



# PAST MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_

BLOOD PRESSURE			MUSCLE/JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
			Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE/JOINT CONDITION					
	YES	NO		YES	NO
Low Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Knee Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Hip Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Foot Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Weakness/limited movement	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

YES  NO If yes list name: \_\_\_\_\_

List all medications you a currently taking: \_\_\_\_\_

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy/Occupational Therapy/Speech Therapy/Chiropractic care?  YES  NO Where: \_\_\_\_\_

Signature of Patient, Parent, Guardian, Personal Representative

Date

# Patient Health Questionnaire - PHQ

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

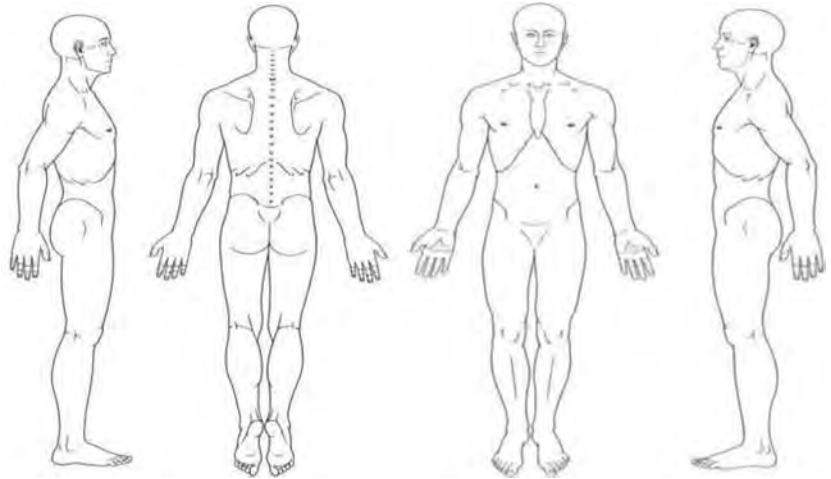
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

## 4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

## 6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

## 7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

## 8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

## 10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## **NOTICE OF PATIENT INFORMATION PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC'S LEGAL DUTY**

MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC 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 are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes.

We also provide information when required by law. In any other situation, our' 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 to stop future disclosures at any time.

MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices 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 the 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 not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

### **CONCERNS AND COMPLAINTS**

If you are concerned that we 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 contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC  
Attn: Privacy Officer  
1810 SWAMP PIKE, STE 100  
GILBERTSVILLE, PA 19525

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## **PATIENT INFORMATION CONSENT FORM**

I have read and fully understand MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC Notice of Information Practices. I understand that MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## **CANCELLATION/NO-SHOW POLICY**

At Mishock Physical Therapy & Associates, LLC, we want to “exceed” your expectations by giving you the best care humanly possible. In order to do this we need your cooperation and help. It is very important that you make your prescribed/scheduled visits. Cancellations or no-shows can make a difference in you succeeding in your treatment goals.

When you don't show up for your scheduled visit, 3 people are hurt: 1.) You because you don't get the treatment you need as prescribed by your doctor and physical therapist; 2.) the Physical Therapist who now has a space in their schedule since the time was reserved for you personally; and 3.) Another Patient who could have been scheduled for treatment if you had given proper notice. Therefore, we require 24 hour notification for cancellations. If you cancel without 24 hour notice or “no-show”, you will be subject to a \$25.00 office fee. Your insurance does not cover this fee.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## **CONSENT FOR TREATMENT**

I or my representative, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and/or physical therapist.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## OFFICE PAYMENT POLICY – MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC

It is the policy of MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC to collect any moneys due for all applicable deductible, co-insurance, co-pays and/or self payments on the date services are rendered as indicated as due and payable by the patient's insurance company (if applicable). A receipt will be given for the collection of moneys received in the facility. It is also the policy of MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC to assure that all fiscal obligations are satisfactory for the patient and that every effort is made to assure the patient receives the scheduled care without regard to fiscal obligations. Our physical therapy charges are based on the procedures and modalities used and the length of your treatment. Treatments are usually 45-60 minutes long. If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are **100% responsible** for all charges incurred; your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the office manager **before** starting your treatments.

**Please initial** your payment method and sign below that you have read, understand, and agree with all of the information on this page:

\_\_\_\_ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a co-pay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Co-pays are due at the time of service.** We will bill you for coinsurance and/or deductible or other payment due after we have been paid by your insurance or notified of their denial for payment. (You may pay towards your deductible or coinsurance at any time)

\_\_\_\_ 2. HMO Insurance: Authorization from your insurance must be obtained prior to treatment. Any co-pay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

\_\_\_\_ 3. MEDICARE: MISHOCK PHYSICAL THERAPY & ASSOCIATES, LLC is a Medicare provider. Medicare has an annual deductible for PT and Speech. Medi-Gap insurance covers the patient portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Please verify all of your insurance benefits and be sure you understand your insurance coverage.

\_\_\_\_ 4. NO INSURANCE: If you do not have insurance and we do not have administrative costs for your services, you may be eligible for an administrative discount. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

\_\_\_\_ 5. OTHER: Please list the other type of payment: \_\_\_\_\_

\_\_\_\_ 6. WORKER'S COMPENSATION CLAIMS: **Authorization from your insurance adjuster is required before you can begin treatment.** Please provide the office manager with the name and phone number of your adjuster, the date of your injury, your claim number and any other pertinent information.

\_\_\_\_ 7. THIRD PARTY PAYERS ANDN AUTO LIENS: We will bill your insurance, however, third party payments will be sent to you for our services, not to us. **You are responsible for payment of all services provided.** Please be sure to contact this office when your case is settled to ensure your account has been paid. ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS: Please sign a release of information authorizing us to discuss your treatment with your attorney. **If you retain an attorney during or after your course of treatment, please inform the office manager of this change.** A statement of account will be sent to you or your attorney on a monthly basis until the account is paid. I have reviewed this office policies statement and discussed it with the clinical office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_