PHYSICAL THERAPY & SPORTS MEDICINE CENTERS

PT for life A PTSMC affiliate

Name: ______________________________________ **Primary Care Physician:**_____________________________

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in appetite
- ❑ changes in bowel or bladder function
- ❑ difficulty maintaining balance while walking
- ❑ difficulty swallowing
- ❑ dizziness/lightheadedness
- ❑ fever/chills/sweats
- ❑ headaches
- ❑ nausea/vomiting
- ❑ pain at night
- ❑ shortness of breath
- ❑ weakness/fatigue
- ❑ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ anemia
- ❑ asthma
- ❑ cancer (type)_____________________
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ diabetes: Circle One: Type 1 / Type 2
- ❑ epilepsy
- ❑ heart disease
- ❑ high blood pressure
- ❑ kidney/liver problems
- ❑ lung problems
- ❑ multiple sclerosis
- ❑ osteoporosis
- ❑ pacemaker inserted
- ❑ Parkinson's disease
- ❑ rheumatoid arthritis
- ❑ stomach ulcers
- ❑ stroke
- ❑ thyroid problems
- ❑ other_________________
- ❑ other_________________

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Is this something with which you would like help? YES YES, but not today NO

Do you smoke? YES NO ______ pack/day

Height:____________________ **Weight:** ___________________

Have you completed a COVID-19 vaccination series? YES Date of Completion ______________ NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

ALLERGIES: ____
Are you latex sensitive? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. ____________________________ 2.______________________________ 3.________________________________

For the injury you are seeing us for today:

Pain at LOWEST: Rate your lowest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain now.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

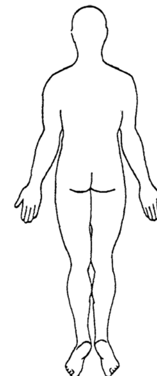
Pain at WORST: Rate your highest pain level IN THE PAST 3 DAYS.

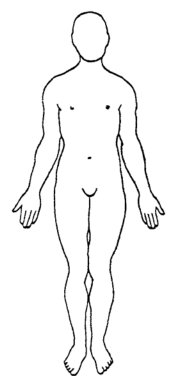
0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning





What is your goal for therapy at this time?_ ____

Patient/Guardian/Responsible Party Signature:____ **Date:**_______________

CONSENT FOR CARE & TREATMENT

I agree and give my consent for ANB-PTSMA Holdings Inc, doing business as ***Physical Therapy and Sports Medicine Centers (PTSMC),*** to provide medical care and treatment that is considered necessary and proper in diagnosing or treating my physical condition.

RELEASE OF INFORMATION - FINANCIAL RESPONSIBILITY

I authorize Physical Therapy and Sports Medicine Centers, to release all information necessary, including medical records, to secure payment. I authorize ***PTSMC*** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to ***PTSMC*** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between ***Physical Therapy and Sports Medicine Centers*** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third-party payer. I agree to inform PTSMC immediately if my insurance benefits change, including a change in carrier or benefits. I understand that I am responsible for balances as a result of my failure to inform PTSMC of a change in benefits. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I acknowledge that there will be an additional $45.00 fee for any checks returned to ***PTSMC*** for insufficient funds. I further acknowledge that there will be a 15% charge added to any delinquent balance that is my responsibility and requires the services of an outside collection agency.

I understand that the above may not apply if I am covered by Worker's Compensation insurance. I understand that if my Worker's Compensation claim and Worker's Compensation benefits are subsequently denied I may be held responsible for the total amount of charges for services rendered to me.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the ***PTSMC*** Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to ***PTSMC*** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and ***PTSMC*** will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicate below who *PTSMC* may speak to regarding your treatment. Please list name and phone number.
Name _________________________________
Phone # _______________________________

Do we have your permission to leave a confidential message at the phone number you provide us?
☐ **Yes - Phone #** ________________________
☐ **No**

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand, and agree to the terms and conditions contained in this consent form including:

Consent for Care and Treatment
Consent to Release of Information and Financial Responsibility
Consent for Use and Disclosure of Health Information
Consent that I have received an electronic copy of the Notice of Privacy Practices*

Patient (Age 18 or older) or Parent /Guardian____

Date: __________________

**If you wish to receive a paper copy of the Notice of Privacy Practices please request one from the front desk staff.*

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Patient Name: ___________________________ **Date:** ______________

Current List of Medications: Please list your current medications, the dosage, frequency and form.

❑ **See Attached List of Medications**

Medication & Dosage	Frequency & Form (pill, injection, spray, inhalant)

Rev 102018
Rev 102015
Rev 082011 WebPT Avon
Rev 01/2011
1/2009