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: _____________________

Metamora
Physical Therapy

Patient Name:____ Date:_____________________

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

Medication	Dosage	Frequency

Please list any allergies you have:

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

Treatment received so far for this diagnosis:

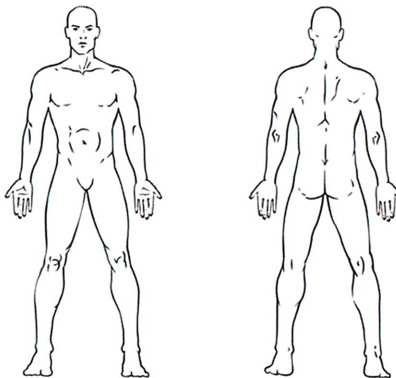
___Physical/Occupational Therapy ___Injections ___Massage ___Chiropractic ___Acupuncture

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

QuickDASH - Initial Patient name:________________________ Date:__________

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

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

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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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: ____________

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

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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 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