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ECRC PHYSICAL THERAPY
INFORMATION PACKET

THANK YOU FOR CHOOSING ECRC PHYSICAL THERAPY!

THIS PACKET INCLUDES IMPORTANT INFORMATION TO ASSIST IN YOUR RECOVERY AND UNDERSTANDING ABOUT OUR SERVICES.

Therapist: ______________________________

Appointment Date: ______________________________

Appointment Time: ______________________________

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR FIRST APPOINTMENT:

- Referral/Prescription Form from your Physician
- A Completed and Signed:
  1. Personal Medical History (PMH)
  2. Consent for Care and Treatment
  3. Authorization to Release Medical Information
  4. Type of Injury / Previous Care
  5. Symptom Questionnaires (SQ) - *please complete on day of evaluation*

(If there are questions about certain parts of these forms, we can help you at the appointment time)

- Wear or bring comfortable clothing that allows you to move easily: loose shorts or stretchy cut-offs, or sweat pants, t-shirt.

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ECRC PHYSICAL THERAPY
NEW PATIENT INFORMATION

Welcome to ECRC Physical Therapy! We appreciate the opportunity to treat you. There are a few things that you need to know to make your appointment run smoothly.

- In addition to your referral/prescription for Physical Therapy, please bring any other information your physician gave you for this referral (reports, office notes, etc.).
- Fill out the paperwork on the New Patient Form prior to your appointment time. If your paperwork is not completed, please arrive at least 20 minutes earlier than your appointment time so we can assist you in competing the forms.
- Your initial appointment will take about 1 hour and follow up appointment will last approximately 45 minutes.
- The times we have given you for your evaluation and treatment are valuable to you and part of a full schedule for our therapists. If you know you will be late by more than 10 minutes behind the scheduled time, please call our office as soon as possible. If you arrive more than 15 minutes after your provided appointment time, we may need to reschedule your appointment.
- If there are missed appointments without your notification (no call or no excuse), we may have to cancel your remaining visits and refer you back to your doctor to continue with your care. **Therefore, if you need to cancel/reschedule your appointment, please call at least 24 hours in advance to allow us to offer your appointment time to other patients. We reserve the right to charge a fee of $25.00 for any no-shows (not calling to cancel appointment) and for cancellations with less than the 24 hours advance notice.**
- We are providers for a wide range of insurance carriers. Almost all require patient co-pay for physical therapy services. We make every attempt to assist you in determining your payment responsibility and your carriers Physical Therapy benefit as a service to our patients. However, **it is your responsibility to know your policy benefits. Please come prepared to pay your portion of the Physical Therapy benefit at the time of service.** Under certain circumstances we do offer payment plans. You can contact your insurance company via the 1-800 number on your insurance card if you have any questions about your physical therapy benefits.

Again, thank you for choosing ECRC Physical Therapy!

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Patient Name: ______________________________ DOB: ________________

CONSENT FOR CARE AND TREATMENT

I, undersigned, agree and give my consent for ECRC to furnish physical therapy care and treatment as considered necessary and proper in the diagnosis and treatment of my illness or injury.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I request that payment of authorized benefits be made on my behalf to ECRC for physical therapy services furnished to me. I authorize any holder of medical information about me to release to my insurance(s) (the "Centers of Medicare and Medicaid Services", formerly the "Health Care Financing Administration" and its agents for Medicare patients) any information needed to determine these benefits or benefits for related services. **We ask that you provide your insurance information to us on your initial visit. This includes Primary and Secondary (if applicable) insurance information.**

CANCELLATION / NO SHOW POLICY

If you need to cancel/reschedule your appointment, please call at least 24 hours in advance to allow us to offer your appointment time to other patients. We reserve the right to charge a few of $25.00 for any no-shows (not calling to cancel appointment) and for cancellations less than the 24 hours advance notice.

AGREEMENT TO PAY

ECRC will bill your insurance company solely as a courtesy to you. All fees for services provided are your responsibility. We recommend you pay your estimated share or co-pay, as specified by your insurance carrier one each visit. We will bill your insurance and the remaining amount will be billed to you. Co-pays for services provided at each date of service will be collected at each visit unless payment arrangements have been made and are adhered to the terms of the agreement between ECRC and you. We do offer payment plans. If you are in need of a payment plan, please speak with the front desk. We encourage you to contact your insurance carrier to make sure you as a member are being given the same eligibility responsibility information as ECRC.

I understand and agree that if I fail to make regular payments as described above, I will be responsible for all costs of collection monies owed, including our costs, collection agency fees and attorney fees.

For Medicare patients: **Medicare will NOT reimburse ECRC for outpatient physical therapy services if you are actively enrolled with a Home Health Care Agency. If Medicare denies payment for services based on the above, member will be responsible for payment.** Medicare has a yearly Physical Therapy cap (maximal amount of payment for physical therapy services per year). If you need services that are more than that cap, you may be responsible for 100% of the cost of therapy services above this limit. We will inform you of your remaining benefits under this plan limitation and your options if further physical therapy is needed.

I have read, understand and agree to the above conditions. I understand my full responsibility for the payment of my account.

E-MAIL ADDRESS

If you would like ECRC Physical Therapy to email you [**no more than** once monthly] regarding issues that pertain to your health and to inform you about our staff and services, please enter your email below:

E-MAIL: ____

x________________________________ ________________

Patient / Guardian **Date**

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Patient Name: ______________________________ DOB: _______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize ECRC to disclose my individually identifiable health information to the following:

1. ____
2. ____
3. ____

I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulation, the information described above could be re-disclosed by such a person or entity and will likely no longer be protected by the federal privacy regulation. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the ECRC staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

x____ _______________

Signature of Patient or Legal Representative **Date**

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES:
I hereby acknowledge that I have reviewed a copy of ECRC's Notice of Privacy Practices (posted in the waiting room and on our web site). I understand that if I have further questions or concerns, I may contact ECRC, Deborah Mercier, 2B Lee Road, Lisbon, CT 06351; (860) 376-2564. I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy is amended or changed in a material way.

x____ _______________

Signature of Patient or Legal Representative **Date**

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TYPE OF INJURY / PREVIOUS CARE

Date: ______________

Patient Name: ____________________________ **DOB:** ______________

You may be treated at our facility for an injury you sustained or for symptoms related to a disease. Please complete the following information. Check all that apply:

The physical therapy is requested due to:

- ☐ Work-Related Injury
  - If so, have you filed a Worker's Compensation claim?
    - ☐ Yes
    - ☐ No
  - Date of Injury: ____________________
- ☐ Not Worker's Compensation or Motor Vehicle Accident Related
- ☐ Auto Accident
- ☐ School Injury
- ☐ Home Accident
- ☐ Disease
- ☐ Other ____

I have been treated for **Physical Therapy / Occupational Therapy / Speech Therapy** and/or **Chiropractic** this year. **** THIS INCLUDES HOME THERAPY****

Note: A majority of insurance plans with a combined benefit of physical, occupational, speech and chiropractic therapies, will not cover more than one therapy on the same day.

- ☐ Yes, # of visits ____________
  - Dates Treated: _________________________________
- ☐ No

I request payment of authorized benefits be made on my behalf of **ECRC** for any services furnished me by **ECRC** staff. I understand my signature requests that payment be made and I authorize release of my medical information necessary to process this claim.

x____ ______________

Signature of Patient or Legal Representative **Date**

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Patient Name: ______________________________ **DOB:** _______________

PERSONAL MEDICAL HISTORY

To help us treat you as a whole person instead of just a body part, kindly fill out the information on ***both pages.*** *Thank you.*

Please check if you have been diagnosed with any of these by a doctor in the past:

- ☐ Diabetes / High Blood Sugar
- ☐ Hypoglycemia / Low Blood Sugar
- ☐ Ulcer / GERD / Stomach Problems
- ☐ Rheumatoid Arthritis
- ☐ Circulation / Vascular Problems
- ☐ Head Injury
- ☐ Asthma
- ☐ Parkinson's Disease
- ☐ Repeated Infections
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Depression
- ☐ Osteoarthritis
- ☐ Lung Problems
- ☐ Stroke
- ☐ Allergies
- ☐ Seizures / Epilepsy
- ☐ Anemia
- ☐ Heart Problems
- ☐ Thyroid Problems
- ☐ Broken Bone / Fracture
- ☐ Osteoporosis
- ☐ Kidney Problems
- ☐ Multiple Sclerosis
- ☐ Skin Diseases
- ☐ Hepatitis
- ☐ Blood Disorder
- ☐ ________________________

Number of falls in the last year: __________

In the last year, have you had any of the following? Please check all that apply.

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Weakness in Arms or Legs
- ☐ Joint Pain or Swelling
- ☐ Difficulty Swallowing
- ☐ Urinary Problems
- ☐ Headaches
- ☐ Heart Palpitations
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Difficulty Sleeping
- ☐ Nausea / Vomiting (not Flu)
- ☐ Weight Loss / Gain
- ☐ Hearing Problems
- ☐ Cough
- ☐ Coordination Problems
- ☐ Difficulty Walking
- ☐ Loss of Appetite
- ☐ Tingling
- ☐ Fever / Chills / Sweats
- ☐ Vision Problems
- ☐ Hoarseness
- ☐ Pain at Night
- ☐ Numbness
- ☐ Bowel Problems
- ☐ ____________________

For MEN only:

Have you ever been diagnosed with prostate disease?

- ☐ No
- ☐ Yes

Do you have:

- ☐ Difficulty Beginning to Urinate?
- ☐ Difficulty Continuing to Urinate?
- ☐ Pain with Urination?

For WOMEN only:

Have you seen a doctor for any pelvic problems?

- ☐ No
- ☐ Yes

Are you pregnant or trying to get pregnant?

- ☐ No
- ☐ Yes

When was your last PAP smear? ___________ Breast Exam? ___________

Do you ever have any urinary leakage?

- ☐ No
- ☐ Yes

SURGERY:

Have you ever had surgery?

- ☐ No
- ☐ Yes (continue below)

If you've had surgery, please list with approximate dates:

____

MEDICATIONS:

[IF YOU HAVE A FULL LIST OF MEDICATIONS, WE CAN COPY THIS FOR YOU IF THIS IS EASIER FOR YOU.] Current medications (prescription and over-the-counter) with dosages:

____

Please Continue on Next Page...

____

PT Initials/Date

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Patient Name: ______________________________ **DOB:** _______________

Are you currently seeing anyone else for the problem that brought you here?

- ☐ Acupuncturist
- ☐ Neurologist
- ☐ Obstetrician / Gynecologist
- ☐ Occupational Therapist
- ☐ Massage Therapist
- ☐ Podiatrist
- ☐ Primary Care Physician
- ☐ Rheumatologist
- ☐ Pediatrician
- ☐ Chiropractor
- ☐ Dentist
- ☐ Cardiologist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ ____________________

Are you allergic to latex?
- ☐ No
- ☐ Yes

Are you allergic to oils, lotions, or creams?
- ☐ No
- ☐ Yes

Do you smoke or chew tobacco?
- ☐ No
- ☐ Yes: _________ Packs per Day; _________ # of Years

How many days each week do you drink alcohol? ________; If 1 drink equals 1 beer or 1 glass of wine, how much do you drink in an average sitting? ________

How much caffeinated coffee [or caffeine containing beverages] do you drink each day? ________

Do you ever feel unsafe at home or has anyone hit you or tried to hit you in any way?
- ☐ No
- ☐ Yes

Anything else we should know about?

____

____

Please Continue on Next Page...

____
PT Initials/Date

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SOCIAL:

With whom do you live?

- ☐ Alone
- ☐ Child
- ☐ Spouse / Significant Other Only
- ☐ Spouse / and Other(s)

Does your home have: [Check ALL that apply]

- ☐ Stairs, No Railing
- ☐ Uneven Terrain
- ☐ Assistive Devices in Bathroom (please list below)
- ☐ Obstacles (please list below)
- ☐ Stairs, Railing
- ☐ Scatter Rugs
- ☐ Ramps
- ☐ Elevator

____

Do you use:

- ☐ Any Assistive Devices: ______________________________
- ☐ Glasses / Contact Lenses
- ☐ Hearing Aids
- ☐ ______________________________

Do you have difficulty with: [Check ALL that apply]

- ☐ Moving in Bed
- ☐ Walking on Stairs
- ☐ Getting Dressed
- ☐ Toileting
- ☐ Preparing Meals
- ☐ Moving from Bed to Chair
- ☐ Walking on Ramps/Hills
- ☐ Bathing
- ☐ Household Chores
- ☐ Driving
- ☐ Walking on Level Ground
- ☐ Walking on Uneven Terrain
- ☐ Eating
- ☐ Shopping
- ☐ Participating in Sports

FAMILY HISTORY:

Please check if appropriate:	Mother	Father	Any Brother / Sister	Any Grandparent
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Psychological	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Other: ____________	☐	☐	☐	☐

* *The above is true to the best of my knowledge.*

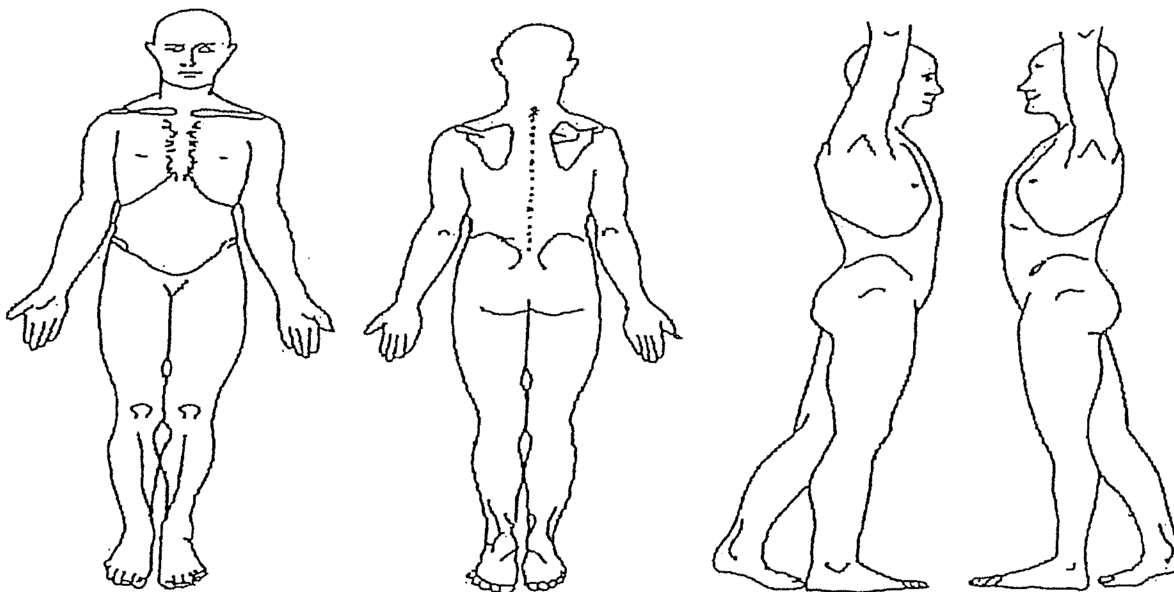
x______________________________ ____________ ____________

Signature of Patient or Legal Representative **Date** **PT Initials/Date**

Symptom Questionnaire

Patient Name: ______________________________ Date: __________________ DOB: ___________

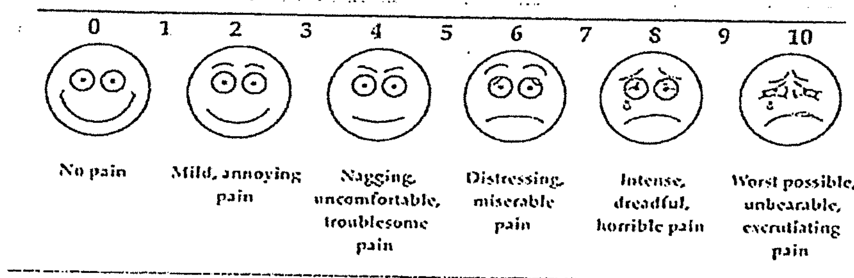
Please mark on the chart the LOCATION of your pain.



Does your pain come and go? YES NO

Please mark on the line (B, W, A) the INTENSITY of your pain.

In the last week, when you are feeling your BEST (B), how low is your pain?
In the last week, when you are feeling your WORST (W), how high is your pain?
What has been your AVERAGE (A) pain over the last 24 hours?



Eastern Connecticut Rehabilitation Centers