Fundamental Physical Therapy

3500 S Boulevard, Ste A1, Edmond, OK 73013
405-513-8118

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Student? ☐ Yes ☐ No	Home phone no.: ( )	Cell no.: ( )	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Email address:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referring Physician:	Date of next appt with Physician:

Patient gives our office permission to leave a message on their answering machine: ☐ yes ☐ no

Patient gives our office permission to email appointment reminders: ☐ yes ☐ no

Patient gives our office permission to text appointment reminders: ☐ yes ☐ no

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance (circle one)	Medicare	BCBS	UHC	Healthchoice	Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize FPT or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

Today's Date__________ PATIENT NAME:___________________________________ DATE OF BIRTH:___/___/____

MEDICAL HISTORY **(Existing or Relevant PREVIOUS Conditions)**

Allergies O Yes O No
Anemia O Yes O No
Anxiety O Yes O No
Arthritis O Yes O No
Asthma O Yes O No
Autoimmune Disorder O Yes O No
Cancer O Yes O No
Cardiac Conditions O Yes O No
Cardiac Pacemaker O Yes O No
Chemical Dependency O Yes O No
Circulation Problems O Yes O No
Currently Pregnant O Yes O No
Depression O Yes O No
Diabetes O Yes O No
Dizzy Spells O Yes O No
Emphysema/Bronchitis O Yes O No
Fibromyalgia O Yes O No
Fractures O Yes O No
Gallbladder Problems O Yes O No
Headaches O Yes O No
Hearing Impairment O Yes O No
Hepatitis O Yes O No
High/Cholestrol O Yes O No
High/Low Blood PressureO Yes O No
HIV/AIDS O Yes O No
Incontinence O Yes O No
Kidney Problems O Yes O No
Metal Implants O Yes O No
MRSA O Yes O No
Multiple Sclerosis O Yes O No
Muscular Disease O Yes O No
Osteoporosis O Yes O No
Parkinsons O Yes O No
Rheumatoid Arthritis O Yes O No
Seizures O Yes O No
Smoking O Yes O No
Speech Problems O Yes O No
Strokes O Yes O No
Thyroid Disease O Yes O No
Tuberculosis O Yes O No
Vision Problems O Yes O No

Describe any other conditions or precautions: (If "yes" to any of the above, please explain with approx dates)

Falls History

Injury as a result of a fall in the past year? O Yes O No
Two or more falls in the last year? O Yes O No
Patient is at risk for falls? O Yes O No

Surgical History

Body Region:_________________________ Surgery Type:__________________________ Date of Surgery:______________
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Body Region:_________________________ Surgery Type:__________________________ Date of Surgery:______________

Current Medications

Name of Drug Amount How often taken (oral, patch,etc)
Drug:___________ Dosage:______ Frequency:_______ Route:________ Reason for Taking:__________________________
Drug:___________ Dosage:______ Frequency:_______ Route:________ Reason for Taking:__________________________
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(Please check)_______ If you are currently NOT taking any perscription medications.

Is your pain? ☐Deep ☐On the surface

My pain/problem is slowly getting ☐worse ☐better ☐staying the same

My pain bothers me ☐constantly 100% ☐most of the time 75% ☐occasionally 50% ☐once in a while 25% or less

Are your symptoms worse in ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same all day

What worsens the pain? ____

What makes the pain better? ____

On a scale from 0-10 (0 = no pain; 10 = worst pain imaginable), what is the **worst** your pain has been in the past several days? ____/10. What is the **best** your pain has been? ____/10
Please rate your **current** pain on the line below

0 . . . . 5 10

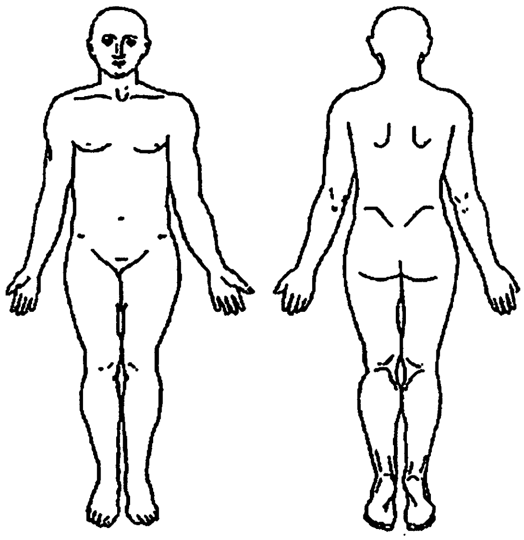
Do you have any regular numbness or tingling? ☐Yes ☐No If yes, where? ________________

How are you able to sleep at night? (check one)
☐Fine ☐Moderate difficulty ☐Only with medication ☐Change positions all night

List the dates and results of any X-rays ________________________________
MRI ________________________________
Bone Density test ________________________________
NCV/EMG ________________________________
Other ________________________________
List of previous hospitalizations/surgeries with approximate dates ________________________________

____

Please mark on the diagram below to indicate where you feel symptoms Use the following key to indicate the different types of symptoms



Deep Ache = ZZZZ
Sharp/Stabbing = ////
Pins and needles = 0000
Burning = XXXX
Throbbing = ++++

PATIENT'S SIGNATURE. ______________________________ DATE ____/____/____

GROUP HEALTH INSURANCE
FINANCIAL STATEMENT

THANK YOU FOR CHOOSING FUNDAMENTAL PHYSICAL THERAPY. WE ARE COMMITTED TO GIVING YOU THE BEST MEDICAL TREATMENT POSSIBLE. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY:

- It is your responsibility to know if Fundamental Physical Therapy is in network w/insurance. We will gladly bill your insurance company as a courtesy to you. Insurance companies have a filing deadline, so please make sure we have a copy of your insurance card.
- All co pays, coinsurance and deductibles are due at the time of service. We accept cash, check, Visa, MasterCard and Discover. Without proof of insurance you will be responsible for payment of fees at the time of service.
- Oklahoma Law requires that we have a current prescription for physical therapy on file from your physician. Please make sure we have a current prescription on file for you treatment. It is the patient's responsibility to obtain updated referrals (scripts) from physician.

FAILURE TO CANCEL YOUR APPOINTMENT WITHIN 24 HOURS WILL RESULT IN A *$25.00* CHARGE TO YOU THAT WILL NOT BE BILLED TO YOUR INSURANCE.

WE HAVE SEVERAL PATIENTS ON A CANCELLATION LIST ON A DAILY BASIS AND WHEN PATIENTS FAIL TO CANCEL OR NO SHOW FOR AN APPOINTMENT THIS IS NOT FAIR TO OUR PATIENTS WHO ARE WAITING FOR AN APPOINTMENT.

IF YOU ARE 15 MINUTES OR MORE LATE FOR YOUR APPOINTMENT YOUR TREATMENT WILL BE ABBREVIATED OR YOU MAY BE RESCHEDULED FOR ANOTHER DAY.

IN THE EVENT YOU ARE UNABLE TO CALL DURING REGULAR HOURS OUR ANSWERING MACHINE IS ON 24 HOURS SO YOU CAN LEAVE A MESSAGE.

FINANCIAL POLICY ACKNOWLEDGMENT:
I have read and understand the above financial policy. I understand that regardless of my insurance coverage I am ultimately responsible for the balance on my account for any services rendered.

Signature_________________________________ Date_____________________
(patient or authorized representative)

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:
I authorize the release of medical information necessary for filing health insurance claims for me by Fundamental Physical Therapy. I also authorize my insurance carrier(s) to make payment directly to Fundamental Physical Therapy.

Signature_________________________________ Date_______________________
(patient or authorized representative)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

FUNDAMENTAL PHYSICAL THERAPY
3500 S. Boulevard, Suite A1
Edmond, OK 73013

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") and the current update (2009), I have certain rights to privacy regarding my protect health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Print Name: ______________________________ Date of Birth: ______________________

Signature: _______________________________ Date: ______________________________

Parent/Legal Guardian signature (if minor): _________________________________ Date: _______________

Relation to patient: ______________________________

☐ Patient advised of HIPAA 45 CFR 164.520 on this ____ day of ______________, 20_.

☐ I understand that I may obtain an updated electronic copy of your *Notice of Privacy Practices.*

☐ Patient gives permission to discuss their medical condition with another person.

Whom? ____

Questions & Complaints

If you have any questions about this notice, or if you think that we may have violated you privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with that entity. Contact information: (405)-513-8118. 3500 S. Boulevard, 73013.