregnant (# wks ____)	Y / N	Asthma	Y / N	Multiple Sclerosis	Y / N
Fibromyalgia	Y / N	Kidney Disease	Y / N	Congestive Heart Failure	Y / N
Lupus	Y / N	Stroke	Y / N	Depression	Y / N

Please circle any that you may have and/or wear: Glasses Contacts Dentures Pacemaker Metal Implant Hearing Aides

Please circle any of the following that may apply:

Mental Disorder: (Type)_____ Dementia/Alzheimer HIV/AIDS Parkinson's Hepatitis: (Type) _____

List all previous surgeries and dates (in the last 5 years):

_____

_____

List all medications/supplements you are taking including dosage and frequency (use additional page if needed) :

_____

_____

List all allergies that you may have:

_____

_____

To the best of my ability, I have given and included all pertinent medical information.

Patient/Guardian signature: _____ Date: ____/____/____

Medical history reviewed by physical therapist and used in determining the plan of care.

Therapist signature: _____ Date: ____/____/____

FLOWERTOWN
Physical Therapy

911 Central Avenue Unit 1
Summerville, SC 29483
Phone (843) 970-7000 Fax (843) 970-7021

PHYSICAL THERAPY TREATMENT CONSENT & FINANCIAL AGREEMENT

For Physical Therapy services rendered by Flowertown Physical Therapy, LLC.

Please Print

1. I, _____ (or parent/guardian for the patient), do hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatments sought by myself and/or as ordered by a physician or their assistance, as defined in the South Carolina Physical Therapy Practice Act.

2. I understand that it is Flowertown Physical Therapy's Policy to collect all co-pays/co-insurance/self-pay payments at the time of service. I understand I am responsible for making payments as services are rendered until my deductible and or co-insurance/co-payment/self-pay payment requirement has been satisfied.

3. I authorize my insurance benefits to be paid directly to Flowertown Physical Therapy and agree that I understand that I am financially responsible for any amounts not covered and/or paid by my insurance.

4. I understand that if I do not pay the full amount as agreed above, Flowertown Physical Therapy may turn my account over to a collection agency if I do not respond to multiple statements and final bill notifications.

5. I hereby authorize Flowertown Physical Therapy to release medical information regarding myself and my current condition to my insurance company for the purpose of payment and/or quality reviews, as well as to referring, consulting, and treating physicians or other medical providers as needed to support continuity of care.

I have read this form and certify that I understand its contents as of this date.

_____

Signature of Patient or Parent/Guardian Date

_____

Signature of Flowertown PT Representative Date

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MISSED APPOINTMENT & CANCELLATION POLICY

Your appointment time is valuable and has been reserved specifically for you and your treatment session. If it is necessary to reschedule your appointment, please provide us with a **24 hour notice.** However, we understand that certain circumstances may arise unexpectedly that will not allow for the 24 hour notice to be given. Some examples of these circumstances include contagious illnesses, death in the family, natural disasters and etc. In these instances, please call the office as soon as possible. We provide an after hours answering machine for any issues that occur after closing.

Flowertown Physical Therapy reserves the right to

CHARGE A $25 CANCELLATION OR NO SHOW FEE.

This fee is not covered by your insurance or workers compensation carrier.

APPOINTMENT REMINDER CONSENT

Check ***One*** of the following and sign below to give your permission for Flowertown Physical Therapy to provide appointment reminders by email, voice call or by cell phone text message.

☐ Flowertown Physical Therapy may send email message reminders for upcoming appointments.

Email address:_____

☐ Flowertown Physical Therapy may send text message reminders for upcoming appointments.

Phone #:_____

☐ Flowertown Physical Therapy may send voice call reminders for upcoming appointments.

Print Name:_____

Signature:_____ Date:_____

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Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We will use your protected health information (PHI) for the purpose of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to send you an appointment reminder, to inform you of our other health related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert serious threat to your health or safety or the health of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you to workers' compensation or other similar programs that provide benefits for work-related injury or illness.
Your authorization is required before your PHI may be used or disclosed by us for other purposes.

Your Privacy Rights

Restrictions
You may have the right to request restrictions on how your PHI is used, however we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communication
You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment to be made to your PHI, of you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures
After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact
If you would like more information about our privacy practices or to file a complaint you may contact:
Name: Emily Baker
Title: Privacy Officer
Address: 911 Central Avenue Unit 1
Summerville, SC 29483
(843) 970-7000

HIPPA SC
US DHHS
Atlanta Federal Center
Suite 3B70
61 Forsyth St.
Atlanta, GA 30303-8909

Patient Name: _____ Date of Birth: _____

Signature: _____ Date:_____

Flowertown PT Witness: _____ Date:_____