A&M Therapy, Inc.

PATIENT MEDICAL HISTORY

Name (PRINTED)________________________ **Referring Physician**________________
Family Physician________________________ **Date of first doctor visit for this injury**__________
Date of Injury or onset of symptoms:______________ **NA** **Date returned to work after this injury**__________
Is injury due to Auto Accident or Workers Comp claim? **YES** **NO**
Have you had surgery for this injury? **YES** **NO** **Number of surgeries:** **1** **2** **3** **4**
Type of surgery________________________ **Date**________________________

Have you had ANY other surgeries in the past? **YES** **NO**
Please enter your – HEIGHT__________ **WEIGHT**__________ **AGE**__________

Are you currently taking any prescriptions or non-prescription medications? **YES** **NO**
List any medications currently being taken:

________________ ________________ ________________
________________ ________________ ________________

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	____	____	EMG/NCV	____	____
Neurologist	____	____	Myelogram	____	____
Orthopedist	____	____	Emergency Room Care	____	____
General Practitioner	____	____	CT Scan	____	____
Occupational Therapy	____	____	MRI	____	____
Physical Therapy	____	____	X-Rays	____	____

OTHER________________________

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma	____	____	Severe/Frequent Headaches	____	____
Shortness of breath/chest pain	____	____	Vision/hearing difficulties	____	____
Coronary heart disease or angina	____	____	Dizziness or Fainting	____	____
Heart attack or surgery	____	____	Weight loss/Energy loss	____	____
Do you have a Pacemaker	____	____	Hernia	____	____
High blood pressure	____	____	Allergies	____	____
Stroke/TIA	____	____	Joint replacement	____	____
Blood clot/Emboli	____	____	Any joint/metal implants	____	____
Epilepsy/seizures	____	____	Shoulder injury/surgery	____	____
Anemia	____	____	Elbow/hand injury/surgery	____	____
Infectious disease	____	____	Neck/Back injury/surgery	____	____
Diabetes	____	____	Knee injury/surgery	____	____
Cancer or chemotherapy/radiation	____	____	Leg./ankle injury/surgery	____	____
Arthritis/swollen joints	____	____	Are you pregnant	____	____
Osteoporosis	____	____	Do you smoke/How long	____	____
Sleeping problems/difficulties	____	____	Difficulty/Frequent urinating	____	____
Anxiety	____	____	Depression	____	____
Alzheimer's	____	____	Dementia	____	____
Thyroid Condition	____	____	Night Pain	____	____

List any other information that would assist us in your care:________________________
Are you aware of your diagnosis?________________________ **YES** **NO**

Patient or responsible party signature________________________**Date:**__________

I have reviewed this information with the patient
Therapist (PRINTED)______________**Therapist (SIGNATURE)**______________**Date:**__________

A&M Therapy, Inc.

PATIENT DEMOGRAPHIC

Patient ID #____________________

Last Name: ____________________ **First Name:** ____________________ **Middle Initial:** ________

Home Phone: ____________________ **Work Phone:** ____________________ **Cell Phone:** ________

Home Address: ____

City: ____________________ **State:** ____________________ **Zip:** ____________________

Date of Birth: ___/_____/_____ **Social Security #:** ______-______-______ **Circle One:** **M** **F**

Spouse Name: ____________________________ **Email Address:** ____________________________

Emergency Contact: ________________________ **Relationship:** ________ **Phone:** ____________

Family Physician: ___________________________ **Phone:** _______________________________

Insurance Information: **(The following section must be filled out COMPLETELY.)**
I hereby instruct the insurance company listed below to make payment directly to A&M Therapy, Inc.

Primary Insurance: ______________________________ **Member ID#:** _______________________

Policy Holder Name: ___________________ **Relationship:** ____________ **DOB:** ____________

Secondary Insurance: ____________________________ **Member ID#:** _______________________

Policy Holder Name: ___________________ **Relationship:** ____________ **DOB:** ____________

Co-Pay per Visit______ **Plan coverage %**___________ **Visits per Year**_______ **Deductible**_________

As a courtesy to you, A&M Therapy, Inc. verifies insurance benefits. However, A&M Therapy, Inc. does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefits plans.

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify A&M Therapy, Inc. of any changes in my status or the above information. I hereby authorize any treatment (s) agreed upon with the Physical Therapist and my referring physician which are deemed medically necessary.

I authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case. I also authorize A&M Therapy, Inc. and its staff to call my home and leave messages regarding appointments with my spouse and/or on the answering machine. Furthermore, I authorize the use of facsimile transmission, email transmission, internet transmission, and electronic transmission of my personal health information for the purpose of treatment, payment, and healthcare operations.

For the purpose of education and research, I hereby consent to the use of multimedia, including but not limited to photos or video taken by A&M Therapy, Inc during Physical Therapy sessions.

Patient or Responsible Party Signature: ______________________________________ **Date:** ____________

A&M Therapy, Inc.

DETERMINATION OF PRIMARY PAYOR:

Patient ID #____________________

- **Have you received OUTPATIENT PHYSICAL THERAPY SERVICES this calendar year?** **YES NO**
  If yes, where?______________________________
- **Is Medicare your secondary? If yes, please indicate the type by circling below.** **YES NO**
  Working Age Beneficiary **End Stage Renal Disease** **No Fault Insurance** **Black Lung**
  PHC or Other Federal **Veteran's Administration** **Disabled Beneficiary** **Other: ____________**
- **Are you currently receiving, or plan to receive, any type of home health care including nursing/home health aide?** **YES NO**
- **Are you currently receiving or plan on receiving any type of chiropractic care?** **YES NO**
- **Is this injury due to an automobile accident?** **YES NO**
  If "YES", what was the date of the accident? ____________State of Accident? ____________
- **Is this injury work related?** **YES NO**
  If "YES", what was the date of injury?______________________________
- **Is your injury the result of any other type of accident?** **YES NO**
  If "YES", please provide us with the details: ______________________________

I understand that if payment of services by Medicare or other insurance payer is denied due to false information I will be held responsible for these charges.

Patient or Responsible Party Signature: ____________________ **Date: ____________________**

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to-day healthcare operations of your practice.**

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

I give permission to share appointment, billing, or medical information with the person (s) named here:

____

____

Patient or Responsible Party Signature: ____________________ **Date: ____________________**