

# Canton Physical Therapy

**PATIENT INFORMATION** (PLEASE PRINT)

Name: \_\_\_\_\_  

First
Middle
Last

Date of Birth ____/____/____ Male ____ Female ____ SSN _____ Marital Status: S M D W Address: _____ City: _____ State: _____ Zip: _____ Home Phone:(        ) _____ - _____ Work Phone:(        ) _____ - _____ Cell Phone:(        ) _____ - _____ Emergency Contact: _____ Emergency Contact Tel:(        ) _____ - _____	Occupation: _____ Employer: _____ Employer Address: _____ City: _____ State: _____ Zip: _____ Referring Doctor: _____ Primary Care Physician: _____ PCP Address: _____ City: _____ State: _____ Zip: _____ Tel:(        ) _____ - _____
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Where may we leave a message regarding your appointment and/or medical information?

<b>Home Phone:</b> <input type="checkbox"/> DO NOT leave message <input type="checkbox"/> On answering machine <input type="checkbox"/> With another person	<b>Work Phone:</b> <input type="checkbox"/> DO NOT leave message <input type="checkbox"/> On answering machine <input type="checkbox"/> With another person	<b>Cell Phone:</b> <input type="checkbox"/> DO NOT leave message <input type="checkbox"/> On answering machine <input type="checkbox"/> With another person	<b>Mail:</b> <input type="checkbox"/> DO NOT send via mail or email <input type="checkbox"/> Send via mail to address above <input type="checkbox"/> Send via email _____
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<p style="text-align: center;"><b>PRIMARY INSURANCE INFORMATION</b></p> Primary Insurance: _____ ID Number: _____ Patient is: Self Spouse Child Other _____ Insured Name _____ Date of Birth ____/____/____ SSN _____	<p style="text-align: center;"><b>SECONDARY INSURANCE INFORMATION</b></p> Secondary Insurance: _____ ID Number: _____ Patient is: Self Spouse Child Other _____ Insured Name _____ Date of Birth ____/____/____ SSN _____
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<p style="text-align: center;"><b>GUARANTOR</b> (Person responsible for payment if other than patient)</p> Name: _____ Relationship to Patient: _____ Street Address: _____ City: _____ State: _____ Zip: _____ Date of Birth ____/____/____ SSN: _____	<p style="text-align: center;"><b>TERMS OF SERVICE</b></p> <ol style="list-style-type: none"> <li>1. Co-pay and/or other payment is due at time of service. This office accepts only cash, checks, and credit cards.</li> <li>2. There will be a \$25.00 charge for returned checks.</li> <li>3. If account remains unpaid and it is necessary Canton PT to engage in collection action, all costs will be charged to you (court, attorney, interest, and collection agency fees).</li> <li>4. Appointments must be canceled at least 24 hours in advance, otherwise \$75 will be charged to the account.</li> <li>5. Charges not authorized by insurance are charged to account</li> </ol>
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**Assignment and Release:** I, the undersigned, assign directly to Canton Physical Therapy, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid for by insurance. I hereby authorize Canton Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions. I understand that I am responsible to know my insurance benefits and that all charges not covered by my insurance will be billed directly to me. Should my injury be related to a workplace or motor vehicle accident I will accept responsibility for payment of physical therapy evaluation and treatment costs should the claim be denied by the third party payer. I have read and understand the Terms of Service above.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Where did you hear of Canton Physical Therapy? (Please circle) Yellow Pages    Referring Doctor    Other _____	<p><b>Please present insurance card and prescription with this completed form.</b></p>
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# Canton Physical Therapy

**MEDICAL HISTORY** (PLEASE PRINT & CHECK ALL BOXES THAT APPLY)

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Next appt with referring doctor** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ lbs  **Right Handed**  **Left Handed**

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Open Wound
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Infection	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dizziness/fainting/lightheadedness	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Fibromyalgia/Myofascial Pain Syndrome	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Swelling of hands / feet
<input type="checkbox"/> Bowel/Bladder Trouble	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Metal or Other Implants	<input type="checkbox"/> Other _____

**Medications** (prescription, over the counter, & supplements): \_\_\_\_\_

**Allergies**  Bees  Strawberries  Shellfish  Lotions  Latex  Rubber  Tape  Cortisone  Other \_\_\_\_\_

**Are you pregnant?** YES NO **Weight gain/loss in last year?** (+-) \_\_\_\_\_ lbs **Use Tobacco** YES NO **Alcohol** YES NO

List any surgeries, serious injuries, fractures, strains, dislocations that you have had	Date

**Injury:** \_\_\_\_\_ **Date of injury:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**How did current injury occur?** \_\_\_\_\_ **Workplace or vehicle accident?** YES NO

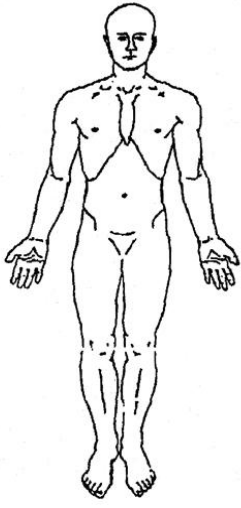
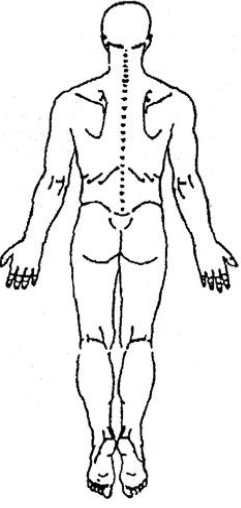
**Date of Surgery:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **What procedure did you have done:** \_\_\_\_\_

**Have you had Physical Therapy in the past year for this injury?** YES NO **Date of last visit** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Did you have:**  X-Ray  MRI  CAT Scan  Other \_\_\_\_\_ **Does your:**  Knee give way  Knee lock up  Knee cap shift

**Does your condition interfere with:**  House/Yard Work  Job/Working  Reaching to the side or overhead  In & out of car or tub  
 Sleeping  Walking up or down stairs  Head movements  Walking  Standing  Sitting  Other: \_\_\_\_\_

**Do you participate in sports, exercise or gym, or activities regularly:** YES NO *Explain* \_\_\_\_\_

<p>Mark on your body where you feel the described sensations. Include all affected areas even if they don't relate to this physical therapy visit.</p> <div style="display: flex; justify-content: space-around;">   </div> <p style="text-align: center;">Aching △△△△</p> <p style="text-align: center;">Numbness =====</p> <p style="text-align: center;">Pins and Needles ○○○○○○○</p> <p style="text-align: center;">Burning X X X X</p> <p style="text-align: center;">Stabbing /////</p> <p style="text-align: center;">Other .....</p>	<p><b>Pain level:</b> (none) 0 1 2 3 4 5 6 7 8 9 10 (high)</p> <p><b>Is pain</b> (all that apply) <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Deep  <input type="checkbox"/> Shooting <input type="checkbox"/> Throbbing <input type="checkbox"/> Pinching <input type="checkbox"/> Tight <input type="checkbox"/> Burning <input type="checkbox"/> Diffuse</p> <p><b>Condition began:</b> <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually <input type="checkbox"/> Trauma <input type="checkbox"/> Chronic</p> <p><b>Condition is:</b> <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same</p> <p><b>What increases pain?</b> _____</p> <p><b>What decreases pain?</b> _____</p> <p><b>Pain with coughing or sneezing?</b> YES NO</p> <p><b>Daily activity:</b> (none) 0 1 2 3 4 5 6 7 8 9 10 (high)</p> <p><b>Rate your balance:</b> (Poor) 1 2 3 4 5 6 7 8 9 10 (Good)</p> <p><b>Have you had a significant fall in the last year?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Do you use brace:</b> YES NO <i>Explain</i> _____</p>
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**Are there any personal circumstances that may affect your physical therapy?** \_\_\_\_\_

**What do you hope to accomplish or gain from physical therapy?** \_\_\_\_\_

**Consent to Treatment:** To the best of my knowledge, information provided herein is correct. I understand that I have been referred for rehabilitative treatment & care to Canton Physical Therapy. I understand my diagnosis and treatment plan will be discussed during my first appointment and I have the right to question and/or refuse any Treatment prior to it being applied. By signing this agreement, I consent to have this facility provide treatment as prescribed by my physician and/or advised by my therapist.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Summary Of Notice Of Privacy Practices

## Canton Physical Therapy

65 Albany Turnpike, PO Box 466, Canton, CT 06019

Rachel Devlin, Privacy Officer

(860) 693-6226

**The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the “Notice”). This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.**

- 1. Uses and Disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care “operations” such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.
- 2. Other Uses and Disclosures.** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
- 3. Your Health Information Rights.** You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
  - a. You may request restrictions on certain uses and disclosures of your information
  - b. You may request that you receive your information from us in a certain way
  - c. You may inspect and copy your medical records
  - d. You may request an amendment to any record you believe is inaccurate
  - e. You may request an accounting of disclosures made of your records
- 4. Changes to the Notice.** We reserve the right to change the Notice. If we do so, we will post it in our office, and provide a copy upon request.
- 5. Complaints.** You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

# Acknowledgement of Receipt of Notice of Privacy Practices

## Canton Physical Therapy

65 Albany Turnpike, PO Box 466, Canton, CT 06019

Rachel Devlin, Privacy Officer

(860)-693-6226

Name of Patient: \_\_\_\_\_

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient: \_\_\_\_\_

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### ***For Office Use Only:***

Signed form received by: \_\_\_\_\_

Acknowledgment refused: \_\_\_\_\_

Efforts to obtain: \_\_\_\_\_

\_\_\_\_\_

Reasons for refusal: \_\_\_\_\_

\_\_\_\_\_

# Canton Physical Therapy and Wellness Center

65 Albany Turnpike (Rt 44)  
Post Office Box 466  
Canton, CT 06019

Tel: 860-693-6226  
Fax: 860-693-8002  
canton-pt.com

