



Recovery
PHYSICAL THERAPEUTIC CENTER
Patrice Peterson, PT

Empowering You to Better Health

Dear New Patient:

Welcome to Recovery Physical Therapy. We are committed to providing you with quality care and service; we are pleased that you have chosen us.

On the day of your appointment, please arrive 15 minutes prior to your actual appointment time and bring the following items:

1. Physicians' Prescription for Physical Therapy
2. Your insurance card
3. Completed forms
4. Any other relevant information, reports, x-rays, etc

If you did not receive your forms, please arrive 30 minutes before your scheduled time. It is **very important** to complete the enclosed forms prior to your arrival.

Attire: Please wear comfortable clothes & tennis shoes. Your physical therapist will need to access the body part to be treated. Shorts will be necessary for hip, knee and ankle problems. You may be asked to put on a patient gown for back, neck or shoulder problems.

We will do everything possible to provide you with a positive experience. Your first visit will consist of a thorough, individualized evaluation by a licensed physical therapist. A treatment plan will be developed and will include hands-on contact by your physical therapist. Be prepared to begin treatment and even exercise on your first visit.

Our staff has been chosen for their caring attitudes, as well as their professional experience. We are proud of our team. Each & every one of them has areas of expertise, from the person who answers the phone to our highly trained aides. As a team, we strive to provide you with great care and optimal results.

Our goal is a patient who has decreased pain and improved function, who is educated so that she or he can maintain their condition and who feels cared for as a real and unique individual. Please do not hesitate to speak with our **Office Manager, Phyliss Torres-Smith**, with any questions or concerns you may have.

Sincerely,

Patrice Peterson, PT
Owner / Director

Recovery Physical Therapeutic Center

NEW PATIENT REGISTRATION

PATIENT'S NAME: _____ HOME#: _____ Cell#: _____

E-MAIL ADDRESS: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: SINGLE ___ MARRIED ___ OTHER ___

SOCIAL SECURITY #: _____ SPOUSE: _____

OCCUPATION: _____ EMPLOYER: _____ WORK#: _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ Relationship: _____ PHONE #: _____

IN CASE OF EMERGENCY CONTACT: _____ Relationship: _____ PHONE#: _____

WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT?: _____ PHONE#: _____

HOW DID YOU HEAR ABOUT RECOVERY PHYSICAL THERAPEUTIC CENTER? RETURNING PATIENT WEBSITE

DOCTOR FAMILY/FRIEND KENNEDY CLUB PHONEBOOK OTHER _____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY? YES ___ NO ___ IF YES, GIVE DATE OF INJURY: _____

INSURANCE COMPANY: _____ PHONE#: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED: _____ ID#: _____ GROUP#: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ PHONE#: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED: _____ ID#: _____ GROUP#: _____

CONSENT FOR TREATMENT – RECORDS RELEASE – ASSIGNMENT OF BENEFITS – FINANCIAL RESPONSIBILITY

Consent for Treatment:

I hereby authorize Recovery Physical Therapeutic Center to provide physical therapy and treatment to myself / minor child considered necessary for treating my physical conditions.

Records Release:

I hereby authorize the release of medical records related to treatment rendered by Recovery Physical Therapeutic Center as necessary for reimbursement for service. I hereby authorize Recovery Physical Therapeutic Center to release my therapy records to my physician.

Assignment of Benefits:

I hereby authorize payment directly to Recovery Physical Therapeutic Center on any claims not to exceed my indebtedness to said therapy corporation. I understand that I am responsible for any amount not covered by my insurance.

Financial Responsibility:

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered..

I have read and fully understand the above agreement. I certify that the information I have given is true and correct to the best of my knowledge. I will notify you of any changes in my health status or in the above information.

Patient's Signature / Parental Consent (Required if patient is a minor)

Date:

Patient Health Questionnaire - PHQ

Form PHQ-202

Health Plan Use Only rev 7/18/05

Patient Name _____ Date _____

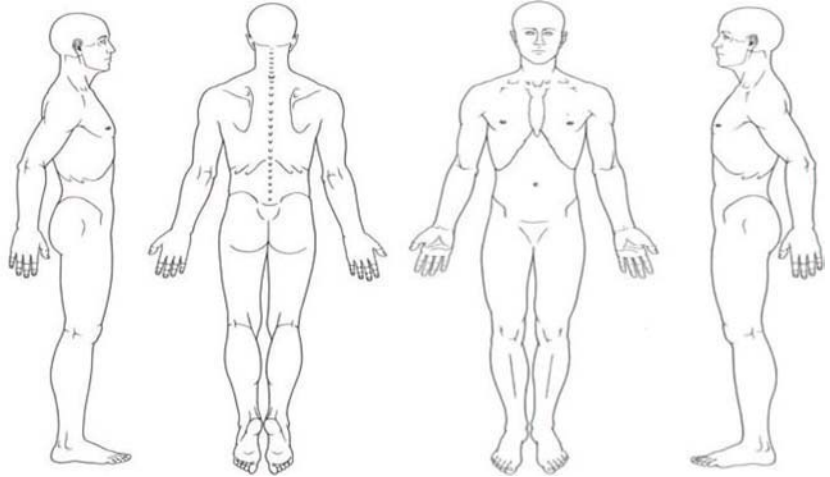
1. Describe your symptoms

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)Plan

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No
- ③ This Office
- ④ Chiropractor
- ⑤ Medical Doctor
- ⑥ Physical Therapist
- ⑦ Other

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

FINANCIAL POLICY

We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. Please provide information as accurately as possible. Our Financial Policy is designed to give you a number of payment options.

Patient Payment Method at Time of Your First Visit, Patient Pays:	
Self Pay	Payment is expected in full unless other arrangements have been made prior to treatment.
Medicare	20% of the approved allowed charge if your supplemental insurance doesn't cover the balance due. We will bill your secondary for you.
Worker's Compensation	Pre-authorization and a referral from your doctor are required.
Personal or Auto Injury	Pre-authorization is required. WE DO NOT ACCEPT LIENS. If there is no medical coverage, payment will be expected at time of visit.
PPO/HMO	We will call your insurance company and verify benefits. A co-payment is required at the time of your visit. You are also responsible for paying any deductible that hasn't been met. We will estimate as closely as possible your coverage. Until we actually receive payment from your insurance, it is just an estimate.

WE CONTACTED YOUR INSURANCE: _____ THE FOLLOWING INFORMATION WAS GIVEN TO US REGARDING YOUR COVERAGE FOR PHYSICAL THERAPY:

_____ DED AMOUNT: _____ DED MET? _____

THERAPY COVERED @: _____ % # OF ALLOWED VISITS PER YEAR: _____

YOUR ESTIMATED CO-PAY / CO-INSURANCE / COST PER VISIT IS:
(subject to deductible being met)

Please call if you have any question's regarding your coverage.

THE INSURANCE COMPANY IS NOT RESPONSIBLE FOR YOUR MEDICAL BILL. YOU, THE PATIENT, ARE.

“I have read, understand, and agree to the provisions of this Financial Policy.”

Patient's Signature: _____ Today's Date: _____

To Our Patients Regarding Cancellations and No-Shows

The following is our policy regarding cancellations and no-shows. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and / or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Then, all you need to do is follow your therapist's instructions and we will be able to help you achieve your therapy goals.

- We require 24 hours notice in the event of a cancellation. It is your responsibility when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- **There is a \$50.00 charge for failure to show for your scheduled appointment or cancellation without proper notice.** This charge will not be covered by your insurance.
- For Worker's Compensation, documentation of any missed appointments is forwarded to your Case Manager and Physician. In which case this could jeopardize your claim. This charge will not be covered by your insurance.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses. Either condition can seem to be a reason not to come in:
 - a) You are worse and think the treatment is not working.
 - b) You are feeling better and it's a great day for surfing, etc.

Neither of these conditions is legitimate as a reason not to come:

- a) If you're in pain, come in and get it fixed.
- b) If you are out of pain, now is the time that we can begin doing some real correction of the underlying cause of your problem, educate you so you won't re-injure yourself.

When you don't show as scheduled, three people are hurt: 1) **You** because you don't get the treatment you need; 2) the **therapist** who now has a space in their schedule since the time was reserved for you personally; 3) and **another patient** who could have been scheduled for treatment.

Please co-operate with us in this regard. We're looking forward to working with you.

FOTO Patient Intake Survey

Generic

Staff to Complete

PATIENT NAME: _____ Patient ID: _____

Gender: Male / Female Date of Birth: ____ / ____ / ____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source _____ *(Type of Plan such as Preferred Provider, HMO, WC, Auto Insurance, etc.)*

Insurance _____ *(Specific Carrier such as Blue Cross, Humana, Aetna, etc.)*

Other Referral Code: Non-PTPN OPTPN Auto OPTPN Group Health OPTPN WC Date of Survey: ____ / ____ / ____

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, does or would your health problem limit:	Yes, limited a lot	Yes, limited a little	No, not limited at all
1. Participating in rigorous contact sports			
2. Lifting 100 lbs. or more			
3. Vigorous activities like running, lifting heavy objects, sports, running more than 5 miles?			
4. Participating in recreation?			
5. Moderate activities, such as moving a table or pushing a vacuum cleaner?			
6. Climbing several flights of stairs?			
7. Climbing one flight of stairs?			
8. Walking more than a mile?			
9. Walking several blocks?			
10. Walking one block?			
11. Going on vacation?			
12. Attending social events?			
13. Lifting or carrying items like groceries?			
14. Lifting overhead to a cabinet?			
15. Gripping or opening a can?			
16. Handling of small items such as a pen or coins?			
17. Feeding yourself?			
18. Getting in and out of bed?			
19. Bathing or dressing?			
20. Bending to the floor?			
21. Kneeling to the floor?			
22. Control of your bladder?			
23. Completing your toileting?			

24. Do you limit the kind of work or other daily activities as a result of your physical health? No Yes

25. Do you reduce the amount of time you spend on work or other regular daily activities as a result of your physical health? No Yes



26. How much does pain interfere with your normal work (including work outside the home, work around the yard, and housework)? Extremely Quite a bit Moderately Not at all
27. How much pain have you had in the past 24 hours? Severe Moderate Mild None
28. Please indicate the number of surgeries for your primary condition. None 1 2 3 4+
29. How many days ago did the condition begin? 0-7 days 8-14 15-21 22-90 91 days to 6 mos. Over 6 mos. ago
30. Are you taking prescription medication for this condition? Yes No
31. Have you received treatments for this condition before? Yes No
32. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? At least 3 times a week Once or twice per week Seldom or never

33. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis) | <input type="checkbox"/> Visual impairment (such as cataracts, glaucoma, macular degeneration) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hearing impairment (very hard of hearing, even with hearing aids) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema | <input type="checkbox"/> Kidney, bladder, prostate, or urination problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Previous accidents |
| <input type="checkbox"/> Congestive heart failure (or heart disease) | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart attack (Myocardial infarction) | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anxiety or Panic Disorders |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Other disorders |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Hepatitis / AIDS |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Prior surgery |
| <input type="checkbox"/> Diabetes Types I and II | <input type="checkbox"/> Prosthesis / Implants |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) | <input type="checkbox"/> Sleep dysfunction |
| | <input type="checkbox"/> Cancer |

34. Height: _____ ft. _____ in. Weight: _____ lbs.

35. This is a statement other patients have made. ***"I should not do physical activities which (might) make my pain worse."*** Please rate your level of agreement with this statement below. (✓response)

- | | | |
|---|---------------------------------|--|
| <input type="checkbox"/> Completely Agree | <input type="checkbox"/> Unsure | <input type="checkbox"/> Somewhat Disagree |
| <input type="checkbox"/> Somewhat Agree | | <input type="checkbox"/> Completely Disagree |

Pain Chart: Please indicate the location of your pain on the diagram below, USING THE KEY BELOW:

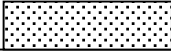
Sharp, stabbing pain=



Dull and achy pain=



Pins & Needles=



Numbness (no sensation) =

