

**Southeastern Physical Therapy
New Patient Introductory Paperwork**

NAME	DATE OF BIRTH	NICKNAME
MAILING ADDRESS		
STREET ADDRESS (If different than above)		
HOME PHONE #	CELL PHONE #	
What phone number is the best for contacting you? HOME / CELL / OTHER:		
EMAIL ADDRESS		
EMERGENCY CONTACT	NAME:	RELATIONSHIP:
		PHONE #:
SOCIAL SECURITY #	REFERRING PHYSICIAN	
INSURANCE TYPE	SUBSCRIBER (If not patient include SSN and DOB)	
Please identify anyone you would like to authorize to have access to your information including medical record and billing regarding PT/OT. Please include their name and relationship to you.		
What are your goals for physical therapy?		
Do you have any additional information you would like the therapist to know regarding your visit?		
Signature: _____		Date: _____

**Southeastern Physical Therapy
Medical Screening Form**

NAME	DOB/AGE	GENDER
CURRENT ISSUE		DATE OF INJURY
RECENT SURGERY		DATE OF SURGERY
Are you currently: student working not working retired other: _____		OCCUPATION
SPORTS	SCHOOL	GRADE
Housing: house apartment condo mobile home other: _____ Do you have stairs? yes no A railing? yes no Steep lot? yes no		
Please rate your general health: excellent good fair poor Any allergies? yes no Please Explain: _____		
Past surgeries/injuries/hospitalizations: _____		
Have you Ever been diagnosed with any of the following conditions?(check all that apply) cancer rheumatoid arthritis diabetes other arthritis high blood pressure depression heart problems tuberculosis stroke bone/joint infection HIV hepatitis asthma COPD chemical dependency seizures blood clots other: _____		
Please check any that apply to you: Latex Sensitive Smoker Pacemaker Pregnant Osteoporosis Pins or Metal		
Any significant family medical history?		
MEDICATION (Provide copy of list if possible)	REASON	DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
CURRENT SYMPTOMS	WHEN STARTED	HOW STARTED
Any imaging performed?		
Have you had similar issues previous to this?		
Any previous treatment for the current issue?		
Using the 0 to 10 scale, with 0 being “no pain” and 10 the “worst pain imaginable” describe: Your current level of pain while completing this survey: 0 1 2 3 4 5 6 7 8 9 10 Circle your best pain level during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10 Circle your worst pain level during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10		
What makes it worse?	What makes it better?	
SIGNATURE:	DATE:	

***SOUTHEASTERN PHYSICAL
THERAPY
Patient Consent Form***

Patient Consents:

(initial)_____ I consent to be evaluated and treated by Southeastern Physical Therapy by a licensed physical therapist, physical therapist assistant, or an occupational therapist.

(initial)_____ I grant permission to Southeastern Physical Therapy to release my medical records to any outside vendors for the purposes of obtaining equipment to aide in my physical therapy treatment.

(initial)_____ **PAYMENT AUTHORIZATION & ASSIGNMENT:** I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment to other healthcare providers. In the case of Medicare, I authorize the release to the Health Care Financing Administration and its agent any information needed to determine benefits payable for related services. I authorize direct assignment of my benefits payable under my insurance to this facility.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for any amounts not covered by my insurance company. I understand that services received at Southeastern Physical Therapy are billed in a clinical setting physical therapy services. This may affect how my insurance pays and any relating precertification, co-pay, co-insurance, out of pocket amount or deductible. Southeastern Physical Therapy recommends for you to contact your insurance company to verify coverage-including visit limits or pre-certification.

Copays are due at time of service. If you cannot afford to pay your copay at each visit, you may fill out a payment plan and pay an amount that you can afford on a monthly basis. If you would like to set up a payment plan, please let us know and we will be happy to assist you with this.

Patient or Guardian Signature

Date

Employee Witness

PRIVACY PRACTICES

Southeastern Physical Therapy cares about your privacy. Southeastern Physical Therapy is committed to protecting your medical information. We do create a record of your treatment to provide you with outstanding care and compliance with legal documentation. We may utilize this information to provide you your medical care or to disclose to bill and receive payment for the services we render; or for the preauthorization needed for your services. We may release information requested by your workers compensation carrier, wc nurse, or wc claim adjuster as well as released to any court order, subpoena, warrant, summons or similar process. We may also use this information to contact you with appointment reminders or to tell you about possible alternative treatment options that may be of interest to you. You also have the right to inspect and or receive your medical information that may be released to above mentioned parties. A written request is required to release your information to yourself or anyone you have authorized. A fee may be incurred for the information requested. Anyone listed as responsible party on your paperwork is able to request your information. You have a right to submit a written restriction or limitation on your account on information that is disclosed. In this request you must list what information is limited and to whom it is to apply. If you believe your privacy has been violated please contact our Operations Director at 828-274-2188. We will try to accommodate all reasonable requests.

Patient Signature or Legal Representative,

Patient Printed Name

Date

To be signed if patient is under 18 years of age

We encourage parent involvement in treatment; however, please sign below if the patient is under the age of 18 and you give consent for Southeastern Physical Therapy to treat your child in the absence of a parent/guardian.

Parent/Guardian Signature _____ Date _____.