SHEPARD THERAPY CENTER

Patient Information

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security #: ____/____/____ Male/Female: _____

Cell #: (____) _____ Home #: (____) _____

Employer: _____ Work #: (____) _____

Preferred Name (Nickname): _____ Best number to call: _____

An appointment reminder is sent to you from an automated system. Would you prefer a text message, a call to your cell phone, or a call to your home number? _____

Who is your primary physician? _____ Phone #: (____) _____

Emergency Contact: _____ Phone #: (____) _____

How did you hear about us? _____

If Patient is a Minor

Guarantor's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ SS#: ____/____/____ Relationship: _____

Cell #: (____) _____ Work #: (____) _____ Home #: (____) _____

RELEASE OF INFORMATION AUTHORIZATION

___ I authorize the release of any information including diagnosis, records, examination finding and claims information to the following (list out names):

Spouse: _____

Child(ren): _____

Other: _____

The release of information is for: ___ the duration of this condition/diagnosis only

___ all previous and future treatments

___ for treatment between the following dates

from: _____ to: _____

___ Information is not to be released to anyone at any time.

The Release of Information authorization will remain in effect until terminated by the patient in writing.

Patient or guardian signature: _____ Date: _____

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Medical History Form

Patient's Name: _____ Today's Date: ____/____/____

What is your daily activity level: _____ Sedentary _____ Light _____ Moderate _____ Heavy

If active, how often do you exercise, play a sport, or do other physical activity? _____

Do you have or have had any of the following:

Pacemaker	Yes	No	Rheumatoid Arthritis	Yes	No
Chest Pain	Yes	No	Osteoarthritis	Yes	No
Heart Disease	Yes	No	Osteoporosis	Yes	No
High Blood Pressure	Yes	No	History of Cancer	Yes	No
Kidney Problems	Yes	No	Metal Implants	Yes	No
Stroke	Yes	No	Ringing in Ears/Vertigo	Yes	No
Seizures	Yes	No	Dizziness	Yes	No
Bowel/Bladder Difficulties	Yes	No	Fainting	Yes	No
Asthma/COPD	Yes	No	Loss of Balance	Yes	No
Liver/Gallbladder Problems	Yes	No	Difficulty Walking	Yes	No
Diabetes – Type 1	Yes	No	Suspected Fractures	Yes	No
Diabetes – Type 2	Yes	No	Currently Pregnant	Yes	No
Tuberculosis	Yes	No	Nausea/Vomiting	Yes	No
Fibromyalgia	Yes	No	Sudden Weight Gain/Loss	Yes	No
Neck Problems	Yes	No	Current Infection	Yes	No
Back Problems	Yes	No	Sensitivity to Heat/Cold	Yes	No
Immunosuppression	Yes	No	Interrupted Sleep	Yes	No

Other medical condition(s): _____

Previous surgeries and dates: _____

Please list ALL allergies: _____

Please list ALL medications and OTC supplements you are taking: _____

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Pain/Injury Questionnaire Form

Patient's Name: _____ Today's Date: ____/____/____

What is the reason for today's visit? _____

How did injury/accident/condition occur? _____

Date injury/accident/condition started? _____

Did you have an X-ray for this injury? Yes/No Date of X-ray: _____ Where: _____

Did you have an MRI for this injury? Yes/No Date of MRI: _____ Where: _____

If X-ray/MRI, do you know the results? Yes/No Results: _____

Did you have surgery for this injury? Yes/No Date of surgery: _____

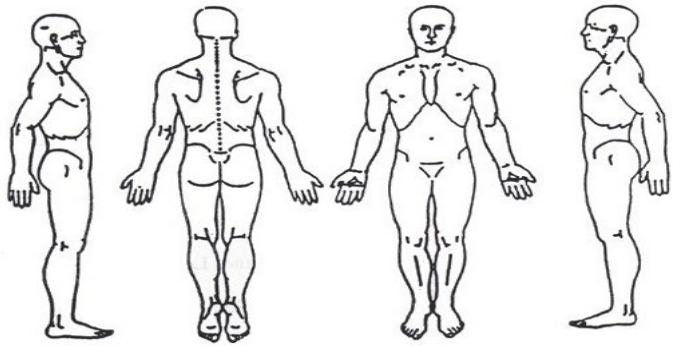
Is this injury due to a car accident? Yes/No Date of car accident: _____

Is this injury a worker's comp case? Yes/No Date of work injury: _____

Have you previously been treated by another professional for this injury? Yes/No

If yes, circle which one(s): physical therapist, acupuncturist, massage therapist, or chiropractor

On the body diagram to the right, please indicate where your pain/injury is located by circling the area(s).



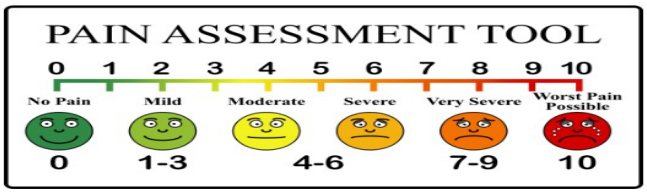
Based on your diagram above, mark each of the following that best describes your pain:

_____ Sharp	_____ Numbness	_____ Piercing	_____ Stabbing
_____ Dull	_____ Tingling	_____ Intermittent	_____ Burning
_____ Deep	_____ Superficial	_____ Shooting	_____ Aching

What makes this condition worse? _____

What makes this condition better? _____

Using the pain scale to the right, please answer the following regarding your pain level



The best it's ever been: _____ The worst it's ever been: _____ At this moment: _____

Please circle when the pain is worse: morning, afternoon, evening, constant, or inconsistent

Please circle if your symptoms are: improving, worsening, or remaining stable

What are your goals or expectations for your therapy treatment? _____

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Consent to Treat, Cancellation/No-Show, Billing, and HIPAA

Patient's Name: _____ Today's Date: ____/____/____

CONSENT TO TREAT

The purpose of Physical Therapy is to treat an injury or disability which is done so by examination by use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid in the patient in achieving their maximum potential and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. By signing below, you are providing consent for Shepard Therapy Center to provide treatment for you.

CANCELLATIONS/NO SHOWS/LATE POLICY

As a courtesy to Shepard Therapy Center and those patients coming in behind you, we ask that you arrive for your appointment 5 minutes before your scheduled time to complete your check-in and start your session on time. If you must cancel your appointment we require at least 24 hour notice before your scheduled appointment time. ***Late cancellations and no shows will result in a $50 fee.*** These fees are not covered by insurance and must be paid by the patient at the time of next appointment. If you are more than 15 minutes late to your appointment you may also be asked to reschedule your appointment or understand that your appointed time will be shorted to still end at its normal time if there is another patient scheduled to come in after you. ***If you miss 3 consecutive appoints, and do not notify us of a special circumstance that may be going on (extended illness, out of town), you will be discharged for non-compliance***. Our software system tracks these incidences and fees are **automatically** assessed to your account unless we are given proper notice to document in the system. Therapy only works when you show up for all your appointments. By signing below you are agreeing to the above terms and conditions.

BILLING

We will make every attempt to verify your insurance coverage before your appointment but quotes of benefits from your insurance provider does not guarantee payment. You are authorizing Shepard Therapy Center to bill your insurance provider directly per your insurance provider's plan and payments made by the insurance provider will be paid directly to Shepard Therapy Center. You are also authorizing Shepard Therapy Center to release medical or other billing information necessary to process any claims as outlined by HIPAA (Health Insurance Portability and Accountability Act of 1996) to our out-sourced billing company, Focus Medical Solutions. **Some insurance providers have deductibles or co-pays and it is your responsibility to know and meet the requirements of your insurance plan. ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE. If the insurance provider does not reimburse for services that were provided by Shepard Therapy Center, by signing below you understand that you are ultimately responsible for all charges not covered**.

HIPAA and RELEASE

The Healthcare Insurance Portability and Accountability act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy and/or use of your health information. We may use and disclose your medical records only for each of the following purposes:

Treatment: Providing, coordinating, or managing health care and related services by one or more health care providers.

Payment: For such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review.

Health Care Operations: Which include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

You understand that Shepard Therapy Center is not required to agree to the restrictions requested and that you may revoke your consent at any time in writing, except to the extent that the organization has already taken in reliance thereon. You also understand that by refusing to sign or revoking the consent this organization may refuse to treat you as permitted by Section 164.506 of the Code of Federal Regulations.

You also understand that Shepard Therapy Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations will send a copy of any revised notice to the address that is on file.

By signing below you understand that as part of Shepard Therapy Center treatment, payment, or healthcare operations, it may become necessary to disclose protected health information to another entity and you consent to such disclosure and accept the terms of this consent.

This consent was signed by: _____ Date: _____

Printed name: _____