TABLE MOUNTAIN PHYSICAL THERAPY

PATIENT & PAYER INFORMATION FORM

Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr. , etc. Nickname

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ Primary (_____) _____-_____ Secondary **Email:** _____

Birthdate: _____/_____/_____ **Sex: M / F**

_____/_____
Emergency Contact Name / Relationship

Legal Photo ID # _____ (Driver's License, Passport, Other State/Federal Photo ID)

S.S # xxx-xx-_____ Last 4 digits

(_____) _____-_____
Emergency Contact Number

(2) Patient's Doctor: Please list the doctor who referred you to therapy, or your Primary Care doctor.

Office Phone: (_____) _____-_____

Dr.'s Name: Last First Initial MD, DO, DDS, Other

(3) Payment Authorization: *(Initials required for all 3 statements)*

_____ **Assignment of Insurance Benefits**

Initials — **I authorize that the payment of my insurance benefits be made directly to Table Mountain Physical Therapy, inc for all services delivered or that are reimbursable by my insurance company, if I have one; if I am paid directly I will promptly pay Table Mountain Physical Therapy, inc all monies paid to me.**

_____ **Guarantee of Payment**

Initials — **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Certification of Information**

Initials — **I certify that the information I have provided Table Mountain Physical Therapy, inc for payment under the Social Security Act (Medicare) when applicable, including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(4) Attendance Agreement: *(Initials required for all statements)*

We recognize that emergencies may occur in rare instances. Missed appointments prolong your recovery, negatively impact your therapist's schedule and create barriers to patients in need of pain relief. These cancellations, especially last minute ones, decrease our ability to accommodate the scheduling needs of the other patients.

_____ **Cancellations/No Shows**

Initials — **I agree to give 24 hours advanced notice if I need to cancel an appointment. I acknowledge that a $50 fee may be charged if I do not give 24 hours notice *or* fail to show (no show) for a scheduled appointment. Being late by more than 30 minutes without notifying us may be treated as a no show.**

_____ **Multiple Cancellations/No Shows**

Initials — **I acknowledge that if I have multiple consecutive no shows or cancellations I may be discharged and all of my future appointments may be taken off the schedule. I will need a new order from my physician to return.**

(5) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

Patients or Patients' Legal Representative Please Sign Section 5

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Table Mountain Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Table Mountain Physical Therapy to release any of my protected healthcare information.

The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at www.tablemountainpt.com or on request from our staff.

_____ _____
Patient's or Authorized Representative's Printed Name Date

_____
Patient's or Authorized Representative's Signature

HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

(optional)

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

_____ _____ (_____)_____-_____
Name Relationship Phone Number:

_____ _____ (_____)_____-_____
Name Relationship Phone Number:

Health Information to be disclosed upon the request of the person(s) named above -- (Check either A or B):

☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Alcohol/drug abuse treatment
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ Hard copy
- ☐ An electronic record or access through an online portal

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date

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Name: _____ **Date:**_____

Occupation and/or activities that comprise your weekday: _____

Are you on a work restriction from your doctor? **YES NO** **Are you latex sensitive?** **YES NO**
Do you smoke? **YES NO** **Do you have a pacemaker?** **YES NO**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**
FOR MEDICARE PATIENTS: Have you had any type of Home Health Care in the last 30 days? **YES NO**

ALLERGIES: List any medication(s) you are allergic to:_____

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

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

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

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

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 ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

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Name: _____ **Date:**_____

Leisure activities, including exercise routines:_____

What date (roughly) did your present symptoms start?_____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, etc) _____

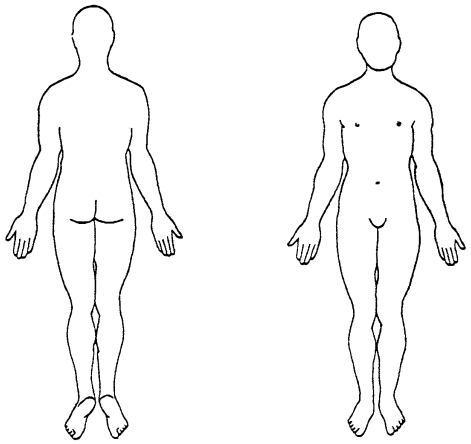
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑ **Yes** ❑ **No When** _____ **Treatment rec'd** _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____