Partners in Physical Therapy
3221 Ryan Street Suite D. Lake Charles, LA 70601
337-439-3344 phone 337-439-3380 fax
www.partnersinpt.com

Dear Patient,

We know you have a choice in physical therapy clinics and we would like to thank you for choosing our office. We take your care and participation in therapy seriously. It is our mission to provide you with excellent care and work as a team with you and your healthcare provider to ensure that your goals are met.

As a part of our efforts to offer excellence in patient care, we are proud to announce the incorporation of a patient advocate to our treatment staff. Erin MacInnes, LCSW is a clinical social worker is available as needed. She can help to assess your progress towards your goals as well as any barriers. She will relay that information to your therapist so that we can modify or update your treatment program to help you achieve your goals faster and she can help with creating action plans to decrease barriers. Please feel free to request a session with Erin.

If you have any questions, please feel free to contact me at 337-439-3344, ext. 0

Again, welcome to our clinic. You are now officially a partner!

Freddie Ann Regan Chandler

Don’t forget to like us on Facebook; we will post clinic updates and useful tips!

Partners in Physical Therapy New Patient Packet

How did you hear about us? **Physician** **Friend** **Previous Patient**
(Please circle)
Website **Other: _____**

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Social Security #: _____ Sex: M F Marital Status: S M D W

Employer: _____

Circle: Auto Accident Worker's Comp Date of accident: _____

Name of attorney or case manager: _____ Phone: _____

Insured Name **(Same as above? YES NO)**

Name: _____ Date of Birth: _____

Address: _____ Social: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Other: _____

Are we authorized to release information to this individual? YES NO
Please list any other individuals that we may share health or personal information:
_____
_____

Patient/Guardian: _____ Date: _____
(Signature)

Partners in Physical Therapy Policies

We work hard so that our office consistently runs on time and that your physical therapy goals are met.

Please be aware of the following:

Be here on time: We start and end appointments on a set schedule. It is important that you arrive on time.

Courtesy Email: We will notify you of your upcoming weekly appointments each Friday.

Appointment Changes: A minimum 24 hour notice for changes in appointment time is required. Cancelation with less than 24 hours notice will be charged a $50.00.

No Shows: If you do not show up for an appointment, a $50.00 no show charge is due at your next visit. This charge is your responsibility and will not be billed to insurance or other payers.

25% Cancellation/No Show Policy: If you miss greater than 25% of your scheduled appointments we reserve the right to cancel all future appointments. *Example: 3 out of 12 missed*

Workman's Compensation: We are required to send documentation of missed appointments to your worker's compensation case manager.

Self-Discharge: Please do not stop therapy without talking to your therapist.

Supplies: Medical supply expenses are due at the time of service. If you would like to bill insurance on your own behalf, please talk with our billing department for assistance.

Please know that every person is different and it is important to work as a team to get you optimal improvement. This requires communication, showing up to appointments, and active participation.

Signature: _____

Date: _____

*** Disclaimer: Please note by providing your e-mail, you are also allowing Partners in Physical Therapy to e-mail you regarding clinic sponsored programs. However, please note you are able to opt out at any time. ***

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I understand that as part of my health care treatment, ***Partners in Physical Therapy*** develops and maintains records containing my health information, which includes information about my health history, symptoms, test results, diagnosis, treatment, claims and payment information, etc. I understand that my health information will be used and disclosed by ***Partners in Physical Therapy*** for treatment, payment and health care operations and serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who may contribute to my care
- A source of information to bill for health care services rendered
- A means by which an insurance company or other third party payor can verify that services were billed and actually provided
- A resource for "health care operations" such as assessing quality and reviewing the competence of health care professionals

I have been provided with the ***Partners in Physical Therapy*** Privacy Notice, which provides a more complete description to the use and disclosure of my health information. I understand that I have the right to review the Privacy Notice prior to signing this consent form. I understand that ***Partners in Physical Therapy*** can change the terms of the Privacy Notice and that ***Partners in Physical Therapy*** reserves the right to make the new Privacy Notice provisions effective for my health information that it already maintains and uses, as well as for any health information that it may receive in the future.

I understand that if I refuse the sign this consent form allowing for the use and disclosure of my health information to carry out treatment, payment or health care operations, ***Partners in Physical Therapy*** may refuse treatment.

I understand that I have the right to request that ***Partners in Physical Therapy*** restrict how my health information is used or disclosed to carry out treatment, payment or health care operations, but such request may not be accepted. I request the following restrictions (N/A if none): _____

I understand that I may revoke this consent at any time by notifying ***Partners in Physical Therapy*** in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

I give my consent to ***Partners in Physical Therapy*** to release my medical records to my referring physician, insurance company, third party insurance, or to my attorney.

I authorize my insurance company to pay directly to ***Partners in Physical Therapy*** proceeds payable under the terms of my policy. I understand and agree to pay any unpaid balance not covered by my insurance company. In the event my account is turned over to collection, I hereby agree to pay all collection cost and fees.

I understand that my insurance company may not cover all charges incurred at *Partners in Physical Therapy* and that insurance companies do not guarantee payment, therefore I will be responsible for these charges.

Patient/Guardian Signature _____ Date: _____

Social Security Number of Patient _____ Patient Date of Birth _____

Partners in Physical Therapy Intake Form

Name: _____ Date: _____ Date of Next MD Visit: _____

Occupation: _____ Age: _____Height: _____ Weight: _____

Tell us why you are here:

_____

What would you like your therapist to know?

_____

What is your goal for physical therapy?

_____

Tests/Medical Management:

Please list any tests or medical services that you have received for your chief complaint:

_____

Allergies:

_____

Current Medication: ☐ ☐ None

List Names of Medications:	Dose or strength:	How often taken:
1) _____	a. _____	b. _____
2) _____	a. _____	b. _____
3) _____	a. _____	b. _____
4) _____	a. _____	b. _____

Medical Condition History

Please list all medical conditions: _____

_____

Please list all past surgeries: _____

_____

Overall Health:

How would you rate your Overall Health?

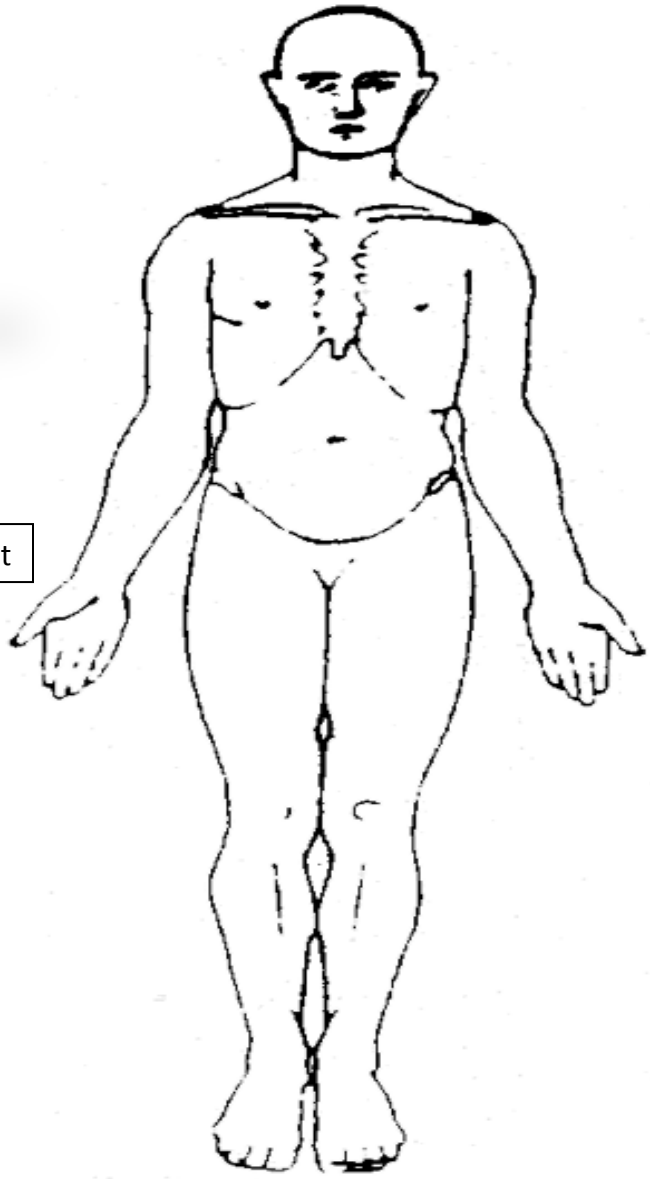
☐☐ Excellent ☐ ☐ Good ☐ ☐ Fair ☐ ☐ Poor

Do you feel your job or home life is stressful?	☐ Yes ☐ ☐ No
Do you have periods of depression or sadness?	☐ Yes ☐ ☐ No
Do you have persistent fears?	☐ Yes ☐ ☐ No
Do you worry excessively?	☐ Yes ☐ ☐ No
Are emotional problems important to your current complaint?	☐ Yes ☐ ☐ No

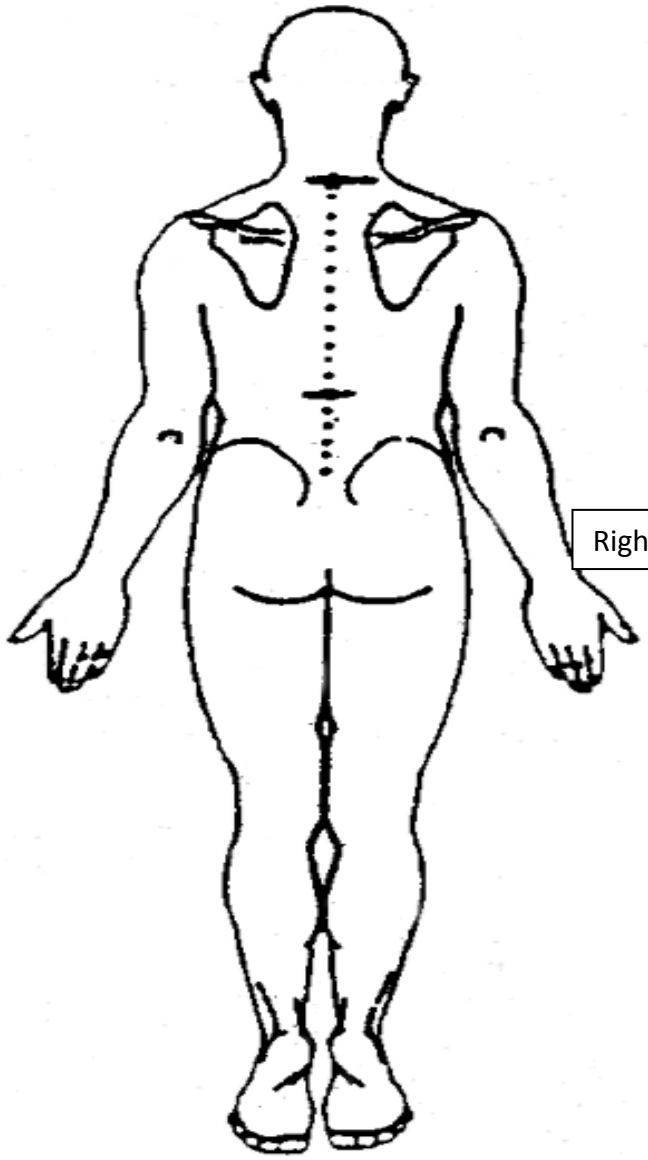
Symptoms:

Please mark on the body your area of complaint using a highlighter:

Right



Left



Right

Pain Intensity:
On a scale of 0 to 10 with 0 being no pain and 10 being the most severe pain imaginable:

Which number would describe your pain THIS WEEK?

What is your pain like NOW? 0 1 2 3 4 5 6 7 8 9 10

What is your LEAST pain? 0 1 2 3 4 5 6 7 8 9 10

What is your WORST pain? 0 1 2 3 4 5 6 7 8 9 10

Is your pain constant? ☐ Yes ☐☐ No **Is your pain worsening?** ☐ Yes ☐☐ No

The Patient-Specific Functional Scale

Addressing function is VERY IMPORTANT. Insurance companies want to see functional goals and research shows that focusing on function improves physical therapy outcomes.

Please take the time to complete the section below:

List three activities that you have difficulty with or are unable to do:

1._____

2._____

3._____

Additional (optional):

_____

_____

Do Not Write Below this line

_____

Patient- specific activity scoring scheme (point to one number)

0	1	2	3	4	5	6	7	8	9	10
Unable to Perform Activity								Able to perform activity at the same level as before injury or problem		

Lymphedema Evaluation

Name:_____ Date:_____

1. How long have you had swelling?_____
2. Have you ever had any infection?_____
3. Do you ever leak fluid?_____
4. Do you take antibiotics to prevent infection?_____
5. Do you take diuretics for swelling?_____
6. Do you take benzopyrones for swelling?_____ Don't know_____
7. Do you take any other drugs for swelling?_____
8. Does anyone in your family have swelling?_____
9. Which extremity has swelling? (check all that apply)

   Left Arm_____ Right Arm_____

   Left Leg_____ Right Leg_____
10. Have you had prior treatment for swelling? (check all that apply)

    Surgery_____ Compression sleeve_____

    Antibiotics_____ Pump_____

    Manual Lymphatic Drainage_____ Physical Therapy_____

    Other_____
11. Do you have bronchial asthma?_____
12. Do you have hypertension?_____
13. Do you have diabetes?_____
14. Do you have allergies?_____
15. Do you have any heart problems?_____
16. Do you have any circulatory problems?_____
17. What medications are you currently taking?_____

    _____

    _____
18. Have you ever had a stroke?_____
19. Have you ever had a DVT (blood clot)?_____
20. Do you have Diverticulitis, Chron's Disease, or Ulcerative Colitis?_____
21. Do you have pain?_____
22. Have you had cancer?_____

23. Do you currently have an active cancer?_____

24. Are you currently receiving treatment for cancer?_____

25. Have you ever had radiation?_____

26. Have you ever received chemotherapy?_____

27. What operations have you had?_____

_____

28. If you are treated at this office, you will be then asked to follow a maintenance program at home.

    This consists of:

    a. Elastic sleeve or stocking worn during the day.
    b. Bandaging of the limb overnight.
    c. Meticulous skin care to avoid infection.
    d. Remedial exercises to accelerate lymph flow.

Are you prepared to follow such a program?_____