MICHIGAN
PHYSICAL THERAPY
ASSOCIATES

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

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

Date of Birth: _____ Age: _____ ☐ Male ☐ Female Social Security # _____

Home Phone: (_____) _____-_____ Alternate Phone (Cell, Pager): (_____) _____-_____ ☐ Former Patient

Spouse / Next of Kin: _____ Relationship: _____ Phone: (_____) _____-_____

WORK INFORMATION

Employer: _____ Work Phone: (_____) _____-_____ Ext: _____

Occupation: _____ Employment Status: ☐ Not Employed ☐ Part Time ☐ Full Time ☐ Retired

PHYSICIAN INFORMATION

Referring Doctor: _____ Primary Doctor: _____

Phone: _____ Phone: _____

When is your NEXT Doctor's Appointment? _____

Currently receiving home health care? ☐ Yes ☐ No If yes, from which agency? _____

INSURANCE INFORMATION

Please Give Your Insurance Cards and Driver's License to the RECEPTIONIST.

AUTO or WORK INJURY CLAIM

Insurance Name: ☐ Auto _____ ☐ Work Comp _____

Adjuster / Claim Manager: _____ Phone: (_____) _____-_____ Ext: _____

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

Claim #: _____ Accident / Injury Date: _____

ATTORNEY INFORMATION

Law Firm: _____ Attorney's Name: _____ Phone: (_____) _____-_____

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

I authorize my insurance benefits be paid directly to Michigan Physical Therapy Associates. I understand that I am financially responsible for any balance. I also authorize Michigan Physical Therapy Associates to release any information required to process my claim.

_____

PATIENT / GUARDIAN SIGNATURE DATE

E-Mail Address: _____ (for a physical therapy wellness newsletter).

5409 Gateway Centre Drive • Suite B • Flint • MI 48507

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CONSENT TO TREATMENT

I, _____, hereby voluntarily request, consent to and authorize the physical therapists, their assistants and other staff to attend me at Michigan Physical Therapy Associates, and to provide medical services, as is deemed necessary and advisable.
I am aware that the practice of medicine/rehabilitation is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examination at Michigan Physical Therapy Associates.
I further understand that my treatment may require more than one occasion of service; therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further outpatient treatment.

_____ Date: _____ _____
(Signature of Patient or Legal Representative) (Signature of Witness)

PATIENT'S PERSONAL POSSESSIONS: Michigan Physical Therapy Associates is not responsible for any patient's clothing, valuables or other personal belongings left with the patient or brought in to the patient. I hereby release Michigan Physical Therapy Associates from any liability for any and all personal possessions, which I choose to keep with me during my visit.
RELEASE OF INFORMATION: I hereby authorize Michigan Physical Therapy Associates, its designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. To:

1. any third party payor, employer, or insurance company (including but not limited to Medicare, Blue Cross/Blue Shield, Medicaid, commercial health insurers, automobile no-fault insurers, worker's disability compensation insurers and health maintenance organizations) which are responsible in whole or in part for paying the patient's bill so that Michigan Physical Therapy Associates may receive payment or reimbursement for the services provided to the patient.
2. any health care facility, physician, durable medical equipment supplier, or other ancillary services provider to which the patient is referred or transferred or to which referral transfer is contemplated for the purpose of facilitating continuity of the patient's health care.
3. any independent auditors hired or retained by any and all third party payors, private health insurers and or any employer providing health insurance benefits to the patient, applicable to the patient's treatment at Michigan Physical Therapy Associates, for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient.

The release of information shall be effective only so long as is necessary to accomplish the purpose for which it is given.
ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer and set over unto Michigan Physical Therapy Associates, as its interest may appear all benefits now due or becoming due to me by virtue of the present treatment.
AGREEMENT TO PAY FOR SERVICES: I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as agent or as patient.

The undersigned certifies that he/she has read the foregoing or that it has been read to him/her, and that he/she understands the same and consents thereto, and that he/she is the patient or the duly authorized representative or agent of the patient to sign this form and consent thereto.

_____ Date: _____
(Signature of Patient or Legal Representative)

_____ _____
(Relationship, if other than patient) (Signature of Witness)

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NOTICE OF PRIVACY PRACTICES

As part of my health care, **Michigan Physical Therapy Associates** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results, and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Michigan Physical Therapy Associates'** personnel and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Michigan Physical Therapy Associates** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **Michigan Physical Therapy Associates** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours.

_____ _____ _____

Signature of Patient or legal representative | Date | Relationship to Patient

_____

Printed Name of Patient

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Patient Information Sheet

Name: _____ Date: _____

Any Know Allergies:

_____

_____

How many falls have you had in the last 1 year? _____ **Any injuries?** Yes No

Current Medication Being Taken

Include all prescription, over-the-counter, herbals, and vitamins/minerals/dietary supplements.
Please notify staff immediately of any changes to medication.

Name	Dosage	Frequency	Administration Route Example: oral

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MEDICAL HISTORY

NAME: _____ **DATE:** _____

Health problems may affect your treatment. Please answer the following questions so that we can administer your care safely and effectively.

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS? (Circle your answer)

Angina	Yes	No
Anxiety or Panic Disorders	Yes	No
Arthritis (rheumatoid/osteoarthritis)	Yes	No
Asthma	Yes	No
Back Pain (degenerative disc disease or spinal stenosis)	Yes	No
Cancer	Yes	No
Congestive Heart Failure (or heart disease)	Yes	No
Depression	Yes	No
Diabetes (Types I and II)	Yes	No
Heart Attack (Myocardial Infarction)	Yes	No
Headaches	Yes	No
Hepatitis or AIDS	Yes	No
High Blood Pressure	Yes	No
Gastrointestinal Disease (hernia, reflux, bowel, liver, or ulcer)	Yes	No
Incontinence	Yes	No
Kidney/Prostate Problems	Yes	No
Neurological Disease (i.e. multiple sclerosis or Parkinson's)	Yes	No
Peripheral Vascular Disease	Yes	No
Prior Surgery	Yes	No
Prosthesis (joint replacement)/Implants (plates or screws)	Yes	No
Pulmonary Disease (COPD/ARDS/Emphysema)	Yes	No
Seizures	Yes	No
Stroke or TIA	Yes	No

Do you have a Pacemaker?	Yes	No
Are you pregnant?	Yes	No
Do you exercise regularly?	Yes	No

Height: _____ Weight: _____

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