



Partners in Physical Therapy
3221 Ryan Street Suite D. Lake Charles, LA 70601
337-439-3344 phone 337-439-3380 fax
www.partnersinpt.com

Dear Patient,

We know you have a choice in physical therapy clinics and we would like to thank you for choosing our office. Care and participation in therapy is important to us. It is our mission to provide you with excellent care and work as a team with you and your healthcare provider to ensure that your goals are met.

As a part of our efforts to offer excellence in patient care, we are proud to announce the incorporation of a patient advocate to our treatment staff. Erin MacInnes, LCSW is a clinical social worker is available as needed. She can help to assess your progress towards your goals as well as any barriers. She will relay that information to your therapist so that we can modify or update your treatment program to help you achieve your goals faster and she can help with creating action plans to decrease barriers. Please feel free to request a session with Erin.

If you have any questions, please feel free to contact me at 337-439-3344, ext. 0

Again, welcome to our clinic. You are now officially a partner!

Freddie Ann Regan Chandler

Don't forget to like us on Facebook; we will post clinic updates and useful tips!

Partners in Physical Therapy New Patient Packet

How did you hear about us?

(Please circle)

Physician

Friend

Previous Patient

Website

Other: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Social Security #: _____ Sex: M F Marital Status: S M D W

Employer: _____

Circle: Auto Accident Worker's Comp Date of accident: _____

Name of attorney or case manager: _____ Phone: _____

Insured Name (Same as above? YES NO)

Name: _____ Date of Birth: _____

Address: _____ Social: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Other: _____

Are we authorized to release information to this individual? YES NO

Please list any other individuals that we may share health or personal information:

Patient/Guardian: _____ Date: _____

(Signature)

Partners in Physical Therapy Policies

**We work hard so that our office consistently runs on time
and that your physical therapy goals are met.**

Please be aware of the following:

Be here on time: We start and end appointments on a set schedule. It is important that you arrive on time.

Courtesy Reminders: Each Friday we will email your schedule for the upcoming week. We will also text a reminder 1 day prior to your appointment.

Appointment Changes: A minimum 24 hour notice for changes in appointment time is required. Cancellation with less than 24 hours notice will be charged a \$50.00.

No Shows: If you do not show up for an appointment, a \$50.00 no show charge is due at your next visit. This charge is your responsibility and will not be billed to insurance or other payers.

25% Cancellation/No Show Policy: If you miss greater than 25% of your scheduled appointments we reserve the right to cancel all future appointments. *Example: 3 out of 12 missed*

Workman's Compensation: We are required to send documentation of missed appointments to your worker's compensation case manager.

Self-Discharge: Please do not stop therapy without talking to your therapist.

Supplies: Medical supply expenses are due at the time of service. If you would like to bill insurance on your own behalf, please talk with our billing department for assistance.

**Please know that every person is different and it is important to work as a team
to get you optimal improvement. This requires communication, showing up to
appointments, and active participation.**

Signature: _____

Date: _____

**** Disclaimer: Please note by providing your e-mail, you are also allowing Partners in Physical Therapy to e-mail you regarding clinic sponsored programs. However, please note you are able to opt out at any time. ****



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I understand that as part of my health care treatment, **Partners in Physical Therapy** develops and maintains records containing my health information, which includes information about my health history, symptoms, test results, diagnosis, treatment, claims and payment information, etc. I understand that my health information will be used and disclosed by **Partners in Physical Therapy** for treatment, payment and health care operations and serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who may contribute to my care
- A source of information to bill for health care services rendered
- A means by which an insurance company or other third party payor can verify that services were billed and actually provided
- A resource for “health care operations” such as assessing quality and reviewing the competence of health care professionals

I have been provided with the **Partners in Physical Therapy** Privacy Notice, which provides a more complete description to the use and disclosure of my health information. I understand that I have the right to review the Privacy Notice prior to signing this consent form. I understand that **Partners in Physical Therapy** can change the terms of the Privacy Notice and that **Partners in Physical Therapy** reserves the right to make the new Privacy Notice provisions effective for my health information that it already maintains and uses, as well as for any health information that it may receive in the future.

I understand that if I refuse to sign this consent form allowing for the use and disclosure of my health information to carry out treatment, payment or health care operations, **Partners in Physical Therapy** may refuse treatment.

I understand that I have the right to request that **Partners in Physical Therapy** restrict how my health information is used or disclosed to carry out treatment, payment or health care operations, but such request may not be accepted. I request the following restrictions (N/A if none): _____

I understand that I may revoke this consent at any time by notifying **Partners in Physical Therapy** in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

I give my consent to **Partners in Physical Therapy** to release my medical records to my referring physician, insurance company, third party insurance, or to my attorney.

I authorize my insurance company to pay directly to **Partners in Physical Therapy** proceeds payable under the terms of my policy. I understand and agree to pay any unpaid balance not covered by my insurance company. In the event my account is turned over to collection, I hereby agree to pay all collection cost and fees.

I understand that my insurance company may not cover all charges incurred at Partners in Physical Therapy and that insurance companies do not guarantee payment, therefore I will be responsible for these charges.

Patient/Guardian Signature _____ Date: _____

Social Security Number of Patient _____ Patient Date of Birth _____

Partners in Physical Therapy Intake Form

Name: _____ Date: _____ Date of Next MD Visit: _____

Occupation: _____ Age: _____ Height: _____ Weight: _____

Employer: _____

Tell us why you are here:

What would you like your therapist to know?

What is your goal for physical therapy?

Tests/Medical Management:

Please list any tests or medical services that you have received for your chief complaint:

Allergies:

Current Medication: _____ None

List Names of Medications:

Dose or strength:

How often taken:

1) _____

a. _____

b. _____

2) _____

a. _____

b. _____

3) _____

a. _____

b. _____

4) _____

a. _____

b. _____

Medical Condition History

Please list all medical conditions: _____

Please list all past surgeries: _____

Overall Health:

How would you rate your Overall Health?

Excellent

Good

Fair

Poor

Do you feel your job or home life is stressful?

Yes No

Do you have periods of depression or sadness?

Yes No

Do you have persistent fears?

Yes No

Do you worry excessively?

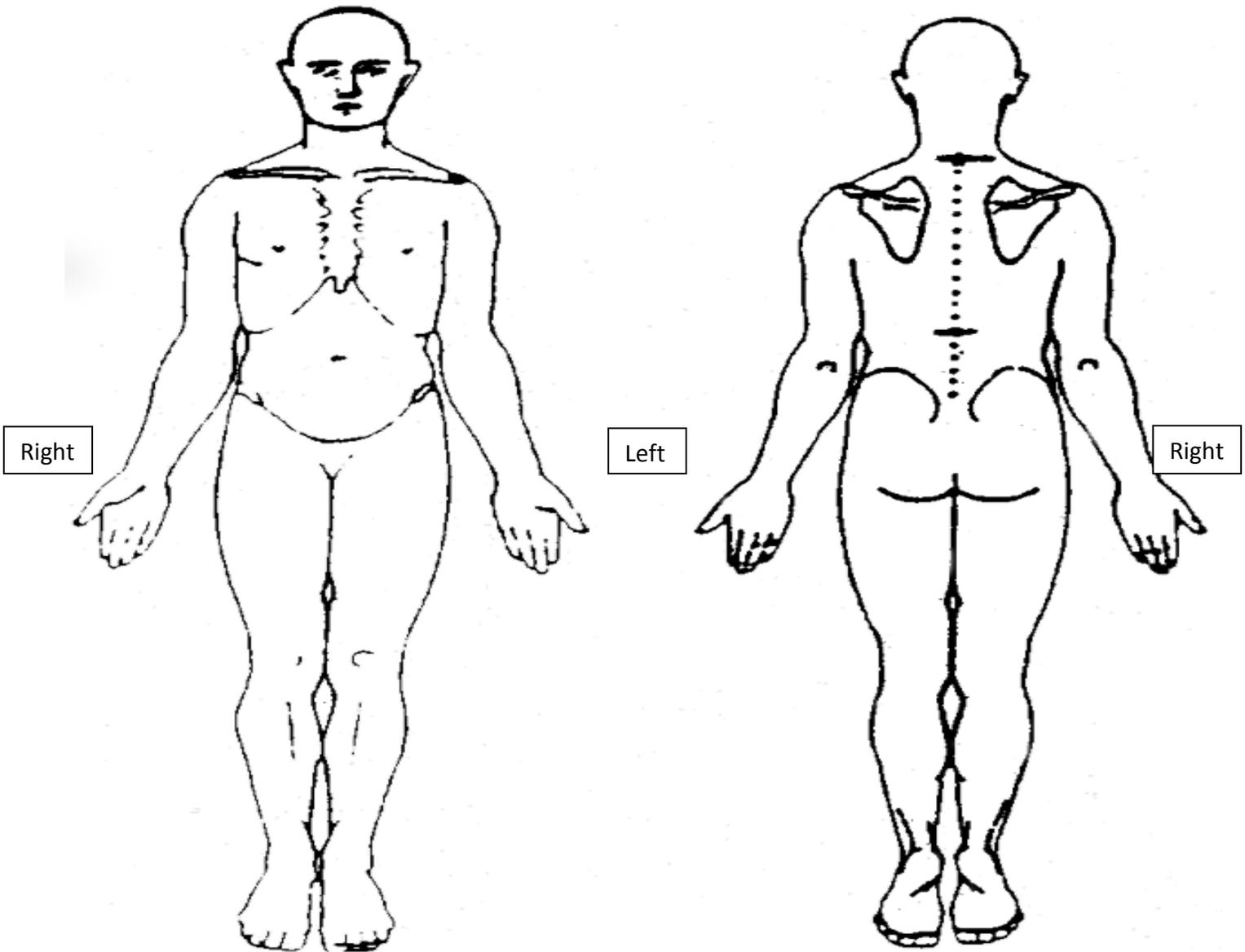
Yes No

Are emotional problems important to your current complaint?

Yes No

Symptoms:

Please mark on the body your area of complaint **using a highlighter:**



Pain Intensity:

On a scale of 0 to 10 with 0 being no pain and 10 being the most severe pain imaginable:

Which number would describe your pain THIS WEEK?

What is your pain like NOW? 0 1 2 3 4 5 6 7 8 9 10

What is your LEAST pain? 0 1 2 3 4 5 6 7 8 9 10

What is your WORST pain? 0 1 2 3 4 5 6 7 8 9 10

Is your pain constant? Yes No

Is your pain worsening? Yes No

The Patient-Specific Functional Scale

Addressing function is VERY IMPORTANT. Insurance companies want to see functional goals and research shows that focusing on function improves physical therapy outcomes.

Please take the time to complete the section below:

List three activities that you have difficulty with or are unable to do:

1. _____

2. _____

3. _____

Additional (optional):

Do Not Write Below this line

Patient- specific activity scoring scheme (point to one number)

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform Activity

Able to perform activity at the
same level as
before injury or problem