Metamora
Physical Therapy

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: _____

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Patient Name:_____ Date:_____

**Please list any medications, vitamins, or supplements you are currently taking:**

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Please list any allergies you have:**

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|---|
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Patient name:_____ Date: _____

Please check all that apply to you:

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

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Treatment received so far for this diagnosis:

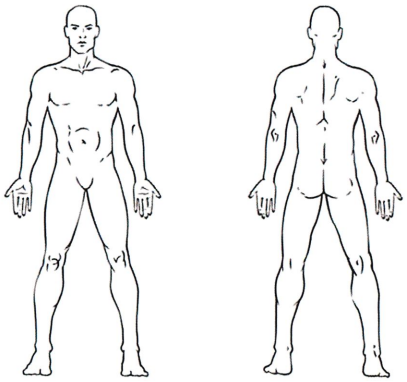
___Physical/Occupational Therapy ___Injections ___Massage ___Chiropractic ___Acupuncture

Other:_____

Have you received physical/occupational therapy in the past year? ___Yes ___No

Have you had testing done for this diagnosis? ___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 information you would like to add?

_____

_____

Date of next physician appointment: _____

**I certify that I have answered the questions on this form accurately and honestly. I understand that providing incorrect information can be harmful to my physical therapy treatment. I understand that it is my responsibility to inform my Physical Therapist of any changes in my medical status.**

_____ _____

Printed name of Patient Date

_____ _____

Signature of Patient/Parent/Guardian Printed name of parent/guardian

PATIENT NAME: _____ ID#: _____ DATE: _____

**Description**: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

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

## MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

**1. Pain Intensity**
(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

**2. Personal Care (washing, dressing, etc.)**
(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

**3. Lifting**
(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

**4. Walking**
(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

**5. Sitting**
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

**6. Standing**
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

**7. Sleeping**
(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

**8. Social Life**
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

**9. Traveling**
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

**10. Employment / Homemaking**
(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.



**Therapist Use Only**

Comorbidities:
- ☒ Cancer
- ☒ Diabetes
- ☒ Heart Condition
- ☒ High Blood Pressure
- ☒ Multiple Treatment Areas
- ☒ Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☒ Obesity
- ☒ Surgery for this Problem
- ☒ Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

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# 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: _____

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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