NEXT LEVEL
PHYSICAL THERAPY

Admission Form

PATIENT INFORMATION

Name:_____ Social Security#:_____

Address:_____

Home #:_____ Cell#:_____ Work#:_____

Birth Date:_____ Sex: M F Date of Injury/Surgery:_____

Email:_____ How did you find us?_____

Would you like to receive text notifications about your physical therapy program, appointment reminders, and or health and fitness updates? Yes No

How would you describe your overall health? Excellent Very good Good Fair Poor

Responsible Party (If different from patient)

Name:_____ Relationship:_____

Address:_____

Birth Date:_____ Phone #:_____

Emergency Contact

Name:_____ Phone #:_____

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Medical History Form

Name:_____ Date: _____

Physician:_____ Diagnosis:_____

Are you presently working? Yes No Occupation:_____

Please check of you have a history of the following:

_____Diabetes _____Arthritis

_____Back Problems _____High Blood Pressure

_____Currently Pregnant _____Cancer (specify)

_____Lung Condition (specify) _____Seizure Disorder (specify)

_____Heart Condition (specify) _____Orthopedic Injuries (specify)

_____Infectious Disease (specify) _____Bleeding Tendencies (specify)

_____Neurological Condition (specify) _____Psychological Condition

List previous major hospitalizations, surgery_____

_____

List current prescription and over the counter medications_____

_____

Consent For Treatment

I do hereby agree and give my consent for Next Level Physical Therapy to provide medical care and treatment considered necessary and proper in treating my physical condition.

Signature_____ Date_____

NEXT LEVEL
PHYSICAL THERAPY

Patient Health Questionnaire – PHQ

Injury Date (if known)_____ Surgery Date (If applicable)_____

Involved Side Right Left Both

1. Describe your symptoms _____

_____

a) Cause or onset of your symptoms _____

2. How often do you experience your symptoms?

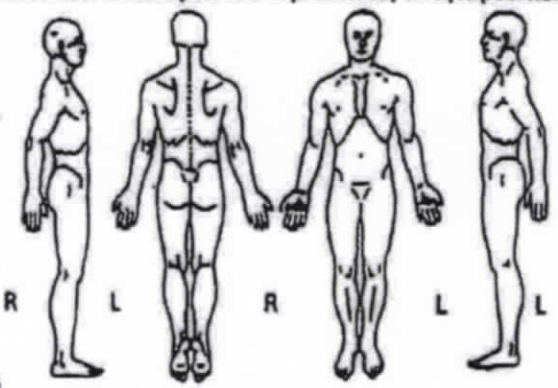
Constantly (76-100% of the day)

Frequently (51-75% of the day)

Occasionally (26-50% of the day)

Intermittently (0-25% of the day)

Indicate where you have pain and/or symptoms.



3. What describes the nature of your symptoms?

Sharp Shooting Dull ache

Burning Numb Tingling

4. How are your symptoms changing?

Getting better Not changing Getting worse

5. Please rate the *severity* of your pain in **the past week** by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worse pain imaginable

6. Are you worse in the: morning afternoon evening doesn't matter

7. What activities increase your symptoms? (sitting, walking, driving,...) _____

_____

8. What eases your symptoms? (ice, rest, lying on your side,...) _____

_____

9. Do your symptoms interrupt your sleep? YES NO

10. Who have you seen for your symptoms?

No one Medical doctor Chiropractor Physical Therapist Other

a) Have you been given any restrictions by your physician? (Please specify)_____

_____

11. What specific activities do you hope to improve through physical therapy? _____

_____

Your therapist will review this questionnaire to better address your needs.

Patient Signature_____ Date_____

NEXT LEVEL
PHYSICAL THERAPY

Financial Policy

We have found that communication with our patients regarding financial policy assists in providing the best services to you. Please take the time to read before you sign.

_____Commercial/HMO/PPO Plans: Our staff is pleased to bill your insurance company as a courtesy to you after your benefits have been verified and authorization is obtained (if required). It is the patient's responsibility to pay any deductions, copays, co-insurance or non-covered charge amounts at the time of service. If your insurance company fails to pay within 60 days of the date of billing. We will expect you to pay the balance of your bill and seek reimbursement from your insurance company.

_____Medicare: This is a Medicare certified facility and we will file claims directly to Medicare. You will be expected to notify us of any other forms of insurance which might be primary to Medicare for treatment being provided such as but not limited to Auto Insurance, Worker's Comp, Group Insurance, Black Lung etc.

_____Secondary Insurance: As a courtesy to you, we will file your supplemental carrier for you. Payment will be expected from you if your supplemental insurance does not pay your deductible, co-insurance, or copays within 30 days of filing.

_____Private Pay: Full payment is expected when services are rendered to continue treatment.

We request a 24-hour notice of cancellation or change of appointment. We value you, our patient that is why we schedule only one patient at a time with a physical therapist. $50 cancellation fee applies for same day cancellation unless appointment is rescheduled for the same week.

I have read and agree to this cancellation policy Initial here: _____

Your insurance company does not guarantee payment or the accuracy of the information we received from them. The amount allowed by your insurance may be more, and may be less than what we anticipate it to be, and is controlled solely by *your insurance.* Please contact your insurance if you have questions about the statements made to us.

I understand that my insurance company does not guarantee the information above and that I will double-check my insurance benefits:
Initial here: _____

Agreement To Pay

I understand and agree that I am responsible and liable for payment of all charges assessed for professional services rendered, I have read and understood the financial policy detailed above. I understand that I am primarily responsible for all charges incurred regardless of my existing insurance coverage. In the event that my insurance forwards payment to me, I will deliver such payment to you. I understand that I am responsible for meeting my insurance deductibles, co-pays, co-insurance and non-covered services at the time of service. Should my account become past due, the balance becomes my responsibility and is immediately due and payable. In the event that my unpaid balance is referred to outside collections, I will be responsible for all collection and legal costs. My signature authorizes release of any medical information necessary to process my claim and assigns payment of benefits to Next Level Physical Therapy INC.

_____ _____

Responsible Party Signature Date

Notice of Patient Information Practice

This notice describes how your medical information may be used or disclosed and how you can get access to information.

Next Level Physical Therapy, INC. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that described herein.

Uses and Disclosures of Health Information

Next Level Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example, Next Level Physical Therapy may use your personal health information to contact you to provide you with appointment reminders., information about treatment alternatives, or other health related benefits that could be of interest to you. Next Level Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing, research studies, and or for emergencies. We will also provide information when required by law.

In any other situation, Next Level Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization at any time. Also, Next Level Physical Therapy may change its policy at any time. When changes are made , a new Notice of Information Practice will be posted in the waiting room and the patient exam area. You may also request an updated copy at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have a right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may also request in writing that we are not to use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, unless when required by law or in emergency circumstances. Next Level Physical Therapy will consider all such request on a case by case basis, but the practice is not legally required to accept them.

Concerns or Complaints

If you are concerned Next Level Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please feel free to contact our manager and owner. You may also send a written complaint to the Department of Health and Human Services. In signing below, you are stating that you have read and understood the above Notice of Information Practice. You are also consenting that Next Level Physical Therapy can use and disclose of your personal health information for purposes noted above. You can revoke this consent at any time by notifying the practice in writing but understand that we will be reviewing each request on a case by case basis, and do not have to agree to any restrictions.

Patient's Printed Name_____

Signature_____ Date_____