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:

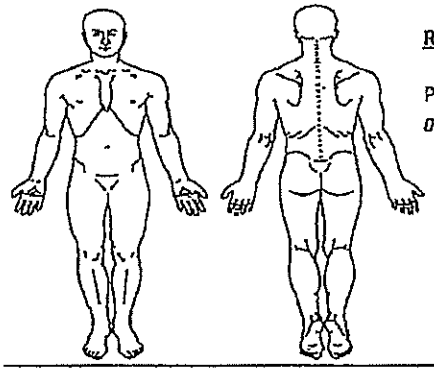
_____
_____
_____
_____
_____

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)*: **( )**

COVID-19 RISK INFORMED CONSENT

I understand the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing.

I understand even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment. I understand possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.

I recognize E6 Physical Therapy, LLC and all staff are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with treatment.

I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19. I would like to proceed with my desired treatment.

Patient's full name (printed):_____

_____ _____

Signature of Patient or Person Authorized to Sign for Patient Date/Time

_____ _____

Witness Signature Date/Time

I have been offered a copy of this consent form (patient's initials) _____

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.
- ***Failure to give 24-hour advance notice to cancel an appointment may result in a CANCELLATION FEE of $25.00; your insurance company will not be billed for cancellation fees.***
- ***Failing to attend your follow-up visits not only delays your rehabilitation progress, but may also result in being discharged from our facility if 2 consecutive appointments are missed; your physician will be notified if you are discharged from physical therapy.***

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.

COVID-19 (Corona Virus) - In order to maintain your safety and the safety of other patients and our staff, the following items are required when you are in our facility:

- You must have your face mask on prior to entering our building.
- Other than your wallet and keys, all other personal belongings (**including your cellphone**), must be stored in your vehicle. Your wallet and keys will be placed in a locker and we ask that you only access them once your appointment is finished.
- You will be required to wash your hands prior to going back into the treatment areas.
- Your tempurature and oxygen saturations will be taken prior to starting your treatment.
- You should come alone to your appointment and if anyone has to come with you, we ask that they wait in your vehicle.
- **Prior to your appointment and/or prior to entering our building, if you are experiencing symptoms of fever, cough, or shortness of breath, please call our office at (505) 830-3678.**

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.

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 of Patient/Legal Guardian & Relationship to Patient Date:
(self, parent or legal guardian)

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) Ele 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 _____