# Patient Case Information

(Please Fill Out Forms Completely & Print)

(IF PATIENT IS UNDER 18 YEARS OF AGE LEGAL GUARDIAN MUST SIGN ALL PAPERWORK)

**Patient Name:**

(Last)_____ , (First) _____ (Middle Initial)_____

**Address:** _____

City: _____ State: _____ Zip Code: _____

**Primary Phone:** _____ Mobile Phone :_____

Work Phone: _____ Email Address: _____

**Date of Birth:** _____ /_____ /_____ **SS#:** _____-_____-_____

**Sex:** ☐ Male ☐ Female **Marital Status:** ☐ M ☐ S ☐ D ☐ W

**Emergency Contact:**

(Last)_____ , (First) _____

Relationship: _____Phone: _____

**Employment Status:** ☐ Student ☐ Working ☐ Retired ☐ Homemaker ☐ Unemployed

Employer: _____ Type of work: _____

**Problem** (Injured Region(s) of Body): _____

**Date of Injury:** ____/____/_____ (**Required:** Date is mandatory to trigger your insurance coverage)

**Referring Physician:** _____ Date of Physician visit: _____

Primary Care Physician:_____

Condition Related To: ☐ Employment ☐ Auto Accident ☐ Other Injury _____

Attorney: Yes ☐ No ☐ Attorney Contact: _____

Are you receiving **ANY HOME HEALTH SERVICES** or do you have a **nurse** that comes to your home?

_____

Do you receive occupational health or speech therapy services?

_____

**How did you find Wheat Physical Therapy:** ☐ Doctor ☐ Friend ☐ Family ☐ Yelp ☐ Google ☐ Facebook ☐ Former Patient ☐ Lecture ☐ Walk by ☐ Other_____

**Patient / Guardian Signature:** _____ **Date:**_____



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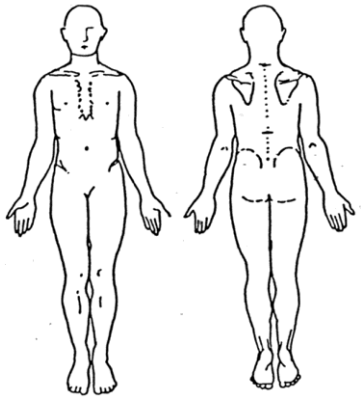
# Functional & Symptom Questionnaire

Are your symptoms? ☐ improving, ☐ becoming worse, or ☐ staying the same?

**A. (Please Circle or Mark Painful or injured areas)**



**B. Pictorial Pain Assessment Scale:**

Which one of the following best describes your pain? (Patient can reply by circling the words, numbers or pictures.

| | Scale | |
|---|---|---|
| No pain | 0 | |
| | 1 | |
| Mild, annoying pain | 2 | |
| | 3 | |
| Nagging, uncomfortable, troublesome pain | 4 | |
| | 5 | |
| Distressing, miserable pain | 6 | |
| | 7 | |
| Intense, dreadful, horrible pain | 8 | |
| | 9 | |
| Worst possible, unbearable, excruciating pain | 10 | |

**Patient / Guardian Signature:** _____ **Date:**_____



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# Medical History

| Past | Current | | Region & Date | |
|---|---|---|---|---|
| ☐ | ☐ | Physical Therapy | ☐ | Acupuncture _____ |
| ☐ | ☐ | Ergonomics Evaluation | ☐ | CT Scan _____ |
| ☐ | ☐ | Chiropractic | ☐ | MRI _____ |
| ☐ | ☐ | Emergency Room Care | ☐ | Bone Scan _____ |
| ☐ | ☐ | Massage Therapy | ☐ | X-Rays _____ |

Please list any surgeries/procedures you have had for this injury: _____
Days a week do you perform physical activity? _____
Are you aware of your diagnosis and prognosis as explained by your doctor? ☐ Yes ☐ No
**Please list (or attach) the names of any current medications (prescribed and over the counter):**

Pharmacy:_____
Do you currently have or have past medical history of any of the following; Mark/Circle if necessary:

| | | |
|---|---|---|
| ☐ Asthma, | ☐ Congestive Heart Failure | ☐ Back Injury/Surgery |
| ☐ Bronchitis, or | ☐ Hernia | ☐ Osteoporosis |
| ☐ Emphysema | ☐ Blood Clot/ Emboli | ☐ Knee Injury or Surgery |
| ☐ Headaches | ☐ Varicose Veins | ☐ Gout |
| ☐ Shortness of Breath | ☐ Latex Sensitivities | ☐ Leg/ Ankle Injury/Surgery |
| ☐ Lung Problems | ☐ Allergies | ☐ Broken Bones/ Fractures |
| ☐ Chest Pain | ☐ Allergies Tapes/Lotions | ☐ Pain with sneezing |
| ☐ Visual Difficulties | ☐ Thyroid Disease | ☐ Pregnant(Current/ Past) |
| ☐ Hearing Difficulties | ☐ Goiter | ☐ Depression |
| ☐ Coronary Heart Disease | ☐ Pins or metal implants | ☐ Tobacco |
| ☐ Angina | ☐ Anemia | ☐ Hypoglycemia |
| ☐ Pacemaker | ☐ Shoulder Injury/Surgery | ☐ Fibromyalgia |
| ☐ Dizziness or Fainting | ☐ Infectious Disease | ☐ Chronic Pain |
| ☐ High Blood Pressure | ☐ Neck Injury/Surgery | ☐ Eating Disorders |
| ☐ Bowel / Bladder Problems | ☐ Diabetes | ☐ Head Injuries |
| ☐ Heart Attack | ☐ Kidney Problems | ☐ Neurological Deficits |
| ☐ Heart Surgery | ☐ Liver Problems | ☐ Metal Implants |
| ☐ Weakness | ☐ Joint Replacement | ☐ Other: |
| ☐ Stroke | ☐ Cancer | _____ |
| ☐ Seizures/Epilepsy | ☐ Elbow/Hand Injury/Surgery | |
| ☐ Weight Loss/ Fatigue | ☐ Arthritis | |

Please list any other information that you believe would assist the therapist in your care:
_____

What are your rehabilitation expectations and goals in this program other than pain relief?
_____

**Patient / Guardian Signature:** _____ **Date:**_____



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## *Consent for Treatment*

I agree to give my consent for *Lori L Wheat, PT, OCS, INC.* to furnish rehabilitation services considered necessary and proper in the treatment for my physical condition.

**Name of Patient:** _____
(Please print complete name)

## *Authorization for Disclosure of Medical Records*

I authorize *Lori L Wheat, PT, OCS, INC.* to release copies of the physical therapy record and billing statements to my insurance company for the purpose of billing for the services rendered.

## *eMail Privacy Statement*

Wheat Physical Therapy's Therapists like to stay in close contact with patients. We will be using secure email at times during your treatment to send pertinent information regarding your account, recovery, exercise pictures, and program progress. Our office is committed to your privacy and will not sell, disseminate, or give your email address to 3rd parties.

## *Information Privacy Statement*

*Lori L Wheat, PT, OCS, INC will* use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution upon request. The undersigned acknowledges receipt of this information.

I understand and agree to *Consent for Treatment*, *Authorization for Disclosure of Medical Records*, *and the Information Privacy Statement* above:

**Patient/ Guardian** _____ **Date:** ___/___/___



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## *Financial Policy Statement*

*Lori L Wheat, PT, OCS, INC* will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. If your insurance company does not remit payment within 60 days, the balance will be due in full from you. If payment for services is made directly to you, you must promptly remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance per your insurance contract.
**Co-Pays are always due at the time of service as described in your insurance policy**.

## *Billing Policy for Wheat Physical Therapy*

If we are billing your insurance company please contact your insurance company for information regarding your physical therapy benefits. As a courtesy our office staff will verify insurance coverage, but this is not a guarantee. It is the patient's responsibility to confirm benefits with their insurance company prior to the first physical therapy appointment. *(Ask our front office if you have questions).*

## *Balances owed to Wheat Physical Therapy*

- Balances unpaid after 30 days will accrue a $35.00 fee each billing cycle.
- Balances unpaid after 60 days must have payment arrangements with our billing office.
- Balances unpaid after 91 days will be turned over to our collection agency.

*Checks returned with non-sufficient funds will be charged a $35.00 fee.

## *Primary and Secondary Insurance Information*

**PRIMARY:**

Name of Insured: _____ Patient Relationship to Insured:_____

Date of Birth of Insured:_____

Insurance Company Name: _____ Phone #: _____

Policy No.: _____ Group No.:_____

**SECONDARY:**

Name of Insured: _____ Patient Relationship to Insured_____

Date of Birth of Insured: _____

Insurance Company Name: _____ Phone #: _____

Policy No.: _____ Group No.:_____


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## *Wheat Physical Therapy Cancellation/ No-Show Policy*

- Wheat Physical Therapy appointments scheduled represent time set aside specifically for you as a patient. All cancellations must be made at least **24 hours** prior to the scheduled visit. Patients who cancel or No-show on three separate occasions will be allowed to schedule additional appointments only at the discretion of the primary physical therapist.

- By law, all cancellations, and No-shows involving Worker's Compensation claims must be reported to your physician and your claims adjuster.

- **All Cancellations (less than 24 hour notice) and No-show appointments will be charged a fee of $30.00 to your account. This fee is due before or at the time of your next physical therapy visit.**

I understand that my insurance company does not guarantee payment and I am financially responsible for all charges incurred with *Lori L Wheat, PT, OCS, INC*. I understand and agree to the financial policy statement, billing policy statement, and cancellation policy.

**Patient/ Guardian** _____**Date:** ___/___/___

## *Appointment Reminder Consent*

Complete this form and sign below to give your permission for Wheat Physical Therapy to provide you with appointment notifications. **By default, our appointment reminder notifications are sent via text message to the cell phone number you provided .** If you would prefer a phone call or email reminder instead, please fill out the following information.

☐ **Email:** Wheat Physical Therapy may send email messages to confirm my upcoming appointment to _____ .

☐ **Phone:** I prefer to receive phone call reminders at this phone number_____ .

***Our cancellation list notifications will also be sent via text, unless specified above.**

**Patient / Guardian Signature:** _____**Date:**_____



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