DURANT PHYSICAL THERAPY, LLC

PATIENT DEMOGRAPHIC FORM

Patient name: _____Sex: M or F Date of Birth: ____/____/____ Age: _____

Address: _____City: _____State: ____ Zip: _____

Home phone: _____Cell phone: _____

Email Address_____

I authorize Durant Physical Therapy to contact and/or leave a personal message on the following phone numbers and/or email address:
Initial all that apply (H) _____(C) _____ (W)_____ (Email) _____

Emergency Contact: _____Relationship: _____ Phone: _____

How did you hear about us: _____

Insurance Information:

Primary Insurance**:** _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Referring Doctor:

Print Name: _____ Phone: _____ Fax: _____

Primary Care Physician: ***Required for Direct Access Patients***

Print Name: _____ Phone: _____ Fax: _____

Employer:

Company: _____Occupation:_____Phone:____ _____

Address: _____ City: _____State: ____Zip: _____

Legal Information (Used only for MVA or W/C Injury)

Attorney: _____ Phone: _____

Address: _____State:_____ Zip: _____

Patient Agreement:

I, the undersigned, have insurance coverage with_____
and assign directly to Tim Durant 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 paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I also acknowledge receipt of this office's H.I.P.P.A. notice of privacy policies.

*****We understand that life happens. The cancellation/no show fee will be waived for your first late cancel or no show visit, all cancel/no shows thereafter will be charged a $50 cancellation fee to you, not your insurance company.*****

Signature: _____ Date: _____

Page 1 - Patient History Name: _____ Age: _____ Date: _____

- **Describe the current problem that brought you here?** _____
  _____
  _____
- **When did your problem first begin?** _____Months ago / _____ Years ago
- **Was your first episode of the problem related to a specific incident?** *(Please circle):* Yes No
  Please describe and specify date?: _____
- **Since that time is it staying** *(please circle):* Same Getting Worse Getting Better
- **If pain is present, please rate from 0-10 scale with 10 being the worst:** 1 2 3 4 5 6 7 8 9 10
  Describe the nature of the pain: (i.e. constant burning, intermittent ache): _____
  _____
- **Describe previous treatment/exercise if applicable:** _____
  _____

- **Activities/events that cause or aggravate your symptoms, *please check all that apply*:**

	Sitting greater than _____ minutes		With cough/sneeze/straining
	Walking greater than _____ minutes		With laughing/yelling
	Standing greater than _____ minutes		With lifting/bending
	Changing positions (i.e. sit to stand)		With cold weather
	Light activity (light housework)		With triggers-running water/key in door
	Vigorous activity/exercise (run/weightlifting/jump)		With nervousness/anxiety
	Sexual activity		No activity affects the problem
	Other, please list:		

- **What relieves your symptoms?** _____
  _____

- **How has your lifestyle/quality of life been altered/changed because of this problem?**
  Social activities (exclude physical activities), specify: _____
  Diet/Fluid intake, specify: _____
  Physical activity, specify: _____
  Other: _____
  _____
  _____

- **Rate the severity of this problem from 0-10 scale with 10 being the worst:** 1 2 3 4 5 6 7 8 9 10

- **What are your treatment goals/concerns:** _____
  _____

- **Since the onset of your current symptoms have you had** (*please check all that apply)*:

	Fever/chills		Malaise (unexplained tiredness)
	Unexplained weight change		Unexplained muscle weakness
	Dizziness or fainting		Night pain/sweats
	Change in bowel or bladder functions		Numbness/tingling
	Other/describe:		

Page 2 - Patient History Name: _____

Health History: Date of last physical exam: _____ Tests performed: _____

_____

General Health *(please circle):* Excellent Good Average Fair Poor
Occupation: _____ **On disability or leave?** Yes No Activity **Restrictions?:** Yes No
Mental Health: Current Stress Level *(please circle):* High Med Low **Receiving psychiatric therapy?:** Yes No
Activity/Exercise *(please circle):* None 1-2 days/wk 3-4 days/wk 5+days/wk
Specify what Activity/Exercise: _____

Have you ever had any of the following conditions or been diagnosed with the following? *(Please circle all that apply):*

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High blood pressure	Multiple sclerosis	Allergies (specify in Other)
Ankle swelling	Head injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/hyperthyroid
Low back pain	Chronic fatigue syndrome	Headaches
Sacrolilliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/drug problem	Arthritic conditions	Kidney disease
Childhood bladder issues	Stress fractures	Irritable bowel syndrome
Depression	Rheumatoid arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint replacement	Sexually transmitted disease
Smoking history	Bone fracture	Physical or sexual abuse
Vision/eye problems	Sports injuries	Raynaud's (cold hands/feet)
Hearing loss/issues	TMJ/neck pain	Pelvic pain
Other (please specify):		

Surgical/Procedure History *(please check all that apply):*

	Surgery for your back/spine		Surgery for your bladder/prostrate
	Surgery for your brain		Surgery for your bones/joints
	Surgery for your female organs		Surgery for your abdominal organs
Other (please specify):			

Ob/Gyn History ***females only*** *(* *please check all that apply*):

	Childbirth vaginal deliveries: # _____		Vaginal dryness
	Episiotomy #_____		Painful periods
	C-Sections: #_____		Mendopause – when?: _____
	Difficult childbirth: #_____		Painful vaginal penetration
	Prolapsed or organ falling out		Pelvic pain
Other (please specify):			

****Males only**** *(* *please check all that apply):*

	Prostate disorders		Erectile dysfunction
	Shy bladder		Painful ejaculation
	Pelvic pain		
Other (please specify):			

Medications (include prescribed and OTC) Start Date Reason for taking

_____

_____

_____

_____

_____

Page 3 - Symptoms Name: _____

Bladder/Bowel Habits/Problems *(please check all that apply):*

	Trouble initiating urine stream		Blood in urine
	Urinary intermittent/slow stream		Painful urination
	Trouble emptying bladder		Trouble feeling bladder urge/fullness
	Difficulty stopping the urine stream		Current laxative use
	Trouble emptying bladder completely		Trouble feeling bowel urge/fullness
	Straining or pushing to empty bladder		Constipation/straining
	Dribbling after urination		Trouble holding back gas/feces
	Constant urine leakage		Recurrent bladder infections
Other (please specify):			

- **Frequency of urination:** Awake hours :___times per day Sleep hours: ___times per night
- **When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?** *(please circle):* Minutes Hours Not at all
- **The usual amount of urine passed is?** *(please circle):* Small Medium Large
- **Frequency of bowel movements?:** ____ times per day, _____ times per week, or _____
- **When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?** *(please circle):* Minutes Hours Not at all
- **If constipation is present, describe management techniques:** _____

  _____
- **Average fluid intake (glass/cup = 8 oz):** _____# glass/cups per day
  Of this total, how many glass/cups are caffeinated: _____# glass/cups per day

- **Rate a feeling of organ "falling out"/prolapsed or pelvic heaviness/pressure:**

	None Present
	Times per month (specify if related to activity or your period
	With standing for _____ minutes or _____ hours
	With exertion or straining
Other (please specify):	

**Skip these questions if *NO leakage/incontinence*

- **Bladder leakage –** *please add number of episodes*

	Times per day
	Times per week
	Time per month
	Only with physical exertion/cough/sneeze

- **Bowel leakage –***please add number of episodes*

	Times per day
	Times per week
	Time per month
	Only with exertion/strong urge

- **On average, how much urine do you leak?**

	Just a few drops
	Wet underwear
	Wet floor

- **How much stool do you lose?**

	Stool staining
	Small amount in underwear
	Complete emptying

- **What form of protection do you wear?** *(Please choose only one)*

	None
	Minimal protection (Tissue paper/paper towel/panty liners)
	Moderate protection (absorbent product, maxi-pad)
	Maximum protection (specialty product/diaper)
Other (please specify):	

On average, how many pad/protection changes are required in a 24 hour day? _____ #

Durant Physical Therapy, LLC

ASSIGNMENT OF BENEFITS

I hereby assign benefits to include major medical benefits, private insurance and any other plan to Durant Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance at the time of service. I hereby authorize said assignee to release all information necessary for payment purposes.

Note: Any estimates of benefits disclosed to us by the insurance representative are merely estimated coverage information we obtain, and are in no way intended to release the patient from total responsibility for their account or be implied as guarantee of payment by the insurance carrier. The patient will be financially responsible for all charges not covered by said insurance. ***It is a policy of our office not to exceed a balance of $150 throughout treatment. This includes, but not limited to: copays, deductibles, co-insurances and self-pay patients.*** **(**Please Initial) _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

If I am covered by an insurance plan that requires a referral and I do not obtain one from my Primary Care Physician or specialist, I will be responsible if my insurance carrier does not pay the claim. This statement also applies to future visits if the referral has expired or additional visits need to be authorized. I am responsible to keep track of my referral. I will be sure to keep a copy of the referral or call my insurance carrier and confirm that a referral was received from my Primary Care Physician or specialist. If I am being treated for a work-related injury, I am required to comply with the referral policy of my employer's insurance plan.

ATTENDANCE

I understand that good attendance is essential to receive the most benefit from my therapy program. I will inform Durant Physical Therapy if I am unable to keep my appointment and give 24 hours notice if possible. I understand that Durant Physical Therapy will make every effort to reschedule my appointment. If I am late for an appointment I understand that the therapist will see me as the schedule permits. I understand that failure to keep my appointments may result in the therapist discussing this with my doctor and may result in discharge.

CONSENT FOR TREATMENT

I hereby give Durant Physical Therapy my consent for any necessary medical evaluation and treatment.

****

I have read and understand all the above policies and I agree to them. I understand, per my insurance contract, that I am financially responsible for any and all charges not paid by my insurance carrier.

_____ _____

Patient / Legal Representative Signature Date

If signed by a legal representative, indicate your relationship to the patient:

( ) Parent ( ) Guardian ( ) Conservator* ( ) Executor of estate* ( ) Power of attorney*

_____ _____

Witness to signature (if legal representative signs) Date

Cancellation / No-Show / Late Walk-In Policy

Durant Physical Therapy Staff understands that unplanned issues can occur and that patients need to cancel or reschedule an appointment. As an office we do our best to accommodate for unforeseen circumstances resulting in late arrivals to the office; this is not always possible. Please keep in mind when a patient does not attend a scheduled appointment, another patient loses an opportunity to be seen.

To allow our therapists to have adequate time with their patients our policies are as follows:

- If a patient is more than 15 minutes late for an appointment, Durant Physical Therapy reserves the right to cancel the appointment and charge a $50 late cancellation fee.
- A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, OR THE PATIENT WILL BE CHARGED A $50 LATE CANCELLATION FEE.**
- A late cancellation may be rescheduled to **AVOID THE CANCELLATION FEE** if the appointment is rescheduled within the same Monday - Friday period (prior to the upcoming weekend). In other words, if a patient begins the week with two appointments and completes the week having had two treatments, no cancellation charges will be assessed if one appointment had been late cancelled and rescheduled.
- If a patient does not honor a rescheduled appointment, **THE PATIENT WILL BE CHARGED FOR BOTH THE ORIGINAL CANCELLATION AND THE RESCHEDULED APPOINTMENT.**
- Should a patient miss two consecutive appointments without calling to cancel, the patient will be taken off the master schedule and will forfeit all further permanent appointments.
- **PLEASE INFORM THE FRONT DESK STAFF OF ALL SCHEDULING CHANGES. YOUR THERAPIST IS RESPONSIBLE FOR YOU THERAPY AND CAN NOT BE RESPONSIBLE FOR YOU SCHEDULE.**

Patient Signature _____ Date_____

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Thank you for being a valued patient and for your understanding and cooperation as with this policy. Please help our Physical Therapists be available for your needs and the needs of all our patients.

The Staff at Durant Physical Therapy

DURANT PHYSICAL THERAPY, LLC
2928 MAIN STREET 2ND FLOOR
GLASTONBURY, CT 06033
(860)430-2344

HIPAA Release Form

I have read the "NOTICE OF PRIVACY POLICIES for DURANT PHYSICAL THERAPY, LLC and understand that all the information regarding:

1. Patient Authorization regarding the privacy notice.
2. Patient Authorization for appointments and scheduling matters.
3. Patient Authorization regarding physical therapy related health services.

Patient Signature: _____ Date: _____

I give authorization for my health information to be shared with the following individual(s), physician(s) or organization(s)

Name:_____ Relationship:_____

Organization:_____

If you are a minor or if you are being represented by another party:

Representative Signature: _____ Date: _____

_____

Description of the authority to act on behalf of the above patient

This authorization may be revoked by you at any time. Revocation may be accomplished by advising Durant Physical Therapy in writing you desire to withdraw you authorization. Processing time will be completed within a reasonable amount of time.