

Canton Physical Therapy and Wellness Center

65 Albany Turnpike
PO Box 466
Canton, CT 06019

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

Thank you for choosing Canton Physical Therapy.

Please bring the following to your first visit:

- Insurance card(s)
- Prescription/referral from your doctor
- Any X-rays or MRIs plus the reports
- Comfortable clothing

Please note, starting October 1, 2006 no referral from a doctor is required to have physical therapy for some insurances (This does not include Medicare). For more information please call us at (860) 693-6226.

Form 1: (Patient information) First page, please fill in all information. Please read the Terms of Service and sign the Assignment and Release section.

Form 2: (Patient Medical History) Please fill in all information

Form 3: (Summary of Notice of Privacy Practices) is a summary of your HIPAA rights.

Form 4: (Acknowledgement of Receipt of Notice of Privacy Practices) This will need a signature stating that you received the summary (Form 3).

If you have any questions please contact Canton Physical Therapy 860-693-6226.

Canton Physical Therapy

1. 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?

Home Phone: <input type="checkbox"/> DO NOT leave message <input type="checkbox"/> On answering machine <input type="checkbox"/> With another person	Work Phone: <input type="checkbox"/> DO NOT leave message <input type="checkbox"/> On answering machine <input type="checkbox"/> With another person	Cell Phone: <input type="checkbox"/> DO NOT leave message <input type="checkbox"/> On answering machine <input type="checkbox"/> With another person	Mail: <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;">PRIMARY INSURANCE INFORMATION</p> Primary Insurance: _____ ID Number: _____ Patient is: Self Spouse Child Other _____ Insured Name _____ Date of Birth ____/____/____ SSN _____	<p style="text-align: center;">SECONDARY INSURANCE INFORMATION</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;">GUARANTOR (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;">TERMS OF SERVICE</p> <ol style="list-style-type: none"> 1. Co-pay and/or other payment is due at time of service. This office accepts only cash, checks, and credit cards. 2. There will be a \$25.00 charge for returned checks. 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). 4. Appointments must be canceled at least 24 hours in advance, otherwise \$65 will be charged to the account.
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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>Please present insurance card and prescription with this completed form.</p>
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Canton Physical Therapy

2. MEDICAL HISTORY (PLEASE PRINT)

Name: _____ Next appointment with referring doctor? ____/____/____

Injury: _____ Date of injury: ____/____/____ Workplace or Vehicle accident? YES NO

Have you had Physical Therapy in the past year? YES NO Date of last visit ____/____/____

(Circle)

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

Medications (prescription, over the counter, & supplements): _____

Allergies	Bees	Strawberries	Shellfish	Lotions	Latex	Rubber	Tape	Cortisone	Other _____
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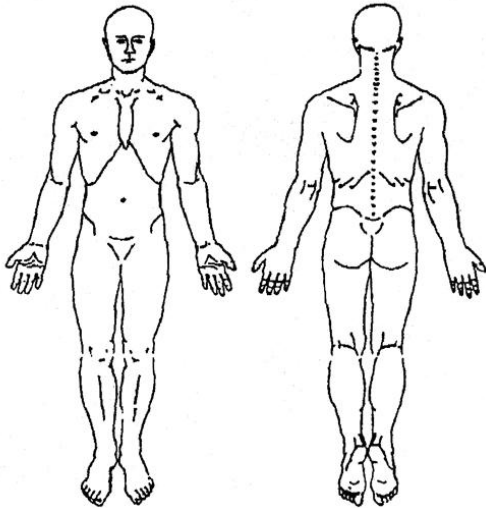
Are you pregnant? YES NO	Height: _____	Weight: _____ lbs	<input type="checkbox"/> Right Handed	<input type="checkbox"/> Left Handed
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Weight gain/loss in last year? (+-) _____ lbs	Tobacco YES NO	Alcohol YES NO	Other _____
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List any surgeries, serious injuries, fractures, strains, dislocations that you have had	Date

Problem began	<input type="checkbox"/> Suddenly	<input type="checkbox"/> Gradually	<input type="checkbox"/> After Trauma	Is condition	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same	How long? _____
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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.



- Aching
△△△△
- Numbness
=====
- Pins and Needles
○○○○○○
- Burning
XXXXX
- Stabbing
////////
- Other
.....

Does your condition interfere with:

In & out of the tub	House/Yard Work	Job/Working
Stepping on Curb	Walking up stairs	In & out of the car
Childcare	Sleeping	Exercising
	Standing	Sitting
Other: _____		

Pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (high)

What increases pain? _____

What decreases pain? _____

Do you participate in sports, exercise, or activities regularly:
YES NO _____

Daily activity: (none) 0 1 2 3 4 5 6 7 8 9 10 (high)

Rate your balance: (Poor) 1 2 3 4 5 6 7 8 9 10 (Good)

Have you had a significant fall in the last year? YES NO

Do you use brace: YES NO _____

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 and 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 and care as prescribed by my physician and/or advised by my therapist.

Signature _____ Date _____

Canton Physical Therapy
3. SUMMARY OF NOTICE OF PRIVACY PRACTICES

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.

Canton Physical Therapy
4. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (PLEASE PRINT)

**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: _____

For Office Use Only:

í Signed form received by: _____

í Acknowledgment refused: _____

Efforts to obtain: _____

Reasons for refusal: _____

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