PREMIER PHYSICAL THERAPY

CAPE GIRARDEAU
1405 North Mount Auburn Rd.
Cape Girardeau, MO 63701
Phone: 573.335.PTOT (7868)
Fax: 573.335.8193

JACKSON
2480 East Main Street, Ste.
B Jackson, MO 63755
Phone: 573.204.PTOT (7868)
Fax: 573.204.1177

ADVANCE
33501 State Hwy 25
Advance, MO 63730
Phone: 573.722.9999
Fax: 573.722.3176

Patient Information Form

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

Nickname (if applicable): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____-_____-_____ Gender ☐ M ☐ F Age____ Date of Birth: ____-____-_____

Primary Phone: _____ Secondary Phone: _____

Work Phone: _____ Height: _____ Weight: _____

Email Address: _____

Employer: _____ Occupation: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Student

How did you make your decision to choose Premier Physical Therapy? (Please mark all that apply)
☐ Physician referral ☐ Friend/family: _____ ☐ Google ☐ Former Patient ☐ Website
☐ Physical Location ☐ Facebook ☐ Radio ☐ Mail ☐ Employee at Premier _____

Referring Doctor: _____ Next Dr. Appointment: _____

Primary Family Doctor: _____

Premier can take my picture and use it for marketing purposes. **Yes** ☐ **No** ☐

I would like to ALSO receive a text reminder prior to my appointment. Yes ☐ **No** ☐

I allow Premier Physical Therapy to… Please Circle: Text me / Call me / Both

T Shirt Size_____

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MEDICAL HISTORY FORM

Date of current episode of symptoms/injury/illness: _____
Have you ever had physical therapy before? ☐ Y ☐ N For this condition? ☐ Y ☐ N
If yes, where? _____ When? _____

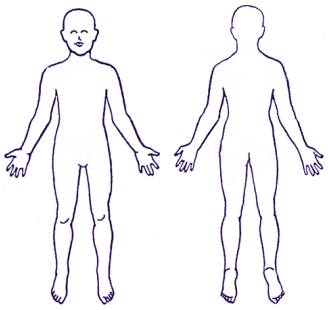
HEART DISEASE	Yes	No
Heart Attack	☐	☐
Do you have a pacemaker?	☐	☐
LUNGS	**Yes**	**No**
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐
BLOOD PRESSURE	**Yes**	**No**
Hypertension	☐	☐
Low Blood Pressure	☐	☐

OTHER CONDITIONS	Yes	No
Rheumatoid Arthritis	☐	☐
Epilepsy	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Fainting	☐	☐
Active Cancer	☐	☐
Dementia	☐	☐
Bipolar	☐	☐
Depression	☐	☐

Have you ever had any of the following? ☐X-ray ☐Bone Scan ☐CT ☐ MRI ☐ Myelogram ☐
For this condition? ☐X-ray ☐Bone Scan ☐CT ☐ MRI ☐ Myelogram ☐
Have you had any surgeries related to this episode? ☐ Yes ☐ No
If yes, please list: _____

Are you allergic to any medications? Yes___ No___ If yes, what? _____
My chief complaint is: _____ Date of onset: _____
My goal for therapy is: _____
Tobacco use:

1. _____ I have used tobacco in the last 12 months.
2. _____ I have NOT used tobacco in the last 12 months.



Please circle on the scale below to indicate your CURRENT level of pain.
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please circle on the scale below to indicate your WORST level of pain.
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please indicate on the figure above the location of your current complaints.

X _____ X _____
Patient/ Guardian Signature Date

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PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and the gain of your physical abilities is something we at Premier Physical Therapy take very seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed to ensure the most optimum results.

We expect you to keep all your appointments. We will write down your appointment times and dates for you, so you do not forget. We will also complete reminder calls the day before your scheduled appointment.

With the exception of SERIOUS emergencies, it is expected that you keep all your appointments. If you need to reschedule an appointment, we require a 24-hour notice. In such a case, please call our office and arrange for a make-up appointment with our front desk receptionist. The make-up appointment needs to be in the same week, preferable the very next day.

In an instance of cancellation without 24 hours notice, or a no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

Should you cancel or no-show for 3 appointments without proper notice or reasons considered not appropriate, you may be discharged from the therapy program.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you!

Dennis Riney, PT
Premier Physical Therapy

I have read and understand the above policy

Print Name_____

Signature _____ Date _____

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Liability Financial Policy

In an effort to keep our charges at a minimum while providing the highest quality of care that this practice is known for, the following policy had to be implemented:

#1 If you have **Health Insurance,** we can file the charges to your health insurance. You will be responsible for any co-pay or % that your health insurance does not cover. All co-pays are collected on the date of service.

#2 If you have **Work Comp** insurance.

#**3** If you have **Medicare.**

#4 If your treatment is due to an **Auto Accident,** we can file it through your auto insurance carrier, but we must run it through your primary insurance first. This is acceptable if the auto insurance will be paying the claim as it accrues and not delay payment until the case is settled. If your health insurance paid part or all of your claims and your auto case settles then, we will refund your health insurance and you if you made any payments to Premier Physical Therapy.

#5 If you have **No Insurance**(self-pay), payment is due at the time of service. This can be paid by cash, check, VISA, or Master Card. Our self-pay rate is $100 per visit.

I hereby authorize **Premier Physical Therapy** to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist all payment for services rendered. I understand that I am responsible for all charges, even those not paid for by my insurance. I understand that by signing, I am giving my permission for treatment. I also authorize **Premier Physical Therapy** to contact the insurance commissioner on my behalf to assist me in receiving my full insurance benefits, if deemed necessary. I have read the above statement and fully understand my options. The option that I believe will handle my situation in the most optimal way would be Option # _____

X _____ X _____

Patient/ Guardian Signature Date

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Release of Medical Information (HIPAA)/Emergency Contact

Please list anyone that you authorize to share your physical therapy information with. This medical information may be used by the person you authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as you may direct.

1. _____Relationship: _____ Phone # _____

2. _____Relationship: _____ Phone # _____

3. _____Relationship: _____ Phone # _____

I understand that I have the right to revoke this authorization, in writing, at any time.. Please sign below authorizing the above individuals to have access to your physical therapy medical and billing information.

Print Patient Name: _____

Patient Signature: _____ Date: _____

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Medication List

ALL SECTIONS MUST BE FILLED OUT PER INSURANCE GUIDELINES

Medication Name	Dosage	Frequency	Route of Administration (How is medicine taken?)	Name of doctor ordering this medication

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Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle to indicate your answer.	*Not at all*	*Several days*	*More than half the days*	*Nearly everyday*
1. *Little interest or pleasure in doing things.*	0	1	2	3
2. *Feeling down, depressed, or hopeless.*	0	1	2	3
3. *Trouble falling or staying asleep or sleeping too much.*	0	1	2	3
4. *Feeling tired or having little energy.*	0	1	2	3
5. *Feeling bad about yourself or that you are a failure or have let yourself or let your family down.*	0	1	2	3
6. *Poor appetite or overeating.*	0	1	2	3
7. *Trouble concentrating on things, such as reading or watching TV.*	0	1	2	3
8. *Moving or speaking so slowly that other people could have noticed. Or the opposite being fidgety or restless that you are moving around more than usual.*	0	1	2	3
9. *Thoughts that you would be better off dead or hurting yourself.*	0	1	2	3

Add columns ___ + ___ + ___

Total: _____

10 If you checked off any problems, how difficult have these problems made it for you to do your work, that care of things at home, or get along with other people?

Not difficult at all _____ *Somewhat difficult* _____
Very difficult _____ *Extremely difficult* _____

Patient Name: _____ *Date:* _____

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VULNERABILITY TO ABUSE SCREENING SCALE (VASS)

1. Are you afraid of anyone in your family? Yes ____ No ____
2. Has anyone close to you tried to hurt you or harm you recently? Yes ____ No ____
3. Has anyone close to you called you names or put you down or made you feel bad recently? Yes ____ No ____
4. Do you have enough privacy at home? Yes ____ No ____
5. Do you trust most of the people in your family? Yes ____ No ____
6. Can you take your own medication and get around by yourself? Yes ____ No ____
7. Are you sad or lonely often? Yes ____ No ____
8. Do you feel that nobody wants you around? Yes ____ No ____
9. Do you feel uncomfortable with anyone in your family? Yes ____ No ____
10. Does someone in your family make you stay in bed or tell you you're sick when you know you're not? Yes ____ No ____
11. Has anyone forced you to do things you don't want to do? Yes ____ No ____
12. Has anyone taken things that belong to you without your OK? Yes ____ No ____

Patient Name: _____ Date: _____