670 North Avenue Ste. 201
Marietta, GA 30060

PhysioEdge
MOVE UP TO PHYSICAL EXCELLENCE

Phone: 770-792-8081
Fax: 770-792-8083

PERSONAL INFORMATION

Name: _____ DOB: _____SSN: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ Home Phone#_____ Which is primary? _____

Email: _____ Would you like email reminders? Yes No

Occupation: _____ Work Phone #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Referring Physician: _____ Phone #: _____

Chief Complaint: _____ Date of Injury/Surgery: _____

Have you had any other Diagnostics for this problem? MRI XRAY Other: _____

Is this injury work related? Y/N Is this injury due to an automobile accident? Y/N

Have you had any physical, occupational, speech therapy, or chiropractic in the last 12 months? _____

Have you had any home healthcare physical therapy visits during this year? _____ Date ended: _____

INSURANCE INFORMATION

Primary Insurance: _____

Name of the main card holder (if other than self): _____ DOB: _____

Relationship to patient: _____

Secondary Insurance: _____

Name of the main card holder (if other than self): _____ DOB: _____

Relationship to patient: _____

WORKER'S COMPENSATION INFORMATION

Employer: _____ Case Worker's Name: _____ Phone #: _____

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Today's Date: _____ Weight: _____ Height: _____

Current Symptoms (circle): Pain Numbness Stiffness **Weakness Condition**: New Chronic

Please list all medications, vitamins, and supplements you take	Dosage	Frequency

Please list any and all medication allergies: _____

Please list any surgeries that you have had: _____

Do you have any of the following conditions?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema			Diabetes		
Shortness of breath			Cancer or Chemo/Radiation		
Coronary Heart Disease			Arthritis/Swollen Joints		
Pacemaker			Osteoporosis		
High Blood Pressure			Varicose Veins		
Heart Attack/Surgery			Gout		
Stroke/TIA			Sleeping Difficulties		
Blood Clot/Emboli			Emotional Psychological Problems		
Epilepsy/Seizures			Bowel or Bladder Problems		
Thyroid Trouble/Goiter			Severe/Frequent Headaches		
Anemia			Vision/Hearing Difficulties		
Infectious Disease			Dizziness or Faintness		
Are you pregnant?					
Do you drink alcohol?			If Yes, how many per day? _____ per week?_____		
Do you smoke?			If Yes, how many per day? _____ per week? _____		

Please list any other medical conditions you may have: _____

	Mild	Mod	Severe	Unable		Mild	Mod	Severe	Unable
Bending					Lifting				
Care for Infirm Family					Pet Care				
Carrying Groceries					Reading				
Sit to stand					Self-Care-Bathing				
Climb Stairs					Self-Care-Dressing				
Driving					Self-Care-Shaving				
Extended Computer Use					Sexual Activities				
Feeding Self					Sleep				
Household Chores					Sitting (Prolonged)				
Kneeling					Standing (Prolonged)				
Lift Children					Walking				
Yard Work					How many times a week do you exercise?_____				

Sports you participate in: _____ Recreational Activities you participate in: _____

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Please read and sign <u>all</u> sections below

Privacy Practice Written Acknowledgement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY:

Uses and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have to right to look at or get a copy of health information about you. If you request copies, we will charge you only normal copy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that the information in your records is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practice, follow the information practices that are described in this notice, and to see your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Complaints: if you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may send a written complaint to the US Department of Health and Human Services. PhysioEdge Physical Therapy & Rehabilitation can provide you with the appropriate address upon request.

I, _____, have had the opportunity to review the PhysioEdge Physical Therapy & Rehabilitation Notice of Privacy Practices

_____ _____
Signature Date

Patient Consent for Use and Disclosure of Protected Health Information

I hereby agree and give my consent to medical treatment and release of my medical records from the referring physician to assist in treating my physical condition. I authorize the release of any medical information necessary to bill and collect from my insurance policy for my physical therapy services rendered, and orthotics and durable medical equipment dispensed. I authorize payment from my insurance benefits to PhysioEdge Physical Therapy & Rehabilitation. I agree I am financially responsible for services rendered and medical equipment dispensed. I agree I am responsible for any contracted fees, deductibles, coinsurance, and co-payments, Furthermore, I understand that I am responsible to inform the office of any changes that occur.

_____ _____
Signature Date

Written Disclosure for Self-Referred Patients (no doctor referral)

A physical therapy diagnosis is not a medical diagnosis by a physician or based on radiological imaging. Physical Therapy services obtained through self-referral may not be covered by your health plan or insurer. It is your responsibility to know your benefits. As a courtesy we will attempt to verify your benefits by your first appointment.

_____ _____
Signature Date