Metamora Physical Therapy

3562 S. Lapeer Rd. Ste F, Metamora, MI 48455 Phone: (810) 212-1277

PATIENT INFORMATION

Date _____

Name: (First)_____ (Last)_____ (Middle) _____ Birth Date_____

Address_____ Apt # _____City _____ State _____Zip_____

Day Phone _____ Home Phone _____ Cell Phone_____

If you **don't** want to receive appointment reminders by text, please check ☐

E-Mail _____(For appointment reminders, updates, seminars, event notices)

Marital Status: ☐ Married ☐ Single ☐ Other Sex ☐ M ☐ F Former Patient: ☐ Yes ☐ No

How did you hear of Metamora PT? _____

Referring Physician_____

If you would like us to send copies of correspondence to your primary care physician, please complete:

Primary Care Physician_____Phone _____

PATIENT INFORMATION

CURRENT EMPLOYMENT/SCHOOL INFORMATION_____

PRIMARY INSURANCE

Primary Insurance Company _____

Name of Policy Holder_____Relationship_____Date of Birth_____

ID # _____ Group # _____

Secondary Insurance Company_____

Name of Policy Holder_____ Relationship _____ Date of Birth _____

ID # _____ Group # _____

Have you verified your therapy benefits with your insurance? ☐ Yes ☐ No

If not, we strongly encourage you to do so.

AUTO

Is this an Auto Accident? ☐ Yes ☐ No Date of accident_____

In what city and state did the accident occur? _____

Is this a Lawsuit? ☐ Yes ☐ No Law firm name _____

Attorney Name_____ Attorney Phone _____

WORKER'S COMPENSATION

Employers Name:_____ Employers Phone#: _____

City/State:_____ Job Title:_____

Is this an approved Worker's Comp Injury? ☐ Yes ☐ No

Date of Injury _____ In what city and state did the injury occur? _____

Law Firm Name _____

Attorney Name_____ Attorney Phone _____

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_____

_____

MEDICAL HISTORY FORM

PLEASE CHECK ALL THAT APPLY:

○	Cancer or Malignancy	○	Diabetes
○	Heart Condition	○	High Blood Pressure
○	Alzheimer's/Dementia	○	Lupus/ Rheumatoid Arthritis
○	Fibromyalgia	○	Ulcer or digestive disorder
○	Gout	○	Respiratory Disorder
○	Chronic Fatigue	○	Bowel or Bladder problems
○	Difficulty swallowing	○	Stroke
○	Pacemaker/Defibrillator	○	Metal implants
○	Osteoporosis	○	Seizures
○	Dizziness/faintness	○	Allergy to latex
○	Are you Pregnant	○	Infectious disease
○	Pain with Sex	○	Incontinence
○	Neurologic condition (MS/ Parkinson's)	○	Fractures
○	Thyroid Condition	○	HIV/AIDS

If yes to any of the above, please describe:

_____

_____

_____

PLEASE LIST ANY OTHER OPERATIONS, SERIOUS ILLNESSES, ACCIDENTS OR ANY BROKEN BONES THAT YOU HAVE HAD FROM BIRTH TO PRESENT:

_____

Do you smoke? ___YES ___NO

Have you gained or lost weight in the past 12 months? ___YES ___NO

During the past month, have you been feeling down, depressed or feeling hopeless? Yes No

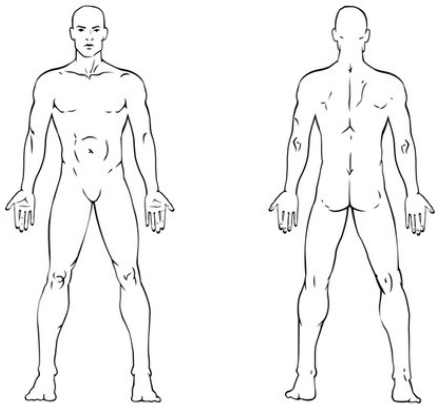
During the past month have you experienced little interest or pleasure in doing things? Yes No

Treatment received so far for this problem: Physical/Occupational Therapy Injections Massage Chiropractic Acupuncture Other:_____

Have you received physical/occupational therapy in the past year? Yes No

Have you had testing done? X-Ray CT Scan MRI Bone Scan

Please mark the following diagrams/scales as they describe your pain level and function TODAY



No Pain Most Pain

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms better?

_____

What makes your symptoms worse?

_____

What time of day are your symptoms worse? Morning Afternoon Evening Overnight

What are your goals for therapy?

_____

Additional Comments and/or informantion you would like to add?

_____

___

Date of next physician appointment_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AT THE PRESENT TIME.

Signed:_____ Date:

_____

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1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $30 or $60 depending on appointment type.

WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Metamora PT, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Metamora PT with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. When you provide a check as payment in the clinic, you authorize us to use the information from your check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day and you will not receive your check back from your financial institution.
Please note that refusal to sign this form does not change responsibility for payment in any way.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Metamora PT all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Metamora PT may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Metamora PT's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Metamora PT's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. HIPAA CONSENTS: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

Name/Relationship_____

Name/Relationship_____

Name/Relationship_____

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

7. CONSENT FOR EMERGENCY CONTACT INFORMATION Person to contact in case of an emergency:

Name_____ Telephone Number_____ Relationship:_____

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person_____ Date_____

Printed Name of above_____ Date _____

Metamora Physical Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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MEDICATION LIST

Patient Name:_____ Date:_____

Medication	Dosage	Frequency

Metamora Physical Therapy, LLC

NOTICE OF PATIENET INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Metamora Physical Therapy, LLC's LEGAL DUTY

Metamora Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Metamora Physical Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Metamora Physical Therapy, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Metamora Physical Therapy, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Metamora Physical Therapy, LLC''s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may revoke that authorization to stop future disclosure at any time.

Metamora Physical Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of out Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Metamora Physical Therapy, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Metamora Physical Therapy, LLC may have violated your privacy rights or you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the Department of Health and Human Services. For further information on Metamora Physical Therapy's health information practiced or if you have a complaint, please contact the following person:

Metamora Physical Therapy, LLC
Office Administrator
3562 S. Lapeer Rd. Ste F, Metamora MI 48455
Telephone: 810-212-1277 Fax: 810-212-1282

Metamora Physical Therapy, LLC
PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Metamora Physical Therapy, LLC's Notice of Information Practiced. I understand that Metamora Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in Metamora Physical Therapy, LLC's Notice of Information practices. U understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____ _____
Signature Date

I also authorize Metamora Physical Therapy, LLC to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies, I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____ _____
Signature Date