

Consent for Care & Treatment: I agree and give consent for medical care and treatment to _____ as considered medically necessary in evaluating and treating my/his/her physical condition.

Patient/Guardian/Responsible Party _____ Date: _____

Benefit Assignment/Release of Information: I agree to assign all medical benefits to which I am entitled to Given Sports & Physical Therapy, PC for services rendered. I hereby authorize release of all information necessary to secure payment for these services.

Patient/Guardian/Responsible Party _____ Date: _____

Financial Policy Explanation:

- Proper identification is needed at the time of the initial evaluation.
- Accurate insurance and injury information must be presented by the patient.
- If benefits are subsequently denied by an insurance company, the patient is fully responsible for the charge of rendered services.
- Although benefits and coverage are verified prior to therapy, the patient is fully responsible to understand their individual benefits and plan details. Pre-verification of benefits/coverage is only an estimate of coverage and not a guarantee of benefits.
- Patients under the age of 18 years old require signed consent from a parent/guardian.
- Patients should be aware that some insurance plans require specific pre-authorization or referral for physical therapy.
- If an insurance carrier does not remit payment within 120 days, the balance shall be considered patient responsibility at that time.
- Pre-collection notices may be sent after the same patient balance is billed on two consecutive occasions. Patients will be responsible for all costs of collecting monies including court costs, additional collection agency fees of 35%, and attorney fees incurred.
- A \$25 charge will be assessed for any dishonored/returned check or any failed payment plan transaction.
- Medical supplies - payment is due in full at the time of receipt as these are not billed to any insurer; payment for medical goods is non-refundable

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
Work Conditioning

Commercial Insurance:

- Co-payments: Without exception, insurance companies require that co-payments be paid at the time of service.
- Co-insurances and deductibles: Estimated co-insurance and deductible payments are due at the time of service. After an EOB is received from the insurance company, any remaining balance will be billed to the patient.
- Any refund due to the patient will be credited to an active account or a refund check will be issued once all insurance payments are received.

Medicare: Claims will be submitted to Medicare and any supplementary/secondary plan. Clients are urged to speak directly to the therapist about the implications of calendar year caps on Medicare services. Clients need to notify this office if any home health therapy or nursing services have just concluded or occur during the course of therapy.

Workers' Compensation: It is our obligation to notify case managers/adjusters of missed or cancelled appointments.

Auto/Personal Injury: The client may 1) elect to self-pay for services or 2) elect that this office bills their personal health or auto insurance. Personal health insurance shall be considered a secondary payor to auto insurance. No 3rd party billing is allowed.

Self-pay: Payment is due at the time of service at the lesser of billed charges or \$125 per treatment session.

Patient/Guardian/Responsible Party _____ Date: _____

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
Work Conditioning

Patient Health Questionnaire

Name _____ Date: _____

Date of Birth _____ Patient Acct. # _____

Referring Physician: _____ Family Physician: _____

Date of 1st doctor visit for this injury/condition: _____

Are you aware of what your diagnosis is? (Yes or No) _____

What are your rehabilitation expectations or goals? _____

Have you had Surgery for this injury? _____

Have you had Surgery for this injury? Yes No _____

Type of Surgery: _____ Approx date(s) of surgery: _____

Your chief complaint: _____

Date of onset of symptoms or Injury: _____

● How often do you experience your symptoms?

- Constantly (76 -100% of the day)
- Frequently (75% of the day)
- Occasionally (26 - 50% of the day)
- Intermittently (0 - 25% of the day)

● What describes the nature of your symptoms: (Choose all that apply)

Sharp Dull ache Numb Shooting Tingling

● How are symptoms changing: Getting better Not changing Getting worse

● During the past 4 weeks:

a. Indicate the average intensity of your symptoms: None Unbearable

b. How much pain interfered with your normal work:
(including both work outside the home and housework)?

Not at all A little bit Moderately Quite a bit Extremely

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
Work Conditioning

- During the past 4 weeks how much of the time has your condition interfered with your social activities? (visiting with friends, relatives, etc.)

All of the time Some of the time None of the time A little of the time Most of the time

- In general, would you say your overall health right now is:

Excellent Very good Good Poor

- Who have you seen for your symptoms? (Choose all that apply)

No One Physical Therapist Chiropractor Medical Doctor Occupational
Therapist Orthopedist Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed

X-Rays MRI CT Scan Other

c. What medication are you currently taking for this injury? _____

- Have you had similar symptoms in the past? Yes or No _____

- If you have received treatment in the past for the same/similar symptoms, who did you see?

This Office Medical Doctor Occupational Therapist Chiropractor
Physical Therapist Orthopedist Other

- What is your occupation? _____

- If you are not retired, a homemaker, or a student, what is your current status?

Full Time Part-time Self-employed Unemployed Off work Other

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
Work Conditioning

Please circle Y (yes) or N (no) If you have, or have had condition. Circle M (medications) If you are taking medications for the condition.

| | | | |
|----------------------------------|---|---|---|
| General | | | |
| Good general health | Y | N | M |
| Recent weight changes | Y | N | M |
| Fatigue | Y | N | M |
| Night sweats / fevers | Y | N | M |
| Cardiovascular | | | |
| Angina / chest pain | Y | N | M |
| Coronary artery disease | Y | N | M |
| Heart surgery | Y | N | M |
| Pacemaker | Y | N | M |
| Musculoskeletal | | | |
| Muscle pains or cramps | Y | N | M |
| Stiffness swelling in joints | Y | N | M |
| Joint Pain | Y | N | M |
| Osteoporosis | Y | N | M |
| Endocrine | | | |
| Excessive thirst/urination | Y | N | M |
| Thyroid disease | Y | N | M |
| Hormone Problem(s) | Y | N | M |
| Ear/ Nose / Throat /Mouth | | | |
| Hearing loss ringing in ears | Y | N | M |
| Sinus Problems | Y | N | M |
| Nose bleeds | Y | N | M |
| Sore throat | Y | N | M |

| | | | |
|--------------------------------|---|---|---|
| Voice Changes | Y | N | M |
| Respiratory | | | |
| Shortness of Breath | Y | N | M |
| Excessive coughing | Y | N | M |
| Asthma | | | |
| Bronchitis | Y | N | M |
| Emphysema | Y | N | M |
| Neurological | | | |
| Frequent headaches | Y | N | M |
| Seizures / Epilepsy | Y | N | M |
| Numbness tingling | Y | N | M |
| Dizziness | Y | N | M |
| Weakness | Y | N | M |
| Stroke/TIA | Y | N | M |
| Hematologic / Lymphatic | | | |
| Bruise Easily | Y | N | M |
| Slow to Heal | Y | N | M |
| Enlarged Glands | Y | N | M |
| Eyes | | | |
| Wear glasses / contacts | Y | N | M |
| Blurred / double vision | Y | N | M |
| Eye Disease or injury | Y | N | M |
| Glaucoma | Y | N | M |
| Allergies | | | |

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations • Work Conditioning

| | | | |
|------|---|---|---|
| Food | Y | N | M |
|------|---|---|---|

| | | | |
|-------|---|---|---|
| Latex | Y | N | M |
|-------|---|---|---|

| | | | |
|----------|---|---|---|
| Medicine | Y | N | M |
|----------|---|---|---|

Gastrointestinal

| | | | |
|-----------------|---|---|---|
| Nausea/Vomiting | Y | N | M |
|-----------------|---|---|---|

| | | | |
|----------------|---|---|---|
| Abdominal Pain | Y | N | M |
|----------------|---|---|---|

| | | | |
|-----------------|---|---|---|
| Rectal Bleeding | Y | N | M |
|-----------------|---|---|---|

| | | | |
|----------------|---|---|---|
| Blood In Urine | Y | N | M |
|----------------|---|---|---|

| | | | |
|---------------|--|--|--|
| Kidney Stones | | | |
|---------------|--|--|--|

Other

| | | | |
|------------------------|---|---|---|
| Skin Infection or MRSA | Y | N | M |
|------------------------|---|---|---|

| | | | |
|--------------------------|---|---|---|
| Changes in hair or nails | Y | N | M |
|--------------------------|---|---|---|

| | | | |
|-------------------|---|---|---|
| Rashes or itching | Y | N | M |
|-------------------|---|---|---|

| | | | |
|-------------|---|---|---|
| Breast Lump | Y | N | M |
|-------------|---|---|---|

| | | | |
|--------------------------|---|---|---|
| Breast Pain or discharge | Y | N | M |
|--------------------------|---|---|---|

| | | | |
|---------------------------|---|---|---|
| Change in menstrual cycle | Y | N | M |
|---------------------------|---|---|---|

| | | | |
|--------------|---|---|---|
| Tuberculosis | Y | N | M |
|--------------|---|---|---|

| | | | |
|--------|---|---|---|
| Cancer | Y | N | M |
|--------|---|---|---|

| | | | |
|--------------------------|---|---|---|
| Radiation / Chemotherapy | Y | N | M |
|--------------------------|---|---|---|

| | | | |
|------------|---|---|---|
| HIV / AIDS | Y | N | M |
|------------|---|---|---|

| | | | |
|----------|---|---|---|
| Diabetes | Y | N | M |
|----------|---|---|---|

| | | | |
|-------------|---|---|---|
| Blood Clots | Y | N | M |
|-------------|---|---|---|

| | | | |
|------------|---|---|---|
| Depression | Y | N | M |
|------------|---|---|---|

| | | | |
|-------------------------|---|---|---|
| Confusion / Memory Loss | Y | N | M |
|-------------------------|---|---|---|

| | | | |
|---------------|---|---|---|
| Do you smoke? | Y | N | M |
|---------------|---|---|---|

| | | | |
|-----------------------|--|--|--|
| Use tobacco products? | | | |
|-----------------------|--|--|--|

| | | | |
|-------------------|---|---|---|
| Are you pregnant? | Y | N | M |
|-------------------|---|---|---|

Patient/Guardian/Responsible Party _____ Date: _____

I have reviewed and discussed this patient medical information with the patient

Therapist _____ Date: _____

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
Work Conditioning

We are committed to providing quality healthcare services to you. An important part of that is facilitating various privacy rights that you have under Federal Law.

This document serves 2 purposes:

1. Acknowledgment by signature that the Notice of Privacy Practices has been made available for review. Signature Indicates understanding and agreement with said Notice.
2. Instructions to request any restriction pertaining to the uses and disclosures of your protected health information ("PHI") that we may make for treatment, payment and operational reasons, as well as for other reasons provided for under applicable law.

Notice of Privacy Practices:

I understand the Notice of Privacy Practices (posted at www.givensportspt.com and available for review in the clinic itself) and consent to disclosure for permitted uses. I fully understand the terms of consent.

Patient Name _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

Restriction Request:

Describe the PHI that you would like restricted including any individual(s), provider(s), Insurance company(s) and/or other organization(s) that you would like to prevent from reviewing the designated PHI.

Detailed Description of restricted information: _____

Persons or Organizations Restricted: _____

It is our policy to process restriction requests within thirty days (30) of receipt. We will use the contact info that we have on file to: 1) follow-up with you for additional information if necessary; and/or 2) send you our written response to your request.

Patient Name _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
Work Conditioning

Authorization:

Given Sports & Physical Therapy may release Information regarding my treatment to the following Individuals:

Name _____ Relationship: _____

Name _____ Relationship: _____

Patient Name _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

Attendance Policy:

You have the right to choose where you attend physical therapy. As a private practice clinic independent of any direct ties to referral sources or hospital networks, we thank you for your decision to attend therapy at Given Sports & Physical Therapy, P.C.

Positive clinical outcomes and customer satisfaction are the measures of our success.

Compliance with your prescribed frequency of physical therapy and suggested home exercise program is a vital component of your progress with our services. Please realize that your schedule affects not only our staff but also other patients. Our commitment to your progress is reflected in the following attendance policy.

Our policy includes the following steps:

1. We have extended times beyond those typical for a medical facility as a means of accommodating the needs of our patients.
2. We will give you a verbal and/or written schedule of your appointments.
3. If you need to cancel an appointment, please do so one or more days prior to your scheduled visit.

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
Work Conditioning

4. If you need to reschedule an appointment, please call our office and we will make every effort to do the same day or later in the week in order to keep your prescribed frequency of therapy.
5. In the event of a missed appointment, you will receive a phone call from our office (usually within 15 minutes of your scheduled appointment time). We will attempt to reschedule the missed appointment to another time during the week.
6. If we are unable to reschedule your missed appointment during the same week of therapy, we reserve the right to charge you a fee of \$25. This fee will not be charged to your insurance. Instead, we ask the fee be paid at your next appointment.
7. Your referring physician will be notified of your attendance and compliance with therapy. If you are a patient with workers' compensation insurance, we are obligated to immediately notify your adjuster or case manager of any scheduling issues.

We understand that serious emergencies and last minute changes in your daily schedule can happen. We simply ask for a courtesy call to inform us if such a event occurs. In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care and will notify your physician of this reason.

Again, we sincerely appreciate your decision to begin treatment at Given Sports & Physical Therapy, P.C. and wish you well in your rehabilitation!

I have read and understand this policy: _____ Date: _____

OPTIMAL INSTRUMENT

Difficulty-Baseline

| Instructions: Please circle the level of difficulty you have for each activity today. | Able to do with little difficulty | Able to do with moderate difficulty | Able to do with much difficulty | Unable to do at all | Not Applicable |
|--|-----------------------------------|-------------------------------------|---------------------------------|---------------------|----------------|
| Lying flat | 1 | 2 | 3 | 4 | 5 |
| Rolling over | 1 | 2 | 3 | 4 | 5 |
| Moving- lying to sitting | 1 | 2 | 3 | 4 | 5 |
| Sitting | 1 | 2 | 3 | 4 | 5 |
| Squatting | 1 | 2 | 3 | 4 | 5 |
| Bending/Stooping | 1 | 2 | 3 | 4 | 5 |
| Balancing | 1 | 2 | 3 | 4 | 5 |
| Kneeling | 1 | 2 | 3 | 4 | 5 |
| Walking - short distance | 1 | 2 | 3 | 4 | 5 |
| Walking - long distance | 1 | 2 | 3 | 4 | 5 |
| Walking - outdoors | 1 | 2 | 3 | 4 | 5 |
| Climbing stairs | 1 | 2 | 3 | 4 | 5 |
| Hopping | 1 | 2 | 3 | 4 | 5 |
| Jumping | 1 | 2 | 3 | 4 | 5 |
| Running | 1 | 2 | 3 | 4 | 5 |

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations •
 Work Conditioning

| Instructions: Please circle the level of difficulty you have for each activity today. | Able to do with little difficulty | Able to do with moderate difficulty | Able to do with much difficulty | Unable to do at all | Not Applicable |
|--|-----------------------------------|-------------------------------------|---------------------------------|---------------------|----------------|
| Pushing | 1 | 2 | 3 | 4 | 5 |
| Pulling | 1 | 2 | 3 | 4 | 5 |
| Reaching | 1 | 2 | 3 | 4 | 5 |
| Grasping | 1 | 2 | 3 | 4 | 5 |
| Lifting | 1 | 2 | 3 | 4 | 5 |
| Carrying | 1 | 2 | 3 | 4 | 5 |

22. Thinking about all of the activities you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with these activities today.

I have extreme difficulty doing any of the activities that I love to do

I have no difficulty doing any of the activities that I love to do

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to climb stairs, kneel, and hop without any difficulty, you would choose: 1, 2, 3

1. _____ 2. _____ 3. _____

© 2005, 2006 American Physical Therapy Association. All rights reserved. No part of this instrument may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise without prior permission of the American Physical Therapy Association. Contact permissions@apta.org or visit www.apta.org/publications. Adapted/ revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz T J, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). Phys Ther. 2005;85:515-530.

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations • Work Conditioning