



PERSONAL INSURANCE PROGRESS PHYSICAL THERAPY REFERRAL



Center Number 23 Center Name Parkview
 Account / Reg# _____ Date Taken _____ Taken By _____
 Appointment Date _____ Time _____ Transportation (Circle One) Y N
 Therapy [Circle One] PT OT Work Harding FCE Job Analysis

PATIENT INFORMATION [intake by Center]

****First Name** _____ MI _____ ****Last Name** _____

****Date of Birth** _____ Gender [Circle One] M F SS# _____ - _____ - _____

****Mailing Address** ****[Street]** _____
****[City]** _____ ****[State]** _____ ****[Zip Code]** _____

Physical Address [Street] _____
 same [City] _____ [State] _____ [Zip Code] _____

****Home Phone** (____) - ____ - _____ ****Work Phone** (____) - ____ - _____

****Cell Phone** (____) - ____ - _____ Emergency Contact _____

****Injured Area of Body** _____

****How did Injury Occur** _____

****Personal Health Ins. Company** _____ Effective Date _____

Billing Address _____ City _____ State _____ Zip _____

Insured / Relationship _____ DOB-[subscriber] _____

****Ins. ID#** _____ Group# _____ CO-PAY \$ _____

Phone # (____) - ____ - _____ Authorization# _____

Primary Physician _____ Phone (____) - ____ - _____

Benefits _____

****Secondary Ins. Company** _____ Effective Date _____

Billing Address _____ City _____ State _____ Zip _____

Insured / Relationship _____ DOB-[subscriber] _____

****Ins. ID#** _____ Group# _____ CO-PAY \$ _____

Phone # (____) - ____ - _____ Authorization# _____

Benefits _____

Emergency Contact Name _____ Phone #(____) - ____ - _____

****Referring Physician** _____

How did you hear about our company? (Circle One)

Doctor Lawyer Friend / Family Employer Phone Book Ad

Other _____

My signature below states that I have reviewed the information and the information is true and correct. My injury is a result of a "Personal Injury".

Patient Signature _____ Date _____

Our Goal is for you to have a DYNAMIC experience—Thank You for choosing Progress Physical Therapy

Dear Patient,

Welcome to Progress Physical Therapy!

We at *Progress Physical Therapy* are dedicated to giving you the highest quality physical therapy care for your injuries. At Progress PT the focus is on the patient (you) and helping you achieve all of your physical therapy goals. This is our mission.

This mission, however, requires your help. We ask that you...

- ...be compliant with your individual plan of care created by your therapist.
- ...be compliant with all appointments scheduled with us.
- ...call us if you are unable to attend an appointment.
- ...schedule to follow-up with your physician every 30 days while you are treating with us to update him of your condition and obtain a new prescription if continued physical therapy is warranted.
- ...be courteous of other patients attending therapy at the same time as you.
- ...never leave your children unattended in the PT clinic to keep them from harm.
- ...understand your health insurance coverage regarding physical therapy.

Ultimately you are responsible for your own well-being. By following the tips above, you will put yourself in the best position to maximize your physical therapy experience. If you have any questions regarding any of your care while attending Progress PT, please do not hesitate to ask any of our knowledgeable staff.

Good Luck! And thank you for choosing Progress Physical Therapy as your rehabilitation provider.

-Progress PT

PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

Patient Name: _____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please check if you have had problems with or are presently complaining of any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Unexplained weight gain/loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis or jaundice |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Chest pain / Chest tightness | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> T.B. | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Low back problems |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Nausea | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Light-headedness | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Balance Deficits |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Amputation | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Loss of use of body region | |
| | <input type="checkbox"/> Seizure Disorder | |

PAST SURGICAL HISTORY

Please list all surgeries you have had, related or unrelated to current problem

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

CURRENT MEDICATIONS

Please list all current medications, related or unrelated to current problem

1. _____
2. _____
3. _____

PROGRESS PT
CENTERS FOR FITNESS AND REHABILITATION

Patient Name: _____

WHAT HAPPENED IMMEDIATELY FOLLOWING THE ACCIDENT?

1.) Your initial reaction: confused dazed distressed dizzy frightened
 lightheaded nervous shaken weak

2.) Where did pain occur? _____

3.) Did you lose consciousness? yes no unsure

4.) Type of emergency care provided: none bandaging bracing CPR
 neck collar splinting

5.) Immediate destination after accident: to work home to school
 to a hospital to a clinic to a doctor's office

6.) Who drove you: yourself a friend an ambulance a family member

7.) Did you have any cuts? yes no
If yes, where? _____

8.) Date of hospital/Doctor visit: ___/___/___

9.) Name of hospital / examining physician: _____

10.) Were you admitted to the hospital? yes no

If yes, date of discharge: ___/___/___

11.) Did you have an X-ray? yes no

If yes, of what? _____ Where was it taken? _____

When was it taken? ___/___/___

12.) Did you have an MRI? yes no

If yes, of what? _____ Where was it taken? _____

When was it taken? ___/___/___

13.) If you answered yes to having an MRI or X-ray, what were the results? _____

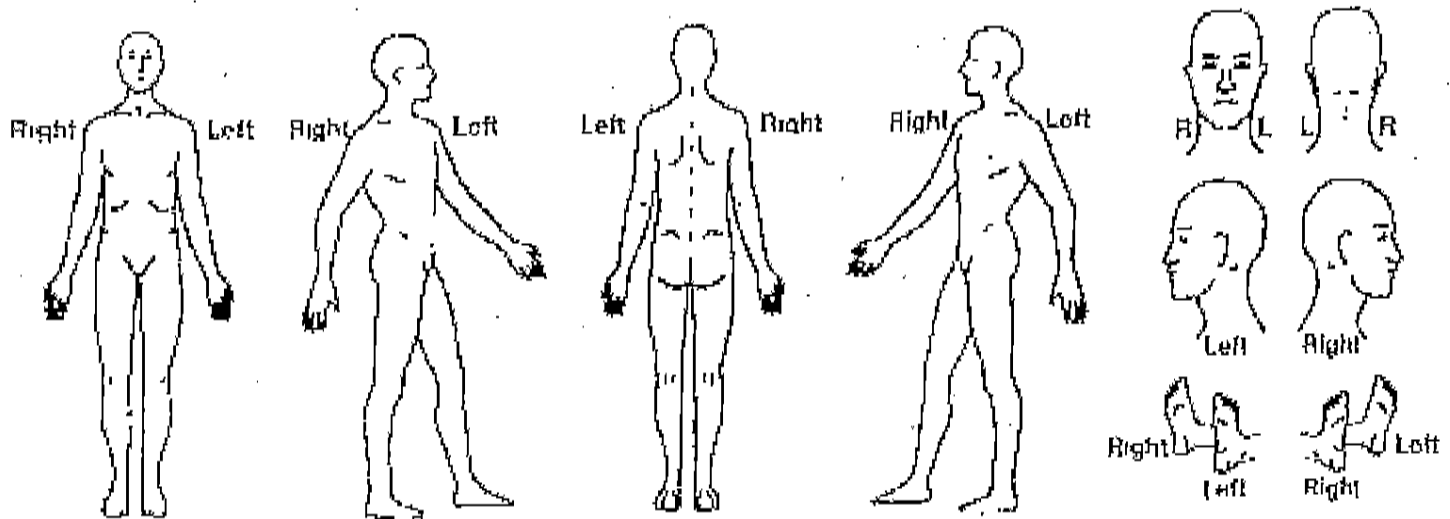
PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

Patient Name: _____

PRESENT COMPLAINTS

- 1.) Please place a circle around each of the body regions for which you are experiencing pain or a problem right now. Place a number in each circle from the pain scale below.



Please rate your average pain level on the scale below:

- 0 – No pain at all
- 1 – Very mild
- 2 – Mild
- 3 – Bothersome
- 4 – Moderate
- 5 – Able to complete daily routine
- 6 – Unable to complete daily routine
- 7 – Unable to do anything, but rest
- 8 – Considering going to the hospital
- 9 – Going to the hospital
- 10 – Calling 911, excruciating

PROGRESS PT
CENTERS FOR FITNESS AND REHABILITATION

I authorize payment of medial benefits to PROGRESS PT Centers for Fitness and Rehabilitation for all care provided by the aforementioned facility or its employees.

Authorized person's signature _____

I authorize the release of any medical or other information necessary to process all medical claims. I also request payment of government benefits either to myself or to PROGRESS PT Centers for Fitness and Rehabilitation.

Authorized person's signature _____

CENTERS FOR FITNESS AND REHABILITATION PROGRESS PHYSICAL THERAPY

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, PROGRESS PT originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Description of the information to be used or disclosed (*check all that apply*):

- The patient's partial or entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed).
- The patient's demographic information (*check all that apply*):
- | | | | |
|-------------------------------|----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Name | <input type="checkbox"/> Address | <input type="checkbox"/> State/Zip Code only | <input type="checkbox"/> Telephone |
| <input type="checkbox"/> Age | <input type="checkbox"/> Gender | <input type="checkbox"/> Race | <input type="checkbox"/> Other: _____ |

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In the event that you are unavailable to be reached, and would like us to leave a message for you, please place a check acceptable ways to notify you (*check all that apply*):

- Answering Machine Family member Friend

I wish to have the following restrictions to the use or disclosure of my health information:

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, PROGRESS PT must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

PROGRESS PT will accept written revocations of this authorization via:

1. Certified U.S. mail or
2. Facsimile at this number: 215-744-7394.

ALL revocations must be sent to PROGRESS PT to the attention of the Privacy Officer, William Leitzel, and are not effective until received by the Privacy Officer.

CENTERS FOR FITNESS AND REHABILITATION
PROGRESS
 PHYSICAL THERAPY

I understand that PROGRESS PT is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that PROGRESS PT reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should PROGRESS PT change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I fully understand and accept / decline the terms of this consent.

 Patient's Signature

 Date

 If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnesses by: _____

 FOR OFFICE USE ONLY

Consent refused by patient, and treatment refused as permitted.

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____

Progress Physical Therapy Van Application/Contract

As a courtesy to our patients, *Progress PT* offers door-to-door transportation for people who qualify. The decision to grant access to our van service for a particular patient is made on an as needed basis by *Progress PT*.

In order to accommodate as many patients as possible on the van, the transportation schedule is based on address and neighborhood and is made by us, the provider. Times of pick-up or drop-off may vary from day to day depending on van volume and traffic volume. Waiting times for patients and familiarity of the driver with different neighborhoods may also affect van pick-up/drop-off times.

For each appointment, a patient must be ready for the van's arrival within one half hour before and after scheduled pick-up time for that day. If the patient would like to cancel van service, they must call at least one hour before pick-up time for that day. Van service is provided for physical therapy appointments only. So if a van pick-up is scheduled, a physical therapy appointment must be completed. Failure to attend PT after a van pick-up will result in dismissal from van services.

Progress PT also reserves the right to dismiss patients from the van service for any reason including, but not limited to, the following: not canceling the van at least 1 hour prior to pick-up time by phone, canceling at the door, not being home upon van arrival, the use of inappropriate language or actions of any kind while riding on the van and abuse of the van driver.

Please note that van drivers are often subject to the stresses of busy traffic, tight schedules and varying personalities and should be given proper courtesy and respect when riding on the van.

Name: _____

Address: _____

Phone#: _____

Insurance Type: _____

Reason for needing van services:

I, the above patient, if approved for van services, agree to follow the rules set forth by *Progress PT* and conduct myself in a proper manner while being transported to my therapy appointment. I understand that failure to follow the rules of riding the van can result in losing my van privileges.

Signed: _____

PLEASE READ THIS SECTION CAREFULLY AND SIGN AT THE BOTTOM!

This is to inform you that, because of your type of insurance coverage, you will have a copay every time you come in for a physical therapy visit. This copay is a policy that your insurance company has chosen to assign to your plan. By law this copay must be collected with no exceptions. The clinic receptionist may inform you of this copay, however, it is your responsibility to make the payment on the day of your treatment. If the payments are not made you will be billed through the mail. Receipts are available when payment is rendered. Thank you for choosing Progress Physical Therapy as your rehabilitation provider.

Insurance Type: _____

Copay Amount Due (per visit): _____

Patient's Signature: _____

PROGRESS PT
CENTERS FOR FITNESS AND REHABILITATION

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

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

Address: _____

City/State: _____ Zip: _____

Phone: _____ SSI #: _____

This is a formal request to have the aforementioned patient's records released from:

*Disclosure may include information relating to psychiatric, drug/alcohol, and or HIV or AIDS related information

The records we are requesting to be released are:

These records are to be forwarded to:

*Progress PT Centers for Fitness and Rehabilitation
1331 East Wyoming Ave., Suite 4120
Philadelphia, PA 19124
Phone: (215)-831-1170 / fax: (215)-744-7394*

Patient Signature: _____ Date: ____/____/____

This authorization will be valid for six months from date of signing. The request may be revoked by the aforementioned patient or legal guardian by written request only.



Photo ID Verification Form

Date: _____

Photo ID (must be government issued):

Patient – Name: _____

If Minor:

Parent/Legal Guardian – Name: _____

ID Type: Drivers License Passport Military

Other: _____

Photo Verified

Address:

Current

Discrepancy – New Address: _____

Address Change Card Other: _____

Security Question – Mother’s maiden name: _____

No Photo ID Available

Patient Name: _____ DOB: _____

Facility Representative Signature: _____

Copy of ID