RESTORE
PHYSICAL THERAPY

Thank you for choosing **RESTORE Physical Therapy. Our Mission** is: ***We Strive to Empower People to Live Healthy and Active Lives***. If you have any questions regarding your first appointment please visit our web site at www.restore-rehab.com and listen to the *First Visit* video or go to the FAQ section.

Our new patient appointments run on time, **please arrive 10 to 15 minutes prior** to your scheduled appointment, hand in your completed paper work and review your registration form. If you wait to complete your paperwork at our office, please arrive 30 minutes in advance. If you arrive exactly at your scheduled visit time for your first session, we may need to cut your session short if your paperwork is incomplete. Also, if you need to **cancel** or change your first appointment, please provide **at least 24 hours** notice so we can offer your scheduled time to another patient as your first appointment lasts 30 minutes to an hour with your physical therapist.

We look forward to participating in your care. Please see **RESTORE's** Promises and Expectations below.

We promise to:

- Welcome you into a caring, fun and professional environment.
- Listen with respect and respond to your concerns.
- Inform you the approximate cost of treatment in advance.
- Do our absolute best to keep your appointment on time.
- Perform our very best standard of physical therapy for you at all times.
- Make no charges for appointments changed or cancelled where 24 hours notice has been given.

We appreciate your commitment to:

- Arrive on time for your appointments.
- Sign-in upon arrival each visit and wait to be brought back to your treatment area.
- Give at least 24 hours notice if for some reason you need to cancel or change your appointment to avoid a cancellation charge.
- Follow our instructions for follow-up exercises.
- Attend review and maintenance appointments as advised.
- Pay for treatment, as required, prior to each visit. We accept cash, personal checks, debit cards and credit cards (Visa, MasterCard, Discover).
- Talk to us. Let us know what you think of what we do, right or wrong.

We are a small business and many of our referrals come from past patients. Please help our practice grow by recommending us to your family, friends and colleagues. If we provide exceptional care, will you do a review for us?

Please print the attached forms, complete and bring them with you to your first visit to speed your initial appointment's registration process.

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MEDICAL HISTORY FORM

Patient Name: ______________________________ Date of Birth: ____/____/____ Date: ____/____/____

Are you presently working? ☐ Yes ☐ No; Occupation:______________________________ Last Day Worked: _____/_____/____

Work Status: ☐ Regular Duty ☐ Restricted/Light Duty ☐ Out of Work ☐ Retired ☐ Student ☐ N/A

Have you participated in physical therapy over the last year? ☐ Yes ☐ No; If yes, how many visits? ____________________

Have you fallen over the past year? ☐ Yes ☐ No; If yes, how many times? __________

Do you normally need a referral or preauthorization to see a specialist? ☐ Yes ☐ No : Date of next physician's visit: _____/_____/_____

Check which apply to your symptoms or injury:

☐ work related injury
☐ motor vehicle accident
☐ cause unknown
☐ recurrence of previous injury
☐ injury related to lifting
☐ athletic / recreational injury
☐ chronic condition
☐ injury related to a slip or fall
☐ other: ______________________

Do you have an attorney for this injury? ☐ Yes ☐ No; Attorney Name: ______________________ Phone Number: ______________

Date of injury/onset: ______/______/______ Have you ever had physical therapy for these symptoms before? ☐ Yes ☐ No

Have you had a related surgery for this condition? ☐ Yes ☐ No ; Date: _____/_____/_____ Briefly explain below:

Have you been hospitalized for this condition? ☐ Yes ☐ No ; Dates: _____/_____/_____ to _____/_____/_____

Have you had home care services for this condition? ☐ Yes ☐ No ; Date of discharge: _____/_____/_____

____

____

Do you have, or have you had any of the following? (You must check either Yes or No. Do not leave any blank)

	Yes	No		Yes	No
Diabetes: Type 1 or Type 2	☐	☐	Allergies to Aspirin	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Ringing in your ears	☐	☐
Stroke/CVA	☐	☐	Dizziness / Fainting	☐	☐
Seizures	☐	☐	Nausea/ Vomiting	☐	☐
Kidney Problems	☐	☐	Headaches	☐	☐
Liver / Gallbladder Problems	☐	☐	Osteoporosis	☐	☐
Are you pregnant?	☐	☐	Rheumatoid Arthritis	☐	☐
Cancer	☐	☐	Pacemaker	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Metal Implants	☐	☐
Urine Leakage	☐	☐	Surgeries	☐	☐
Asthma / Breathing Difficulties	☐	☐	Recent Fracture	☐	☐
X-ray	☐	☐	EMG	☐	☐
MRI or CAT Scan (circle)	☐	☐	Are you a Smoker?	☐	☐
Bone Scan	☐	☐			

If you answered yes on any of the above, please briefly explain and give the approximate dates and results:

____

____

____

Please list 2 Goals you would like to achieve with physical therapy? Example: (Sleep without pain. Walk without a walker.)

1. ____

2. ____

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Patient Name: ______________________________ **Date of Birth:** ____/____/____ **Date:** ____/____/____

Are you presently taking Medication? ☐ Yes ☐ No

If yes, please list what medications (dosage and frequency) and for what condition:
(All four must be completed for each medication)

Medication: ________________ Dosage: ________ Frequency: ____________ Condition: _____________
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Medication: ________________ Dosage: ________ Frequency: ____________ Condition: _____________

In case of an emergency, whom should we contact?

Name: ____ Relationship to patient: ______________________

Phone Number: ___________________________________

Prior to your injury, did you participate in any sports, exercise programs or activities on a regular basis?
☐ Yes ☐ No If yes, please describe.

____

____

If you work, how would you rate your work activity? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

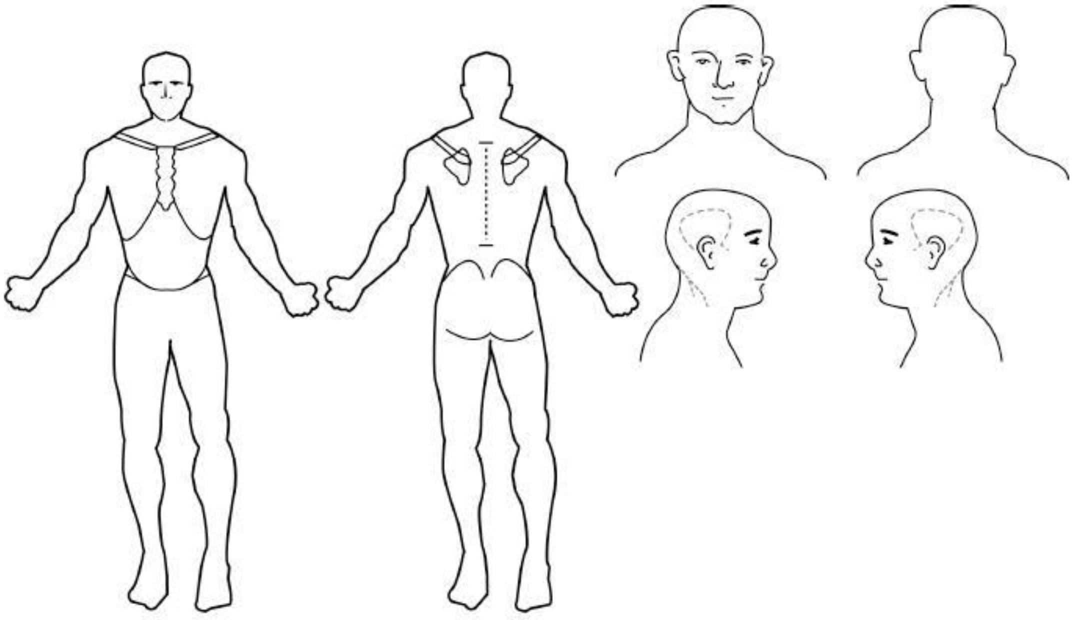
______________________________ ____/____/____ ______________________________
Patient's Signature Date Signature of Guardian if patient is a minor

I have reviewed the present and past medical history with the patient.

______________________________________ ____/____/____
Therapist Signature Date

Patient Name: ______________________________ Date of Birth: ____/____/____ Date: ____/____/____

Please indicate below where your symptoms are located. Use **X** marks where you have pain and //// marks to show where you feel numbness, tingling or pins and needles **TODAY**.



If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain imaginable. Please answer all three questions below. (Please circle number) Please consider worse is worse and least is least even if you are doing no activity.

Please rate your **worse** pain over the last 3 days.

No Pain 0-----1-----2-----3-----4-----5-----6 -----7-----8-----9 -----10 Worst Pain Possible

Please rate your **current** pain.

No Pain 0-----1-----2-----3-----4-----5-----6 -----7-----8-----9 -----10 Worst Pain Possible

Please rate your **least** pain over the last 3 days. (Includes when at rest)

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain Possible

Which best describes the pain you have mostly: (Please Circle) None , Dull/Aching, Sharp, Throbbing, Burning, Numbness, Tingling, Constant, Intermittent, Radiating

If 100% is your goal (where you **want** to be), what percent of your goal would you rate yourself **currently**?
(0 to 100%) ________ %

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Patient Name: ______________________________ Date of Birth: ___________________
Initial Evaluation Date: ______/______/______

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

We appreciate the confidence you have shown in choosing us to provide your therapy services. As a courtesy, RESTORE Physical Therapy will verify your primary insurance and provide you with a written verification of your eligible benefits prior to treatment initiation. **If you have any questions about your benefits, you should contact your insurance company directly.**

As you know, you or your representative are responsible at the time of service for payment of your deductible or its balance and the co-payment/co-insurance as determined by the contract with your insurer. If you elect to receive non-covered services or services beyond your approval period, you will be responsible for the balance unless prohibited by law or payer policy.

If your estimated amount is different than what we indicated on the Insurance Verification form, you will be billed following us receiving the “Explanation of Benefits” from your insurance carrier.

Additional fees:

- A collection fee for balances older than 60 days will accrue at 3% per month.
- A returned check fee will be assessed at $35.00.

I authorize my insurer to pay RESTORE Physical Therapy, L.L.C. the full allowable amount per my plan.

CONSENT FOR TREATMENT

I hereby authorize RESTORE Physical Therapy, L.L.C.’s assigned licensed therapist, to evaluate my condition and develop a plan of treatment. Following the examination, a written Plan of Care outlining the treatment procedures and goals will be discussed and, upon agreement, signed by our licensed therapist and you or your representative or guardian.

By signing this document, I attest that I have read and understand my responsibilities as related to financial responsibility and consent to treatment.

Signature: ____ Date:__________________
Patient/Representative/Guardian

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Under HIPPA guidelines we are unable to discuss any part of your care (including appointment times, release of records, billing or your medical condition) to any individual in your family or representative of you without written authorization. Please complete this form if you wish to share your information. *You **do not** need to place physician names here.*

Patient Disclosure Authorization Form

Patient Name: ______________________________ Date of Birth: ____________

I authorize disclosure of my protected health information to the individual(s) named below.

Name	Relationship to Patient

Description of information to be released: (please check all that apply)

☐ Appointment Times
☐ Medical Records Release
☐ Billing Information
☐ Medical Condition/Prognosis
☐ Other (specify):______________________________

This authorization provides that:

- I may revoke this authorization at any time, provided that my request is made in writing to RESTORE Physical Therapy.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA rules and regulations.
- I have a right to access my protected health information that will be used or disclosed.

Signature: ______________________________ Date: ____________________

Relationship to patient (if signed by guardian/personal representative): ________________________

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