



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,

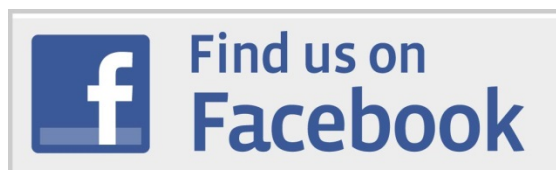
We know you have a choice in physical therapy clinics and we would like to thank you for choosing our office. We take your care and participation in therapy seriously. It is our mission to provide you with excellent care and work as a team with you and your healthcare provider to ensure that your goals 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,
Owner and Physical Therapist



P.S. We recommend that you follow our Partners in Physical Therapy Facebook Page.

**It helps you get to know us!
It helps keep you informed of clinic closures or changes!
It gives you useful resources that may help your condition!**

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)

PLEASE TAKE THE TIME TO READ EACH PAGE

Partners in Physical Therapy Policies

***We work hard so that our office consistently runs on time
and 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 Reminder: We send SMS notifications at 12 noon the day before your appointment.

Appointment Changes: A minimum 24 hour notice for changes in appointment time is required. Cancellation with less than 24 hour notice will be charged \$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: We do not bill insurance for medical supplies. Therefore, payment is due at the time of service. If you would like to bill your insurance for supplies, please talk with our billing department for assistance.

Insurance benefits: Please be aware that our office works extremely hard to get your benefits and claims processed correctly. However, it is not possible for our office to guarantee insurance participation or benefits due to the significant number of individual policies that exist. Therefore, we **STRONGLY RECOMMEND** that each patient call their insurance provider and verify network participation as well as covered physical therapy benefits and/or limitations.

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, active participation and team work.

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. ****



• RECORDS • PRIVACY NOTICE • INSURANCE AUTHORIZATION • PATIENT RESPONSIBILITY •

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 link to the **Partners in Physical Therapy** Privacy Notice, which provides a more complete description to the use and disclosure of my health information (notice is located on our website: www.partnersinpt.com):

<http://www.partnersinphysicaltherapy.com/uploadedFiles/File/privacyrights.pdf>

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; including those services that my insurance company may contend are not medically necessary. 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: _____

Partners in Physical Therapy Intake Form

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

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

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?

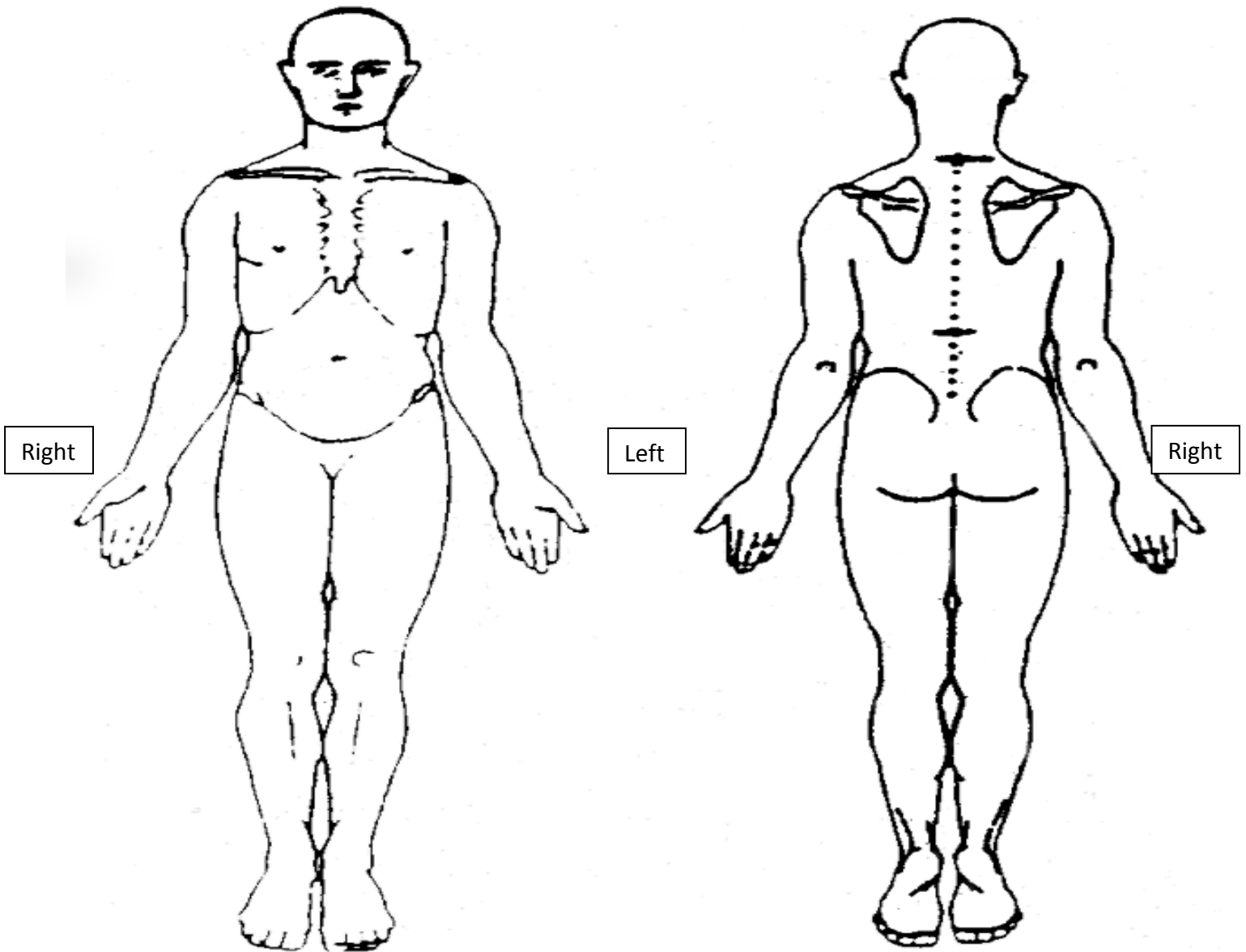
Yes No

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

OPTIMAL INSTRUMENT

Name: _____

Difficulty-Baseline

Date: _____

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking-short distance	1	2	3	4	5	9
11. Walking-long distance	1	2	3	4	5	9
12. Walking-outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to climb stairs, kneel, and hop without any difficulty, you would choose: 1. 13 2. 8 3. 14)

1. _____ 2. _____ 3. _____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to climb stairs without any difficulty, you would choose: primary goal. 13)

Primary goal _____

The OPTIMAL may be used without permission or restriction per our website, www.apta.org/optimal. Please note, however, that it remains the copyrighted intellectual property of Physical Therapy (PTJ) and the following citation must be included for all uses:

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OPTIMAL INSTRUMENT

Name: _____

Confidence-Baseline

Date: _____

Instructions: Please circle the level of confidence you have for doing each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Standing	1	2	3	4	5	9
10. Walking-short distance	1	2	3	4	5	9
11. Walking-long distance	1	2	3	4	5	9
12. Walking-outdoors	1	2	3	4	5	9
13. Climbing stairs	1	2	3	4	5	9
14. Hopping	1	2	3	4	5	9
15. Jumping	1	2	3	4	5	9
16. Running	1	2	3	4	5	9
17. Pushing	1	2	3	4	5	9
18. Pulling	1	2	3	4	5	9
19. Reaching	1	2	3	4	5	9
20. Grasping	1	2	3	4	5	9
21. Lifting	1	2	3	4	5	9
22. Carrying	1	2	3	4	5	9

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Lymphedema Evaluation

Name: _____

Date: _____

1. How long have you had swelling? _____
2. Have you ever had any infection? _____
3. Do you ever leak fluid? _____
4. Do you take antibiotics to prevent infection? _____
5. Do you take diuretics for swelling? _____
6. Do you take benzopyrones for swelling? _____ Don't know _____
7. Do you take any other drugs for swelling? _____
8. Does anyone in your family have swelling? _____
9. Which extremity has swelling? (check all that apply)
Left Arm _____ Right Arm _____
Left Leg _____ Right Leg _____
10. Have you had prior treatment for swelling? (check all that apply)
Surgery _____ Compression sleeve _____
Antibiotics _____ Pump _____
Manual Lymphatic Drainage _____ Physical Therapy _____
Other _____
11. Do you have bronchial asthma? _____
12. Do you have hypertension? _____
13. Do you have diabetes? _____
14. Do you have allergies? _____
15. Do you have any heart problems? _____
16. Do you have any circulatory problems? _____
17. What medications are you currently taking? _____

18. Have you ever had a stroke? _____
19. Have you ever had a DVT (blood clot)? _____
20. Do you have Diverticulitis, Chron's Disease, or Ulcerative Colitis? _____
21. Do you have pain? _____
22. Have you had cancer? _____

23. Do you currently have an active cancer? _____

24. Are you currently receiving treatment for cancer? _____

25. Have you ever had radiation? _____

26. Have you ever received chemotherapy? _____

27. What operations have you had? _____

28. If you are treated at this office, you will be then asked to follow a maintenance program at home.

This consists of:

- a. Elastic sleeve or stocking worn during the day.
- b. Bandaging of the limb overnight.
- c. Meticulous skin care to avoid infection.
- d. Remedial exercises to accelerate lymph flow.

Are you prepared to follow such a program? _____