TLC PHYSICAL THERAPY

NEW PATIENT PAPERWORK – WORKERS COMPENSATION

PATIENT INFORMATION		
Patient Name:	Preferred:	DOB:
Address, City, State, Zip:		
Email Address:	Social Security #:	

Home Phone:
Cell Phone:
Work Phone:

Appointment Reminder Method
Home Phone ☐ Cell Phone ☐ Text ☐

Please keep in mind that communication via email over the Internet is not a secure form of communication. By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Partner's Name:		
Financial Responsibility: ☐ Self ☐ Other		
Emergency Contact:	Phone:	Relation:

Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No # of visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No # of visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No Home Healthcare Provider:

CONSENT TO TREAT

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient, performed by the staff at TLC Physical Therapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternative to the treatment plan that has been recommended.

Patient/Guardian Signature: Date:

AUTHORIZATION

If you do not have personal health insurance OR you do not want TLC Physical Therapy to file claims to your personal health insurance, please read and sign below:
I have asked TLC Physical Therapy to NOT file claims to my personal health insurance carrier. If I decide at a later date to have TLC Physical Therapy send claims to my personal health insurance carrier, I understand PTMS 3.0, LLC will only do so at its discretion because possible contract obligations, pre-certifications, etc., may not have been performed, which would prohibit the likelihood of benefit coverage of my services. I understand and accept responsibility for full payment of any and all services provided.

Patient/Guardian Signature: Date:

Please fill out the Accidental Injury Questionnaire (page 2) for the physical therapy care being the result of an injury related to Workers Compensation.

NEW PATIENT PAPERWORK – WORKERS COMPENSATION

If you are filing your claims with your group health plan, it may have a reimbursement provision for claims resulting from an act or omission of a third party. The term "Third Party"can be a person, business, or other entity. In most cases, the third party has insurance to cover your claims. The medical expenses that your group health plan pays, which are also paid by the third-party insurance, may need to be reimbursed to your group health plan.

I hereby authorize any third party or insurer to reimburse my group health plan for benefit payments made on my behalf as a result of this accident involving myself and/or my dependents. The above answers are true to the best of my knowledge. I understand that I am fully responsible for any balance for services rendered. I also understand that if payment is denied by the above-mentioned parties, I will be personally responsible for the full amount charged for all services rendered.

Patient/Guardian Signature: Date:

ACCIDENTAL INJURY QUESTIONNAIRE	
Is this physical therapy care the result of a Workers Compensation claim?	Yes ☐ No
Date of Accident:	Location of Accident:
Attorney's Name:	Phone #:
Please provide the following information:	
Name of Employer:	Phone #:
Address:	
Employer's WC Insurance Carrier:	Phone #:
Address:	
Worker's Compensation Claim or Case #:	
Nurse Case Manager Name:	Phone #:
Adjuster Name:	Phone #:

NOTICE OF PRIVACY PRACTICE

(Patient/Guardian Initials)_____I acknowledge that I have received the practices Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Confluent Health Compliance and Privacy Officers listed on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Providerand/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practices Notice of Privacy Practice.

Patient/Guardian Signature: _____ Date: _____

For questions, please contact the Compliance Department (Toll free) at 888-937-4479.

NEW PATIENT PAPERWORK – WORKERS COMPENSATION

PATIENT HEALTH QUESTIONNAIRE
Occupation: Height: Weight: Sex: ☐ Male ☐ Female
Leisure Activities/Hobbies:
Are you? ☐ Right-handed ☐ Left-handed
Where do you live? ☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other
With whom do you live? ☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other
Does your home have? ☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain Please explain:
How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
General Health Status, please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any known allergies (including medications, latex, etc.) below:

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please indicate route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Surgery / Hospitalization, please include date and reason.	

Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/chronic cough	☐ Yes ☐ No	Pain wakes me at night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent fever, chills, sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No
Hearing loss/ringing in ears	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual weakness	☐ Yes ☐ No	Fatigue or myalgia	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Unexplained weight changes	☐ Yes ☐ No

NEW PATIENT PAPERWORK – WORKERS COMPENSATION

Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Anxiety or Panic Disorders	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer If yes, Site:	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Emphysema/Bronchitis	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Stroke/TIA	☐ Yes ☐ No
Gall Bladder Problems	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Gastrointestinal Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Hepatitis If yes, Type:	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No

Social History / Wellness	
Do you drink alcoholic beverages?	☐ Yes ☐ No / Comments:
Do you use tobacco?	☐ Yes ☐ No / Comments:
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never	

Current Condition
When did this problem(s) first begin?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same all day

NEW PATIENT PAPERWORK – WORKERS COMPENSATION

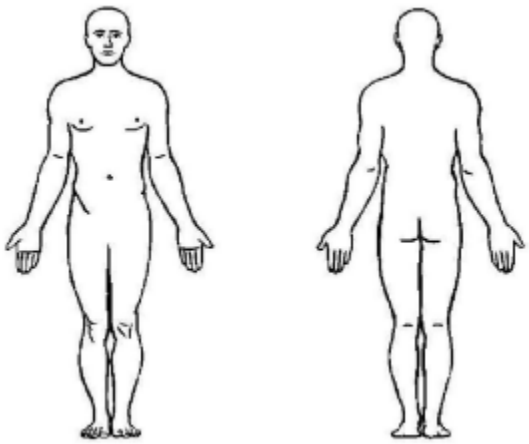
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the same
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the time (75%) ☐ Occasionally (50%) ☐ Once in a while (25%)
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Please list the dates and results of any:
X-Rays:
MRI:
Bone Density Test:
Nerve Conduction Test:
Other:
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

Symptoms Rating

Mark location of symptom(s)

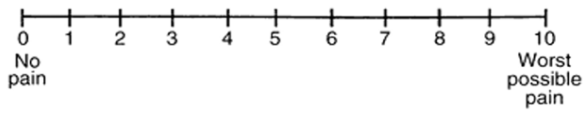
O for pain

X for numbness/tingling/burning



Please rate your pain - on a scale from 0 – 10
(0 = No Pain; 10 = Worst pain imaginable)

Current: / 10	Best: / 10	Worst: / 10



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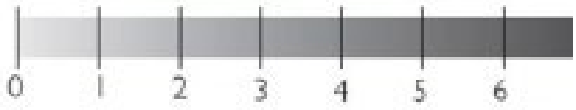
"I should not do physical activity which (might) make my pain worse."
Please rate your level of agreement on the scale below:



Completely Disagree

Unsure

Completely AgreE

Patient/Guardian Signature: _____ Date: _____