**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#:

**Is a home healthcare agency coming to your home?** Yes No

***\*\*If yes, Medicare and Medicare Advantage plans will NOT pay for Out-Patient Physical Therapy if you are having home healthcare services. Medicare and Medicare Advantage plans views the patient as homebound, therefore out-patient services are not covered.***

**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 byinsurance. I hereby authorize the doctor to release all information necessary to secure the payment ofbenefits. 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* **• Bowel leakage –***please add number of episodes*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Times per day |  | Times per day |
|  | Times per week |  | Times per week |
|  | Time per month |  | Time per month |
|  | Only with physical exertion/cough/sneeze |  | Only with exertion/strong urge |

* **On average, how much urine do you leak? • How much stool do you lose?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Just a few drops |  | Stool staining |
|  | Wet underwear |  | Small amount in underwear |
|  | Wet floor |  | 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 my plan has a visit max combined of: physical therapy, speech therapy, occupational therapy and chiropractic services, I understand that only 1 visit is allowed per day. 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 Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Signatures are valid for 1 year from date signed.*

**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\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

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

*Signatures are valid for 1 year from date signed.*

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.

*Signatures are valid for 1 year from date signed.*