Liaga Physical Therapy and Wellness

Patient Information

Name _____ **Date**_____
Date of Birth_____ **SSN**_____ **Driver's License**_____
Address_____**Apartment/Suite**_____
City_____ **State**_____ **Zip Code**_____
Home Phone (_____)_____**Cell Phone(_____)**_____
Email address_____
Preferred Method of Communication: (please select) ☐Home Phone ☐Cell Phone (call or text) ☐Email
Sex (please select) ○male ○female **Occupation** _____

Employer Name_____
Employer Address_____
City, State, Zip_____
Work Phone_____

Referring Doctor_____**Referring Doctor's Phone Number**_____
Date of Your Next Doctor's Appointment_____

Emergency Contact

Emergency Contact Name_____**Phone (_____)** _____
Relationship to Patient_____

Parent/Responsible Party

Please complete this section if patient is a minor or responsible party is different from patient.
Name_____**SSN**_____
Date of Birth_____ **Driver's License**_____
Sex (please select) ○male ○female
Address_____ **Apartment/Suite**_____
City_____ **State**_____ **Zip code**_____
Home Phone (_____)_____**E-mail Address**_____
Relationship to Patient_____

Signed (Patient/Client)_____**Date**_____
Signed (Parent/Responsible Party)_____**Date**_____

INSURANCE (select one): ☐**Medicare (add secondary below or write none)(BC/BS, Cigna, etc)**
☐**Reg Insurance** ☐ **Work Comp** ☐**Personal Injury**
PRIMARY INSURANCE:_____
Subscriber Name:_____
Insurance Phone Number:_____
Subscriber ID No:_____
Or claim number Ins Claims address_____

SECONDARY INSURANCE:_____
Subscriber Name:_____
Insurance Phone Number:_____ Subscriber ID No:_____
Ins Claims Address:_____

If Personal Injury/Legal:
Attorney Name:_____ Phone no:_____

Authorization to Release Information and Assignment of Benefits:
I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plan to Colleen M. Liaga Physical Therapy. I authorize the release of medical or any other information to the Health Care Financing Administration , my insurance carrier(s) or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Colleen M. Liaga Physical Therapy. This assignment will remain in effect until revoked by me in writing. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier (s)m, or other medical entity, if requested. The original authorization will be kept on file. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient's Signature:_____**Date:**_____

My (new) insurance is:_____
Primary Care Physician:_____
Medical Group:_____

I understand that by signing this form, I am accepting financial responsibility as explained above for all payments for medical services and /or supplies received.

_____
Patient Name (Please Print)

_____
Insured Name (Please Print)

_____ _____
Patient/Insured's Signature Date

Liaga Physical Therapy and Wellness

New Patient Questionnaire

Patient Name_____ Sex (please select) ☐male ☐female
Age_____ Height_____ Weight_____
Name of Referring Physician_____Date of Next Doctor's Appt_____
Hand Dominance ☐Right ☐Left **Foot Dominance** ☐Right ☐Left
Occupation_____ Are you currently working? ☐Yes ☐No
Working Status (please select) ☐Full Duty ☐Modified Duty ☐Not Applicable
My commute time to work/school takes_____minutes.
How did you hear about Colleen?_____

When did your pain start? _____
What activity were you performing?_____
If you had surgery, when was the date of surgery?_____
Are you having treatment because of an accident or work related injury? If yes, please describe.
_____
Where were you when your injury occurred?_____
CAUSE: My problem likely began because (details)_____
_____

TREATMENT: Treatment of my problem to date has included (e.g. x-rays, surgery, PT):
_____
YOUR GOALS (what do you want PT to help you with? e.g. return to walking/running):
_____
I have been treated by Colleen before (details):_____
_____
I have had X-rays, CAT scans, MRI etc. for this problem (details):_____

_____

MEDICATIONS (Please mark the appropriate 'NO' lines, or if YES, provide details)

NO		DETAILS
☐	**I am taking over-the-counter anti-inflammatory, pain meds, or muscle relaxants**	**_____**
☐	**I am taking prescription anti-inflammatory, pain meds, or muscle relaxants**	**_____**
☐	**I am allergic to medications**	**_____**
☐	**I am taking other medications**	

FALLS:

Have you had more than 2 falls, or one fall resulting in injury, in the past year?

☐ Yes ☐ No

PROBLEMS(check and provide details)

	MILD	MODERATE	SEVERE
Pain 1 (area) _____	◯	◯	◯
Pain 2 (area) _____	◯	◯	◯
Swelling	◯	◯	◯
Headaches	◯	◯	◯
Numbness/Abnormal sensation	◯	◯	◯
Other symptom/feeling_____	◯	◯	◯
Loss of function (normal activities)	◯	◯	◯
Loss of strength	◯	◯	◯
Loss of flexibility	◯	◯	◯
Loss of sleep	◯	◯	◯
Loss of balance (e.g. standing on 1 leg)	◯	◯	◯
Loss of bowel/bladder function	◯	◯	◯
Loss of energy	◯	◯	◯
Other loss _____	◯	◯	◯

SPECIAL QUESTIONS(Please mark the appropriate 'NO' lines, or if YES, provide details)

NO		DETAILS
☐	I am pregnant or think I might be pregnant	_____
☐	I have a pacemaker, surgical hardware or other implanted device	_____
☐	I have weight-bearing restrictions given to me by my doctor	_____
☐	I have osteoporosis, osteopenia, or history of fractures	_____
☐	I have contact allergies to tape adhesives &/or latex, etc.	_____
☐	I was told to limit physical activity due to a heart condition or onset of chest pain during activity	_____
☐	I have other reasons why I should not do physical activity	_____
☐	I have been diagnosed with any of the following: Hepatitis A, B &/or C; HIV/AIDS, sexually transmitted disease(s) or infections (i.e. herpes simplex, gonorrhea, HPV, etc.), vaginitis, pelvic inflammatory disease, yeast infection, trichomoniasis	_____

REVIEW OF SYSTEMS (Please mark the appropriate 'NO' lines, or if YES, provide details)

NO		DETAILS
☐	General/Constitutional (e.g. fever or chills, poor general health, unexplained weight loss)	_____
☐	Skin (e.g. rashes, new skin lesions, or a change in moles)	_____
☐	Eyes (e.g. blurred vision, or change in visual acuity)	_____
☐	Ears (e.g. ear pain, or difficulty hearing)	_____
☐	Nose (e.g. nasal congestion, discharge, or bleeding)	_____
☐	Mouth/Throat (e.g. sore throat, or difficulty swallowing)	_____
☐	Neck (e.g. neck, jaw pain, headache, face numbness)	_____
☐	Respiratory (e.g. shortness of breath, cough, wheezing, pain with breathing)	_____
☐	Cardiovascular/Heart (e.g. high/low blood pressure, chest pain)	_____
☐	Gastrointestinal (e.g. nausea, vomiting, diarrhea, constipation, abdominal pain, discolored stools, fecal incontinence, change in appetite)	_____
☐	Genitourinary (e.g. problems initiating or controlling my bladder, or have urinary frequency)	_____
☐	Musculoskeletal (e.g. joint or muscle pain, or back pain)	_____
☐	Neurological (e.g. numbness, weakness, or tingling, seizures)	_____
☐	Endocrine (e.g. heat or cold intolerance, weight loss or gain, increasing thirst)	_____
☐	Hemato-Immunologic (e.g. bruise easily; bleeding, oral ulcerations or recurrent infections)	_____
☐	Psychiatric (e.g. depression, anxiety, substance abuse or suicidal thoughts or attempts)	_____
☐	Vestibular (dizziness)	_____

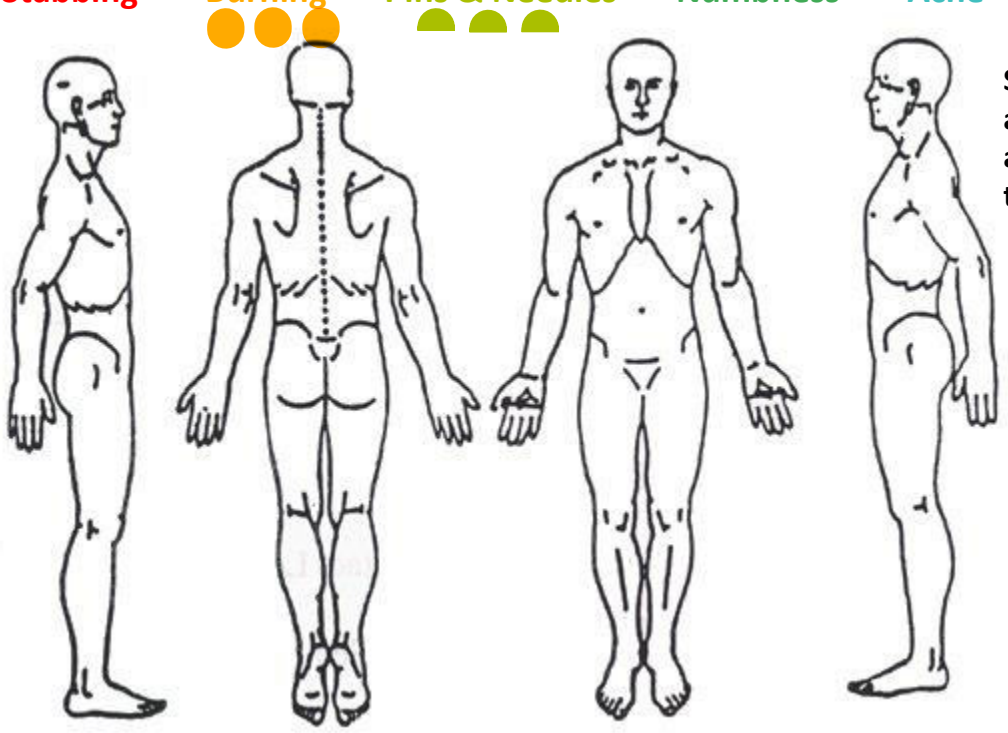
SOCIAL HISTORY

1. **Do you smoke or use any form of tobacco? ☐ Yes ☐ No**
   If Yes, how many a day?_____ For how long?_____
2. **Do you consume alcohol? ◯ Never ◯ Daily ◯ Once a Week ◯ Once a Month**
3. **Describe your exercise history over the last year.**
   Activity Type_____
   Minutes/Day_____
   Days/Week_____

Pain Diagram and Pain Rating

INSTRUCTIONS: Please indicate where your pain is located and what type of pain you feel *<u>at the present time</u>*. Use the symbols below to describe your pain.

KEY: **Stabbing** **Burning** **Pins & Needles** **Numbness** **Ache** **Other**



Select the level of pain and move the dot to the area on the body using the arrow keys

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ☐ 1. Sharp
- ☐ 2. Dull ache
- ☐ 3. Numb
- ☐ 4.Shooting
- ☐ 5.Burning
- ☐ 6.Tingling

13. Please rate your current level of pain on the scale below by circling a number:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

None tolerable Unbearable

Please rate your worst level of pain over the last 2 weeks by circling a number:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

None tolerable Unbearable

How are your symptoms changing? (1.) Getting Better (2.) Not Changing (3.) Getting Worse

What makes your pain worse?_____

What makes your pain better?_____

PAST MEDICAL HISTORY(Please mark the appropriate 'NO' lines, or if YES, provide details and/or underline the conditions pertaining to you)

NO	DETAILS
☐ I have had serious infections (e.g. tuberculosis, pneumonia)	_____
☐ I have had chronic illnesses (e.g. chronic sinusitis, arthritis, other autoimmune disorders, asthma, COPD, cancer in any area, diabetes, epilepsy, dizziness, headaches, angina, heart disease, heart attack, hernia, stroke, MS, Parkinson's, kidney, bladder, prostate, ulcers, GERDS, osteoporosis, osteopenia)	_____
☐ I have had the following general surgeries (e.g. appendectomy, gastrointestinal surgery, tumor removal, heart, kidney, and or lung transplant, CABG, pacemaker/pump or any other type of implant, carotid endarterectomy, laparoscopy, mastectomy, breast augmentation/reduction, cosmetic surgery, tubal ligation, ovarian cystectomy, hysterectomy, hernia repair, TURP)	_____
☐ I have had the following orthopedic surgeries (e.g. arthroscopy, repair, reconstruction, replacement, fusion, laminectomy, discectomy, ORIF (pins, plates, screws) to any area/joint)	_____
☐ I have had a history of falls or near falls	_____
☐ Any OTHER medical history or procedures	_____

I verify the above information is complete and accurate, and have not omitted any medical conditions or history.

_____ _____

Patient or Responsible Party Signature **Date**

HIPAA Privacy Authorization Form
Liaga Physical Therapy and Wellness

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization
I authorize __ Liaga Physical Therapy and Wellness___ (healthcare provider) to use and disclose the protected health information described below to _____
(physician/individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____. **OR** b. ☐ all past, present, and future periods.

3. Extent of Authorization
a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR
b. ☐ I authorize the release of my complete health record with the exception of the following information:

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

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and his or her relationship to patient

_____
Date

Liaga Physical Therapy and Wellness
Physical Therapy Policies

In order to ensure a safe and positive experience while participating in physical therapy, please abide by the following guidelines:

- Copayments are due at the time of service. Co-insurance or share of cost will be billed to the insurance first, and then you will receive a bill for your portion.
- You are responsible for any charges not covered by your insurance company.
- Commit to your physical therapy appointments.
- Please call 24 hours in advance if you are unable to attend your scheduled appointment or would like to reschedule.
- Be compliant with your home exercise program as you are a huge reason why you meet your goals for physical therapy.
- Please limit your cell phone usage. Please place your cell phone on silent to maximize your physical therapy session.

Liaga Physical Therapy and Wellness is dedicated to providing you with the utmost professionalism and quality care. Please accept your responsibility by following the above-mentioned policies.

Signature:_____Date:_____
By signing, I declare that I have read and understand the above outlined policy.

Liaga Physical Therapy and Wellness

Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices from Liaga Physical Therapy and Wellness.

I may be contacted at the numbers/addresses listed below regarding my current treatment, scheduling, or financial arrangements. Best method of contact (check):

_☐_ Email :_____
_☐_ Cell:_____
_☐_ Home: _____
_☐_ Work:_____

You may communicate with the persons listed below regarding my current treatment, scheduling, or financial arrangements.

Name:_____ Relationship_____
Name:_____ Relationship_____

_____
Patient Name (Print)

_____ _____
Patient or Guardian Signature Date

Accounting of Disclosures of PHI (office use only)

(Accountings do not have to include disclosures for treatment, payment, healthcare operations, unless there is a written request of restriction)

Date	Disclosed to whom Address or fax #	Authorized (yes/no)	Description of PHI	Purpose of Disclosure	Method Sent	Disclosed by

A. Notifier: Liaga Physical Therapy and Wellness

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** (physical therapy codes) below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** *physical therapy codes* below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Service(s): **97161** **G0283** **97162** **97116** **97163** **97140** **97164** **97530** **97110** **97535** **97112**	**Service(s) may not be covered after Benefits have exceeded $2010.00** **Or** **Services(s) may not be deemed medically necessary**	**$100.00- 250.00 Per visit**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: