Premier® PHYSICAL THERAPY

Past Medical History Form

Patient Name _____ Date _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: _____

Date of Injury/Surgery: _____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your current condition:

☐ Work-related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other _____
☐ Cause unknown ☐ Athletic / recreational injury

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest pain / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Nausea / Vomiting	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Ringing in your ears	☐	☐
Urine leakage	☐	☐	Rheumatoid Arthitis	☐	☐
Asthma / Breathing Difficulties	☐	☐	Stroke / CVA	☐	☐
Liver / Gallbladder Problems	☐	☐	Hypoglycemia	☐	☐
Smoking	☐	☐	Depression	☐	☐
Other _____	☐	☐	Anxiety	☐	☐

If yes on any of the above, please briefly explain and give approximate dates

_____

_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

List current medications (prescriptions, over the counter, herbals, vitamin/mineral/dietary supplements) including name, dosages, frequency and route.

_____

_____

_____

_____

_____

_____

_____

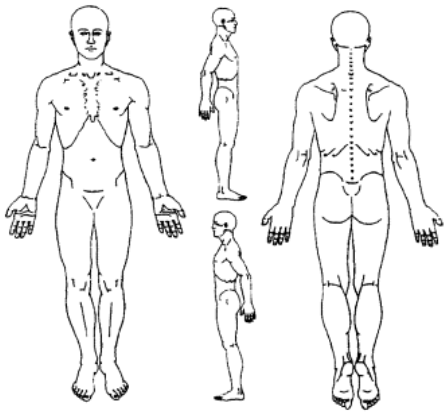
In the rare instance of an emergency whom should we contact?

Name_____

Phone( )_____

Do you participate in any sports, exercise programs or activities on a regular basis? □ Yes □ No

Please indicate on the picture below where your symptoms are located:



Numeric Pain Rating Scale

1. How would you rate your pain RIGHT NOW.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

2. How would you rate your USUAL level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

3. How would you rate your BEST level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

4. How would you rate your WORST level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

_____ _____ _____ _____

Patient's Signature Date Signature of Guardian if patient is a minor Date

_____ _____

Therapist Signature Date

PREMIER ORTHOPAEDIC AND SPORTS MEDICINE ASSOCIATES, LTD.
PATIENT FINANCIAL POLICY

Premier Orthopaedic and Sports Medicine Associates., Ltd. ("Premier") appreciates the confidence you have shown in choosing us to provide for your rehabilitation needs. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Premier participates with a variety of insurance plans. However, it is your responsibility to:

    1. Bring your insurance information at the time of your visit.

    2. Pay any co-payment, deductible, or coinsurance responsibilities at the time of the service or upon billing. For your convenience we accept cash, checks or credit cards (i.e.; VISA and Mastercard)

- As a courtesy, we will verify your primary insurance carrier and file a claim with your insurance, for services rendered. If any amounts are denied or unpaid, they will be billed to you. Since the relationship is between you, the subscriber, and your insurance carrier, you will be responsible for obtaining payment after that point. Payment of any outstanding amount will be expected from you.

- If you have insurance with which we do not participate, our office is happy to file the claim upon request, however, payment in full is expected at the time of service.

- If you elect to continue receiving services from Premier past the time period that your insurance approves such therapy, you will be responsible for payment of those fees.

- Referrals: It is your responsibility to obtain/secure any required referrals/authorization numbers at, or prior to your exam. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.

- Our facility attempts to accommodate patients' appointments by scheduling at their convenience, but requests that you give us at least 24 hours' advance notice if you are cancelling an appointment. Premier reserves the right to charge a fee of $25.00 for any missed appointments ("No-Show") and appointments which are not cancelled with 24 hours' advance notice. Generally, No-Show fees are not covered by insurance and it will be your responsibility to pay such fees prior to your next appointment.

- If you have any questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (the contact information is generally found on your insurance card) or your employer's human resource department.

Premier firmly believes that good patient relationships are based upon understanding and good communication. By signing below, you agree: (1) that you have read the above policy regarding financial responsibility; (2) to your responsibility under the policy; (3) authorize and direct Premier to furnish any and all information and record of treatment and services rendered to you related to a claim to your primary insurance carrier.

Patient Name: _____

Patient Signature: _____ **Date**: _____

Patient's Representative: _____ **Date**: _____
(If patient is a minor or if authorized by patient)

PREMIER ORTHOPAEDIC AND SPORTS MEDICINE ASSOCIATES, LTD.
CONSENT TO TREATMENT FOR PHYSICAL THERAPY

I consent to physical therapy evaluation and treatment by a licensed physical therapist employed by or contracted with Premier Orthopaedic and Sports Medicine Associates, Ltd.

I can expect the physical therapist to explain to me the purpose of the evaluation and proposed treatment plan. I understand physical therapy involves the manual application of specialized techniques to specific areas of the body to trigger a therapeutic response. Physical therapy almost always includes exercise, and can include stretching, core exercises, weight lifting, and walking. My physical therapist may also use techniques such as heat, cold, water, ultrasound, and electrical stimulation. Beneficial effects associated with physical therapy include decreased pain, improved mobility, and increased flexibility and strength. Physical therapy generally is considered safe, but as with most types of health care, there are associated risks. The most commonly reported reactions include soreness, discomfort, and swelling as the body rehabilitates and recovers. Rare, but medically significant, risks associated with physical therapy include, but are not limited to, falls or accidents during physical therapy that can lead to further injury. I also understand that it is possible that I will feel no improvement in my condition after physical therapy.

I acknowledge that I have read and fully understand this patient consent form and have had the opportunity to have questions answered by my physical therapist. I, hereby, consent to physical therapy treatment. I understand my consent may be revoked verbally or in writing at any time. If the patient is a minor the patient's personal representative understands that his/her consent is ongoing in the event that he/she chooses not to accompany the minor to his/her physical therapy sessions in the future.

_____	_____	_____
Name of Patient	Signature of Patient	Date
_____	_____	_____
Name of Personal Representative *(If patient is a minor or if authorized by patient)*	Signature of Patient Representative	Date

Acknowledgement of Receipt of Privacy Notice (HIPAA)

I acknowledge that I received or was offered the Notice of Privacy Practices for Premier Orthopaedics & Sports Medicine Assoc.

Patient Signature:_____ **Date**:_____

Patient's Representative:_____ **Date**:_____

Billing Disclosures to Individuals Involved in Patient's Care (HIPAA)

I authorize Premier to disclose my health information that is directly related to my current treatment to the individuals listed below for purposes of their role in my payment for the health services I have rendered.

Name of Individuals:	Relationship to Patient:
_____	_____
_____	_____