HAUSMANN
PHYSICAL THERAPY

Patient Admission

SSN: _____-____-_____ Date of birth: _____/____/_____ Gender: □ M □ F Date: _____/____/_____

Last Name: _____ M.I.: ____ First Name: _____

Address:_____ City:_____ State:____ Zip : _____

Home Phone: (_____)_____ Mobile: (_____)_____ E-mail**:** _____

How would you like to receive appointment reminders? □ Text □ E-mail □ Voice mail

Emergency Contact: _____ Relationship: _____ Phone: (____)_____

Marital Status: □ SINGLE □ MARRIED □ OTHER: _____

EMPLOYMENT STATUS: □ EMPLOYED □ UNEMPLOYED □ RETIRED □ STUDENT

Employer: _____ □ Full Time □ Part Time

Supervisor: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: ____ Zip:_____

RESPONSIBLE PARTY: □ SELF □ SPOUSE □ PARENT □ OTHER:_____

Responsible Party Date of Birth: ____________ Relationship to patient:_____

Last Name:_____ M.I.: _____ First Name:_____

Address:_____ City:_____ State:____ Zip: _____

Responsible Party Primary Phone number: (_____)_____

Is your injury related to any of the following? □ Auto related □ Work related □ Other Accident □ None

Date of Accident: ____________

Work Comp/Accident Carrier:_____ Adjuster: _____

Adjuster Phone: _____ Claim #:_____

INSURANCE INFORMATION: □ I do not have insurance □ Self-pay

Primary Insurance Name: _____ Policy ID:_____ Group #: _____

Policy Holder: _____ DOB:_____ Relationship to patient:_____

Secondary Insurance Name: _____ Policy ID:_____ Group #: _____

Policy Holder: _____ DOB:_____ Relationship to patient:_____

Are you a Medicare patient? □ Yes □ No

Are you receiving home health or have you received any in the past 60 days? □ Yes □ No

Home Health Agency:_____ Discharge Date: _____

How did you hear about Hausmann Physical Therapy? □ Doctor Referral □ I've had PT here before

□ Friend/Family □ Website □ Google Review □ Other:_____

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Patient Case

Case #: _____ (Office use only) Date: _____/_____/_____

Last Name: _____ **M.I**.: _____ **First Name**: _____

Date of Birth: _______________ **Date of injury**: _______________

Tell us about your injury or symptoms:

_____

_____

What region(s) are affected by your current symptoms? □ Head/Neck □ Upper Back □ Shoulder □ Lower Back
□ Arm □ Hand/Wrist □ Hip □ Pelvis □ Knee □ Leg □ Other: _____

Have you received any previous treatment for this condition? □ Yes □ No Explain: _____

What kind of pain are you experiencing? □ Tenderness □ Spasm □ Numbness □ Tingling □ Aching □ Sharp
□ Shooting □ Dull □ Other: _____

When are your symptoms worse? □ In the morning □ During the day □ At night □ With activity □ At rest
□ Symptoms come and go □ Symptoms are constant □ None

When are your symptoms best? □ In the morning □ During the day □ At night □ With activity □ At rest
□ Symptoms come and go □ Symptoms are constant □ None

Indicate the intensity of your pain over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain ever):
Current Pain (0-10) _____ Best Pain (0-10) _____ Worst Pain (0-10) _____

Have you had any of the following diagnostic tests for this issue before? □ MRI □ X-Ray □ CT Scan
□ Myelogram □ Other: _____

Have you had surgery for this issue? □ Yes □ No Date of Surgery: _______________

Were you hospitalized for this issue? □ Yes □ No Hospitalization Date: _______________

Which forms or treatment have you had for this issue in the past? □ Physical Therapy □ Occupational Therapy
□ Speech Therapy □ Chiropractic □ Other: _____

Have you fallen within the last year? □ Yes □ No

Do you feel unsteady when standing or walking? □ Yes □ No

Do you worry about falling? □ Yes □ No

Who is your referring doctor? _____ Phone: _____
Clinic name: _____ □ I don't have a referring doctor

What are your goals for therapy? _____

_____

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Patient Health History

Date: _____/_____/_____

Last Name: _____ M.I.: ____ First Name: _____

Do you have, or have you ever had, any of the following conditions?

Yes	No		Yes	No	
□	□	Allergies	□	□	Hernia
□	□	Alzheimer's/ Dementia	□	□	High Blood Pressure
□	□	Angina	□	□	High Cholesterol
□	□	Anxiety or Panic Disorders	□	□	HIV/AIDS
□	□	Arthritis	□	□	Hypoglycemia
□	□	Asthma	□	□	Immunosuppressant Condition or Medication
□	□	Back Injury	□	□	Joint Replacement
□	□	Bleeding Disorders	□	□	Kidney Problems
□	□	Bowel/Bladder Abnormalities	□	□	Ligament or Tendon Injury
□	□	Cancer	□	□	Liver/Gallbladder Problems
□	□	Carpal Tunnel Syndrome	□	□	Metal Implants
□	□	Chronic Obstructive Pulmonary Disease	□	□	Multiple Sclerosis
□	□	Congestive Heart Failure	□	□	Nausea/Vomiting
□	□	Defibrillator	□	□	Osteoporosis
□	□	Degenerative Disc Disease	□	□	Pacemaker
□	□	Depression	□	□	Parkinson's Disease
□	□	Diabetes	□	□	Peripheral Vascular Disease
□	□	Dizzy or Fainting Spells	□	□	Pregnancy
□	□	Emphysema	□	□	Ringing in your ears
□	□	Epilepsy or Seizure Disorder	□	□	Sexual Dysfunction
□	□	Fracture	□	□	Shingles
□	□	Headaches	□	□	Skin Abnormalities
□	□	Head Injury	□	□	Smoking
□	□	Hearing Impairment			

Are you currently taking any medication? □ Yes □ No If yes, please list below:

Medication: _____ Dosage:_____ Medication: _____ Dosage:_____

Medication: _____ Dosage:_____ Medication: _____ Dosage:_____

Medication: _____ Dosage:_____ Medication: _____ Dosage:_____

Medication: _____ Dosage:_____ Medication: _____ Dosage:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Hausmann Physical Therapy of any changes in medical status.

Patient/Guardian Signature: _____ Date: _____

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Patient Information Practices and Consent

Consent to Treatment

I hereby agree and give my consent to Hausmann Physical Therapy to furnish appropriate rehabilitative care and treatment as considered necessary by my physician and/or recommended by my physical therapist. I understand that benefits and possible risks to all interventions will be explained, and I have the right to ask and have any questions answered prior to receiving any treatment.

Assignment of Benefits

I hereby authorize my insurance carrier(s) to directly pay Hausmann Physical Therapy for physical therapy services rendered. I understand that my insurance policy is a contract between my insurance company and myself. Hausmann Physical Therapy is not a party to that contract. I understand and agree that I am financially responsible for any charges not covered by my insurance including deductible, co-insurance, and/or co-payment amounts. In the event of default, I agree to pay collections costs and reasonable fees as may be required to obtain collection of my account.

Liability Claims and Auto Accidents

I understand and agree that it is my responsibility to provide Hausmann Physical Therapy with billing information pertaining to a liability claim, auto accident, or legal case when another party is responsible, or if I have an attorney acting on my behalf.

Workers' Compensation

If my injury is the result of a work accident and a workers' compensation claim has been initiated, I agree to provide Hausmann Physical Therapy with the employer information, representative, claim number, and carrier to ensure payment of the account.

Cancellation, Late Cancellation and No-Show

If cancellation is necessary, we require that you call at least 24 hours in advance. If calling outside of normal business hours, you may leave a detailed voicemail message. We will return your call as soon as possible.

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $25 missed appointment fee. I understand that insurance companies do not reimburse for missed appointments and any fees resulting from missed appointments are my responsibility.

Payment and Collections

Hausmann Physical Therapy will impose an interest fee of 16% for any balance over 60 days and will not carry balances over 90 days. I understand and agree that if my account reaches 90 days past due and I have not contacted Hausmann Physical Therapy to make payment arrangements, my account will be turned over to a collection agency.

Uses and Disclosures of Health Information

I hereby authorize Hausmann Physical Therapy to use my personal health information primarily for treatment, obtaining payment, internal administrative activities, and evaluating the quality of care that they provide. They may also disclose my personal health information, without my consent, for public health purposes, auditing, emergencies, and when required by law. In any other situation, Hausmann Physical Therapy will obtain my written authorization prior to disclosing any personal health information including general, medical, mental health, and HIV/AIDS information. I understand that I may withdraw my consent at any time.

Notice of Privacy Practices

I have been given the opportunity to read, review and receive a copy of the Notice of Privacy Practices and I understand its contents. I understand that Hausmann Physical Therapy has the right to change its Notice of Privacy Practices and I have the right to request a current copy at any time.

By signing below, I certify that I have read, understand, and fully agree to each of the statements in this document.

Patient/Guardian Signature: _____ Date: _____