E6 PHYSICAL THERAPY PAST MEDICAL HISTORY FORM

Patient name:_____ Today's date:_____

Doctor's name referring you to physical therapy:_____
Date of next doctor visit?_____
How long have you had these symptoms/injury?_____
Are you presently working? Y N
Have you had these symptoms before? Y N
Have you had recent surgery for these symptoms? Y N Surgeon's name:_____
Do you smoke? Y N
Do you participate in any sports, exercise programs or activities on a regular basis? Y N

Have you had any diagnostic testing for these symptoms?

☐ X-ray Date:_____ ☐ CT Scan Date:_____

☐ MRI Date:_____ ☐ Injections Date:_____

☐ EMG/NCV Date:_____

Check the item that best describes how your symptoms occurred:

____Work related injury ____Motor vehicle accident ____Lifting injury
____Athletic/recreational injury ____Unknown ____Other (explain)_____

Please check if you have, or ever had any of the following:

☐ Diabetes	☐ Chest Pain/Angina	☐ Stroke (CVA)/TIA
☐ Heart Attack	☐ Heart Palpitations	☐ Allergies to aspirin
☐ Seizures	☐ Heart Disease	☐ Allergies/poor tolerance to heat/cold
☐ Hernia	☐ Pacemaker	☐ Other Allergies
☐ Cancer	☐ High Blood pressure	☐ Metal Implants
☐ Headaches	☐ Asthma/Breathing difficulties	☐ Skin Abnormalities
☐ Recent Fractures	☐ Dizziness/Fainting	☐ Sexual Dysfunction
☐ Nausea/Vomiting	☐ Rheumatoid Arthritis	☐ Bladder/Bowel Abnormalities
☐ Surgeries	☐ Kidney problems	☐ Liver/Gallbladder problems
☐ Ringing in your ears	☐ Special Diet guidelines	Are you currently pregnant? Y N

Are you currently taking medication? Y N
If yes, give name & the condition it's for:

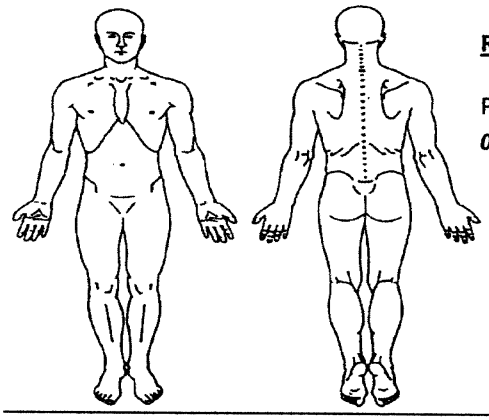
_____
_____
_____
_____
_____

Is there any other information about your past medical history that we need to know?

_____
_____
_____
_____
_____

Pain / Symptoms:

On the Body Diagram, indicate your region of pain using the symbols below.
(X) : Sharp (+): Numb/Tingling (#): Dull/Aching (B): Burning



Rate your Pain:

Pain Level (0-10):_____
0=No Pain & 10= Emergency Room

_____
Patient or Guardian Signature & Relationship to the Patient

_____
Date of Signature

E6 Physical Therapy

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your claim with your insurance company; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical, occupational or speech therapy coverage. Many insurance companies have stipulations that limit the benefit in some way, such as sessions, supplies, deductibles, co-pays, etc. These stipulations should be noted in your policy manual. ***Please see E6 Physical Therapy's Financial Notice for further information regarding the benefits we were quoted.***

SUPPLIES POLICY

Payment for all supplies not covered by insurance is due at the time of service.

MEDICARE PATIENTS: Medicare does not cover supplies. You are responsible for payment for all supplies used in your treatment at the time of each visit.

ITEMS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly. WORKER'S COMPENSATION benefits will be verified; however, this does not guarantee payment. In the event of a denial, this account will become YOUR RESPONSIBILITY.

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to E6 Physical Therapy. A representative for E6 Physical Therapy will describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. ***By signing this agreement, I consent to have E6 Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.***

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of E6 Physical Therapy. I hereby authorize E6 Physical Therapy to furnish my insurance company(s), attorney, or legal representative all information that said parties might request concerning my present illness or injury. I hereby assign E6 Physical Therapy all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to E6 Physical Therapy. I also designate E6 Physical Therapy as an authorized representative to act on my behalf to appeal any denials of benefits and to pursue any remedies otherwise available under law, including under ERISA (Employee Retirement Income Security Act). It is understood that any money received from the above named parties over & above my indebtedness will be refunded to me when my bill is paid in full. ***I am financially responsible to E6 Physical Therapy for charges not covered by my insurance company. By signing this document, I, the undersigned, have read the above items, understand the above items and agree to the items as outlined above.***

Patient Name ***(please print)***: _____

Signature & Relationship to Patient ***(self, parent or legal guardian)***: **Date:**

BUSINESS DISCLOSURES TO INDIVIDUALS INVOLVED IN THE ABOVE NAMED PATIENT'S CARE

I, _____, authorize E6 Physical Therapy to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

EMERGENCY CONTACT INFORMATION

Name: **Relationship to Patient:** **Phone#** ***(incl Area Code)***: **( )**

E6 Physical Therapy

WELCOME TO E6 PHYSICAL THERAPY

It is our mission to help you reduce pain, improve mobility and strength, and return to work and/or recreational activities as quickly as possible.

Listed below are a few items that we would like to make you aware of during your visit(s).

ATTENDANCE - Your medical care is very important to us and your physical therapy visits are based upon your physician's orders and the treatment plan that we create for you. Therefore, it is important that you attend your scheduled follow-up visits as recommended by your doctor and physical therapist. Attending your follow-up visits ensures that we are able to oversee your progress and modify your regimen in response to your improvement. ***Failing to attend your follow-up visits ensures that the rehabilitation process and your progress will be delayed.***

If you are unable to attend an appointment, you must notify our office 24 hours in advance and reschedule to make up for the missed appointment. ***Failure to give a 24 hour advance notice to cancel an appointment will result in a CANCELLATION FEE of $25.00 to be paid on your next scheduled appointment*** (cash, check or credit card are accepted forms of payment). Your insurance company will not pay for cancellation fees. ***2 consecutive missed appointments will result in discharge from our facility and your physician will be notified.***

Worker's Compensation Patients only – please be aware that your physician, employer, case manager/insurance adjustor will be notified of cancellations/no shows and this in turn could be detrimental to your worker's compensation claim.

HOME EXERCISE - You will receive a Home Exercise Program that has been individually tailored to you and your specific condition. It is very important that you perform your exercise program exactly as your therapist has outlined. It is our experience that patients who perform their exercise program improve at a faster rate and report a greater level of satisfaction with their overall recovery. Please feel free to ask your therapist if you have questions about your exercises as they are the most important part of your recovery. We look forward to partnering with you through the process of rehabilitation and are excited to provide you with the skills necessary to meet your goals.

CELL PHONE/PAGERS

In order to maintain an atmosphere with minimal distractions, we ask that all cell phones are turned to vibrate and ***if you need to make/take a call, please step outside of the office.***

MUSIC - We believe that upbeat music is an integral part of the rehabilitative process by creating a positive environment and to motivate and facilitate exercise.

GUESTS – Guests and children are to stay in the reception area during your treatment, however, if you have a concern, please speak to you therapist. ***An adult must remain with children at all times and quietly supervise them.*** Please understand that this policy is in place to promote safety for you, your guests, and children.

By signing this document, I, the undersigned, have read the above items, understand the above items and agree to the items as outlined above.

Patient Name *(please print)*: _____

Signature & Relationship to Patient *(self, parent or legal guardian)*: **Date:**

WORKER'S AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)

I, (Print Worker's Name) _____, hereby authorize the health care provider (HCP) – (the name of HCP is optional and not required for release of medical information) (Print Health Care Provider's Name) ___26 PHYSICAL THERAPY___ the use or disclosure of my health information as described in this authorization.

1. **INFORMATION** WCA No. _____

Date of Birth _____ Date of Injury _____ SSN _____

Address _____ Phone _____

Worker's representative, if any: _____ Phone _____

Address: _____

2. **RELEASE**

I authorize the Health Care Provider (HCP) or any member or employee of its office or association who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment, to my employer, _____, and/or its insurance carrier, _____, and/or their attorneys, and/or duly authorized representatives of the New Mexico Workers' Compensation Administration and its current medical cost containment contractor or their duly authorized agents. Copies of all documentation released pursuant to this authorization shall be sent to the agency requesting the information and to me or my representative as listed above.

3. I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: medical reports; clinical notes; nurses' notes; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession. This Authorization also includes, if applicable, any hospital operational logs, emergency logs, tissues committee reports, psychiatric reports and records, physical therapy records, and all outpatient records. This release may also be used to request a Form Letter to HCP as approved by the Workers' Compensation Administration. I understand that I have the right to restrict the information that may be provided by signing this authorization to the extent provided by law.

CONDITIONS

4. I understand the purpose of this request is to determine the proper level of workers' compensation benefits and may include information regarding any of the following: to determine my occupational injury or illness status; to determine my eligibility for workers' compensation benefits; to determine my current and future medical status after occupational injury; to determine my current medical status and/or return-to-work capability.

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying the company named in Paragraphs 1 and 2. I understand that the revocation is only effective after it is received and logged by that company and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive occupational injury or workers' compensation benefits governed by this revocation.

6. I understand that after this information is disclosed, the recipient may continue to use it pursuant to my prior authorization, regardless of my subsequent revocation of this authorization. I further understand that different protections may be available pursuant to state and federal law.

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to WCA and its current medical cost containment contractor or their duly authorized agents.

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization ☐ Yes ☐ No - If Yes, I have received a copy _____ (initial)
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature of Employee _____ Date _____

Personal Representative Section:

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation): _____
_____.

Signature of Personal Representative _____ Date _____