Green Physical Therapy & SportsCare
2717 S. Arlington Road
Akron, Ohio 44312
330-245-1791
Fax 330-245-1793

INFORMATION FOR NEW PATIENTS

Your initial evaluation should take approximately an hour to an hour and a half.

Filling out all your paperwork prior to your first appointment will speed up your check-in process. If you have not filled out your paperwork in advance, please arrive 15 minutes early for your first appointment to complete the necessary forms.

Please bring to your first appointment:

- Your prescription for physical therapy
- Your insurance card
- Your completed paperwork

Wear loose, comfortable clothing and athletic shoes.

Please feel free to call our office at 330-245-1791 with any questions you many have.

DIRECTIONS

Directions from the North (Akron, Stow, Hudson):

Take I-77 South to the Arlington Road Exit (Exit 120).
Turn left on S. Arlington Road.
Continue to follow S. Arlington Road for less than one mile.
Travel through the S. Arlington Road/Killian Road intersection and make an immediate right into first driveway.
Our office is located at the front of the building facing Auto Zone.
Parking is available directly in front of the office.

Directions from the South (North Canton, Canton):

Take I-77 North to the Arlington Road Exit (Exit 120).
Turn right on S. Arlington Road.
Continue to follow S. Arlington Road for approximately one half mile.
Travel through the S. Arlington Road/Killian Road intersection and make an immediate right into first driveway.
Our office is located at the front of the building facing Auto Zone.
Parking is available directly in front of the office.

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2717 S. Arlington Rd. Suite A
Akron, Ohio 44312
(330) 245-1791
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Appt Date: _____ Therapist: _____ Account #: _____

Patient Name:		Social Security #:	
Address:		_____Male	_____Female
City:	State:	Zip:	
Phone:	Date of Birth:	Circle: Single Married Divorced Widow Other	
Responsible Person:		Relationship to Patient:	
Resp. Person Address:		City: State:	Zip:
Emergency Contact:	Phone:	Patient's E-Mail: No Billing, Informational Only	

Patient Employer/School Name:		Phone:	
Address:	City:	State:	Zip:

Referring Physician:	Primary Care:
Diagnosis:	Script Date:

Is Patient's Condition Related to: Auto___ Employment___ Date on Onset/ Injury Date: _____ / _____ / _____
Has patient had chiropractic, physical, occupational or speech therapy **this year**? Yes___ No___ **If Yes,** Date(s) Seen _____ Where seen ? _____
MEDICARE PATIENTS: Have you had any In-Home / Home Health Care **this year**? Yes___ No___ **If Yes,** Date(s) Seen _____ By Whom / What Agency ? _____
How did you become aware of our services? Physician___ Patient___ Ad___ Radio___ Website___ School___ Other___

Primary Insurance: Health____ Auto____ Workers' Comp____ Other_____

Name of Insurance:		Phone#:	
Address:	City:	State:	Zip:
Policy Holder:	SS#:	Date of Birth:	
Policy / ID#:	Group #:	Employer:	

Secondary Insurance: Health____ Auto____ Workers' Comp____ Other_____

Name of Insurance:		Phone#:	
Address:	City:	State:	Zip:
Policy Holder:	SS#:	Date of Birth:	
Policy / ID#:	Group #:	Employer:	

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ABOUT FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Office co-payments are due at the time services are rendered. We accept cash, checks, credit and debit cards. We will gladly discuss your proposed treatment plan and answer any questions relating to your insurance.

Please understand that:

1. Your insurance is a contract between you, your employer and insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to a maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to know your own contract.
4. If your workers' compensation claim is denied you are ultimately responsible for payment of services.
5. If you are self-pay, a payment on your balance is required at the time of each visit. Your payment will be _____.

While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If your account is turned over to a collection agency, you will be responsible for an initial fee of 38% plus any other associated fees for debt collection.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

CONSENT FOR TREATMENT

I consent to the examination, tests, and treatments, which may be done by my therapists and therapy staff during my course of therapy. I understand I have the right to be informed about my treatment.

RELEASE OF RESPONSIBILITY

I understand that Physical Therapy and SportsCare Centers, Inc. is not responsible for my personal property, money, or valuables left unattended. I understand that any valuables should be left in my locked car.

RELEASE OF INFORMATION

I authorize Physical Therapy and SportsCare Centers, Inc. and the therapists involved in my care to release information about my care and treatment: a.) as required to process payment of claims and b.) to other facilities or providers for the continuity of my care. This authorization includes release of information regarding therapy treatment and outcome.

ASSIGNMENT OF BENEFITS

I authorize payment and release of healthcare information of my current and future insurance to Physical Therapy and SportsCare Centers, Inc. I understand that as a courtesy to me, Physical Therapy and SportsCare Centers, Inc. will file an insurance claim with my insurance company, but I am financially responsible for charges incurred at this office.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature if Patient is a Minor Date

PRIVACY NOTICE

The following notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review the information carefully.

- Your confidential healthcare information may be released to other healthcare professionals within Physical Therapy and SportsCare Centers, Inc. for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Physical Therapy and SportsCare Centers, Inc. receiving payment for providing you with healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may **not** be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by Physical Therapy and SportsCare Centers, Inc. to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to restrict the use of your confidential healthcare information. However, Physical Therapy and SportsCare Centers, Inc., may chose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of the privacy notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Physical Therapy and SportsCare Centers, Inc. is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- Physical Therapy and SportsCare Centers, Inc. will abide by the terms of this notice. Physical Therapy and SportCare Centers, Inc. reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to Physical Therapy and SportsCare Centers, Inc. if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to Physical Therapy and SportsCare Centers, Inc.:

ATTN: Robert R. Zimmerman, P.T., O.C.S.
Physical Therapy and SportsCare Centers, Inc.
2717 South Arlington Road, Suite A
Akron, OH 44312

- All complaints will be investigated.
- This notice is effective as of August 1, 2006

Print patient name: _____

Patient signature: _____ Date: _____

If minor, Parent/Guardian signature: _____ Relationship: _____

Green Physical Therapy & SportsCare

Patient Name_____ **Date** _____

1. What is your occupation? _____ ○ Full Time ○ Part Time

2. Describe your symptoms _____

_____

_____

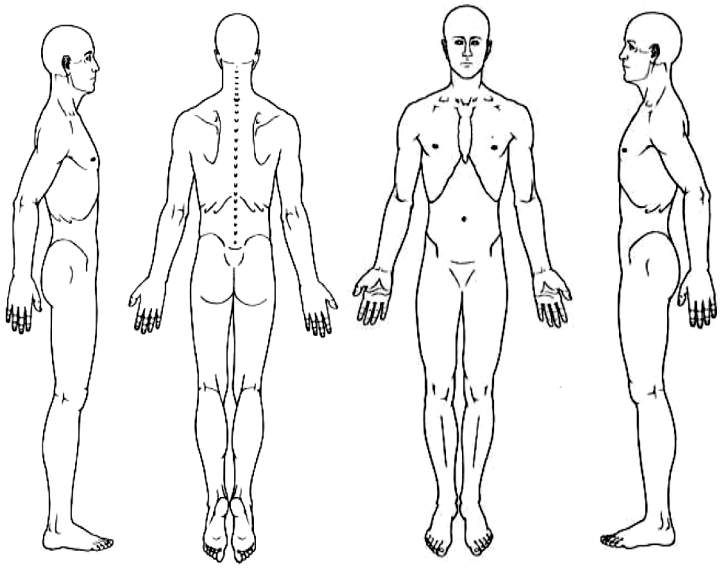
a. When / How did your symptoms begin?_____

_____

3. How often do you experience your symptoms?

① Constant (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)

Indicate where you have pain or symptoms?



4. What describes the nature of your symptoms?

① Sharp Pain ④ Shooting
② Dull Ache ⑤ Burning
③ Numbness ⑥ Tingling

5. Are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

6. During the <u>past 4 weeks</u>:
Indicate the average intensity of your pain / symptoms

None Unbearable
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

7. What tests have you had for your symptoms?

① Xrays date: _____ ③ CT Scan date: _____
② MRI date: _____ ④ Other date: _____

8. Have you had similar symptoms in the past? ○ Yes ○ No

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

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

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

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

10. Medical History (check any that apply):

Heart Disease:

- ○ Congestive Heart Failure (CHF)
- ○ High Blood Pressure
- ○ Heart Attack (Myocardial Infarction)(MI)
- ○ Atherosclerotic Disease (CAD)
- ○ Angioplasty
- ○ Valvular Disease
- ○ Stents
- ○ Arrhythmia
- ○ Coronary Artery Bypass Graft (CABG)
- ○ Angina

Lung Disease:

- ○ Chronic Obstructive Pulmonary Disease (COPD)
- ○ Emphysema
- ○ Asthma
- ○ Recent Pneumonia

Vascular Disease:

- ○ Peripheral Arterial Disease
- ○ Acquired Respiratory Distress Syndrome (ARDS)
- ○ Diabetes
- ○ Taking Blood Pressure Meds
- ○ Stroke / TIA
- ○ Chronic Bronchitis
- ○ Hypertension

General Medical Conditions:

- ○ Arthritis (rheumatoid/osteoarthritis)
- ○ Allergies
- ○ Neurological Disease (such as MS or Parkinson's)
- ○ Headaches
- ○ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ○ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
- ○ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ○ Hepatitis / AIDS
- ○ Prior Surgery(s):

  _____ Date:_____

  _____ Date:_____
- ○ Osteoporosis
- ○ Anxiety or Panic Disorders
- ○ Depression
- ○ Previous Accidents
- ○ Kidney, Bladder, Prostate or Urination Problems
- ○ Incontinence
- ○ Hearing Impairment, very hard of hearing, even with hearing aids
- ○ Sleep Dysfunction
- ○ Prosthesis / Implants
- ○ Cancer

Other Disorders: _____

_____

For Patients 65 years of age and older:

11. Have you fallen in the past year? ○ Yes ○ No

If "Yes" to #11, continue to #12

If "No" to #11, Stop

12. Did you sustain an injury from the fall? ○ Yes ○ No

13. Have you had 2 or more falls in the past year? ○ Yes ○ No

Patient Signature _____ **Date** _____

Green Physical Therapy & SportsCare

Patient's Name_____
Date_____

MEDICATION CHECKLIST

We need to keep a current record of the medications you take. Please take a few minutes to check off any medications you currently take as well as list any we don't have on our checklist. We also need you to list any medications you may be allergic to. Please check only the medications you are currently taking.

MEDICATION	✔YES
Aleve	
Amaryl	
Anaprox	
Antibiotic	
Arthrotec	
Aspirin	
Atrovent	
Aventyl	
Baclofen	
Birth Control	
Blood Pressure Medication	
Calcium	
Cardizem	
Catapres	
Celebrex	
Clonopin	
Codeine	
Darvocet	
Darvon	
Daypro	
Decadron	
Demerol	
Depakene	
Dexedrine	
Diabeta	
Dilantin	
Elavil	
Estrogen	
Feldene	
Ibuprfen	
Inhaler	
Insulin	
Klonopin	
Lidocaine	
Lorinal	
Lipitor	
Magnesium	
Medrol Dose Pack	
Meridia	

MEDICATION	✔YES
Morphine	
Motrin	
Muscle Relaxant	
Naprosyn	
Norvasc	
OxyContin	
Paxil	
Percocet	
Plaquenil	
Prednisone	
Premarin	
Prevacid	
Prilosec	
Provera	
Prozac	
Relafen	
Ritalin	
Sarafem	
Sinequan	
Steroids	
Synthroid	
Tamoxifin	
Tegretol	
Therapen	
Tofranil	
Tylenol	
Vicodin	
Zanaflex	
Zoloft	
Zyrtec	
MEDICATIONS NOT LISTED	
MEDICATION ALLERGIES	