



Date _____

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

Address: _____ Apt #/PO Box # _____

City _____ State _____ Zip _____

Day Phone _____ Home Phone _____ Cell Phone _____

*If you **do not** want to receive appointment reminders, please check

E-Mail _____

(For appointment reminders, updates, seminars, event notices)

Marital Status: ___ Married ___ Single ___ Other Sex: ___ Male ___ Female

Former Patient: ___ Yes ___ No

How did you hear of Metamora Physical Therapy? _____

Are you currently receiving any home care services? (PT, OT, Nursing, Speech) ___ Yes ___ No

Have you had home care services this year? (PT, OT, Speech) ___ Yes ___ No

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: _____

AUTO

Is this an Auto Accident? ___ Yes ___ No If yes, please complete the following:

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

Is this a worker's compensation claim? ___ Yes ___ No If yes, please complete the following:

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: _____



Patient name: _____ Date: _____

Please check all that apply to you:

<input type="checkbox"/> Cancer or Malignancy	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> Lupus/Rheumatoid Arthritis
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Ulcer or digestive disorder
<input type="checkbox"/> Gout	<input type="checkbox"/> Respiratory Disorder
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Pain with Sex
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Stroke
<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Metal implants
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Dizziness/faintness/vertigo	<input type="checkbox"/> COPD
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Infectious disease
<input type="checkbox"/> Constipation or diarrhea	<input type="checkbox"/> Urinary or bowel incontinence
<input type="checkbox"/> Neurological condition (MS/Parkinson's)	<input type="checkbox"/> Fractures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> ADHD	<input type="checkbox"/> TMJ
<input type="checkbox"/> Psychological disorder	<input type="checkbox"/> Anxiety and/or depression
<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Sleep disorder	<input type="checkbox"/> Asthma
<input type="checkbox"/> Digestive issues	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Headache/migraines	<input type="checkbox"/> Allergies

If yes to any of the above, please describe:

Please list any operations, serious illnesses, accidents, or broken bones that you've had from birth to present:

Do you smoke? ___ Yes ___ No If yes, what do you smoke? _____

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

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____ Date: _____

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling “yes or “no” or “sometimes” for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

- | | | | | |
|------|--|------------------|-----------------|------------------------|
| P1. | Does looking up increase your problem? | Yes ¹ | No ² | Sometimes ³ |
| E2. | Because of your problem, do you feel frustrated? | Yes ¹ | No ² | Sometimes ³ |
| F3. | Because of your problem, do you restrict your travel for business or recreation? | Yes ¹ | No ² | Sometimes ³ |
| P4. | Does walking down the aisle of a supermarket increase your problem? | Yes ¹ | No ² | Sometimes ³ |
| F5. | Because of your problem, do you have difficulty getting into or out of bed? | Yes ¹ | No ² | Sometimes ³ |
| F6. | Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties? | Yes ¹ | No ² | Sometimes ³ |
| F7. | Because of your problem, do you have difficulty reading? | Yes ¹ | No ² | Sometimes ³ |
| P8. | Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem? | Yes ¹ | No ² | Sometimes ³ |
| E9. | Because of your problem, are you afraid to leave your home without having someone accompany you? | Yes ¹ | No ² | Sometimes ³ |
| E10. | Because of your problem, have you been embarrassed in front of others? | Yes ¹ | No ² | Sometimes ³ |
| P11. | Do quick movements of your head increase your problem? | Yes ¹ | No ² | Sometimes ³ |
| F12. | Because of your problem, do you avoid heights? | Yes ¹ | No ² | Sometimes ³ |
| P13. | Does turning over in bed increase your problem? | Yes ¹ | No ² | Sometimes ³ |
| F14. | Because of your problem, is it difficult for you to do strenuous housework or yard work? | Yes ¹ | No ² | Sometimes ³ |
| E15. | Because of your problem, are you afraid people might think you are intoxicated? | Yes ¹ | No ² | Sometimes ³ |
| F16. | Because of your problem, is it difficult for you to go for a walk by yourself? | Yes ¹ | No ² | Sometimes ³ |
| P17. | Does walking down a sidewalk increase your problem? | Yes ¹ | No ² | Sometimes ³ |
| E18. | Because of your problem, is it difficult for you to concentrate? | Yes ¹ | No ² | Sometimes ³ |
| F19. | Because of your problem, is it difficult for you walk around the house in the dark? | Yes ¹ | No ² | Sometimes ³ |
| E20. | Because of your problem, are you afraid to stay home alone? | Yes ¹ | No ² | Sometimes ³ |
| E21. | Because of your problem, do you feel handicapped? | Yes ¹ | No ² | Sometimes ³ |

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes ¹	No ²	Sometimes ³
E23.	Because of your problem, are you depressed?	Yes ¹	No ²	Sometimes ³
F24.	Does your problem interfere with your job or household responsibilities?	Yes ¹	No ²	Sometimes ³
P25.	Does bending over increase your problem?	Yes ¹	No ²	Sometimes ³

SECTION II - Part II

Instructions: Put a check in the box that best describes you:

- Negligible symptoms (0)
- Bothersome symptoms (1)
- Performs usual work duties but symptoms interfere with outside activities (2)
- Symptoms disrupt performance of both usual work duties and outside activities (3)
- Currently on medical leave or had to change jobs because of symptoms (4)
- Unable to work for over one year or established permanent disability with compensation payments (5)

Therapist Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD Code: _____



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 and understand the following:

1. I must provide at least a 24-hour notice when I need to cancel or reschedule an appointment. I understand that a cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of \$50.00.
2. I understand that three (3) cancelled appointments in a row, regardless of given notice, will result in an automatic discharge from physical therapy.
3. I agree to provide a credit card to remain on file for cancellation/no show charges. **I understand my card will be charged automatically if I no-show an appointment.** (We understand that cancellations will occur due to sickness, scheduling conflicts, emergencies, etc. We will consider appropriate allowances in these circumstances.)

Printed name: _____

Signature: _____

Date: _____



3562 S. Lapeer Rd. Ste F, Metamora, MI 48455

Phone: 810-212-1277 Fax: 810-212-1282

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 a 24-hour 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 \$50.

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 give consent to the following individuals to receive verbal information regarding the billing and scheduling 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/Legally Responsible Person: _____

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.

Metamora Physical Therapy, LLC

NOTICE OF PATIENT 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 later revoke that authorization to stop future disclosures 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 our 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 if 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 US Department of Health and Human Services. For further information on Metamora Physical Therapy's health information practices 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 Practices. 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. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

Patient Name

Signature

Date