SEARCY PHYSICAL THERAPY

Life Should Not Be A Pain

PATIENT INFORMATION			**EMAIL ADDRESS:**
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:		Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

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

PATIENT /GUARDIAN SIGNATURE DATE

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____

_____

_____

_____

WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

Searcy Physical Therapy

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I consent to the use of disclosure of my Protected Health Information (PHI) by Searcy/ Des Arc Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Searcy /Des Arc Physical Therapy. I understand that diagnosis or treatment of me by Searcy/Des Arc Physical Therapy may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI information is used or disclosed to carry out treatment, payment or health care operations of this practice.

Searcy/ Des Arc Physical Therapy is not required to agree to the restrictions that I may request. However, if Searcy/Des Arc Physical Therapy agrees to a restriction that I request, the restriction is binding on Searcy/Des Arc Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Searcy/Des Arc Physical Therapy has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Searcy/Des Arc Physical Therapy's Notice of Privacy Practices (NPP) prior to signing this document. The NPP describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my therapy services, or in the performance of health care operations of Searcy/Des Arc Physical Therapy. The NPP of Searcy/Des Arc Physical Therapy is provided at 2921 Hawkins Drive, Searcy, AR 72143/1108 Hwy 11 N. Suite B Des Arc, AR 72040. This NPP also described my rights and Searcy/Des Arc Physical Therapy's duties with respect to my protected health information.

Searcy/Des Arc Physical Therapy reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	Personal Representative's Authority

Searcy/ Des Arc PHYSCIAL THERAPY
ADDENDUM: PATIENT PRIVACY

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

In an effort to comply with current **HIPPA** (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters:

_____Phone_____Relationship_____

_____Phone_____Relationship_____

_____Phone_____Relationship_____

In the event that we are unable to reach you personally, do you give your permission to a staff member of Searcy/Des Arc Therapy to leave a message on your answering machine, voice mail, and/or with someone at your home number or cell number concerning your private health information or financial matters? (Please check yes or no)

YES_____ NO_____

I understand I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing with me first.

_____ _____
Patient or legally authorized individual signature Date

_____
Relationship to patient if signed by anyone other than the patient such as (parent, legal guardian, personal representative, etc.)