TRI-CITY
PHYSICAL THERAPY

233 Doucet Rd., Suite B2
Lafayette, LA 70503
(337) 991-9972

Patient Information

Patient: _____ Date: _____
Last First Middle

SSN: _____ DOB: ___ ___ /___ ___ /___ ___ Referring Doctor: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Email: _____ Gender: ☐Male ☐Female

Employer: _____ Work Phone: (__ __ __) __ __ __ - __ __ __ __

Home Phone: (__ __ __) __ __ __ - __ __ __ __ Cell Phone: (__ __ __) __ __ __ - __ __ __ __

Are you recievnig Home Health? ☐ Yes ☐ No **Is this a Worker's Compensation case?** ☐ Yes ☐ No

Do you have an attorney or plan to retain one for this injury? ☐ Yes ☐ No

If so, please provide Attorney information. _____

Is this related to an auto accident? ☐ Yes ☐ No

Where did you hear about us? ☐MD Refferal ☐ Employee ☐ Former Patient ☐ Friend/Relative
☐Social Media ☐ Print Ad ☐ Other _____

Insurance Information

Primary Insurance Co.: _____ Member ID#: _____ DOB: _____

Policy Holder Name: _____ Group #: _____

Secondary Insurance Co.: _____ Member ID#: _____ DOB: _____

Policy Holder Name: _____ Group #: _____

Emergency Information

A friend or relative to contact in case of emergency (**NOT Responsible Party**)

Name:_____ Relationship:_____ Phone: _____

TRI-CITY PHYSICAL THERAPY

INITIAL EVALUATION SUBJECTIVE HISTORY

Patient Name:_____ Date of Evaluation:_____

SUBJECTIVE

Therapist Comments

Age:_____ Hand dominance: ❑ Right ❑ Left

Date symptoms began:_____

Briefly describe the current symptoms/problem that brought you here._____

_____

_____

Have you had any imaging or other diagnostic testing? ❑ X-rays ❑ MRI ❑ CT Scan ❑ Other

Results:_____

Have you had prior treatment(s) for these symptoms? ❑ Yes ❑ No If yes, explain below.

❑ Medication – beneficial? ❑ Yes ❑ No Explain._____

❑ Injection – beneficial? ❑ Yes ❑ No Explain._____

❑ Physical therapy – beneficial? ❑ Yes ❑ No Explain._____

Did you have surgery? ❑ Yes ❑ No If yes, date of surgery:_____

If yes, what procedure did you have done?_____

CURRENT PROBLEM

Therapist Comments

If you are having pain, what is your pain level?

(0 = no pain; 5 = moderate pain , 10 = extreme pain)

At worst: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

Currently: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain. Check all that apply.

❑ Constant ❑ Comes & goes ❑ Aches ❑ Sharp

❑ Shooting ❑ Burning ❑ Numbness/tingling

❑ Other:_____

Does your pain seem to be WORSE at a certain time(s) of day?

❑ Yes ❑ No If yes, ❑ Morning ❑ Evening ❑ Other____

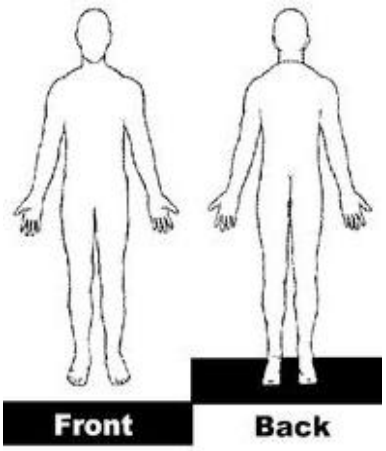
Does your pain change as the day progresses? ❑ Yes ❑ No

If yes, explain._____

Do you have nighttime pain/pain with sleeping? ❑ Yes ❑ No

If yes, explain._____

Mark the location of your pain with an "X" on the diagram below.



FUNCTIONAL ABILITIES AND/OR RESTRICTIONS

Therapist Comments

What activities were you doing prior to this injury that you are currently having difficulty with or are unable to do? Please list any additional activities you are having difficulty with.

❑ Squatting ❑ Sitting ❑ Driving ❑ Reaching ❑ Work tasks ❑ Gripping

❑ Standing ❑ Walking ❑ Lifting ❑ Dressing ❑ Stairs ❑ Bed position

❑ Kneeling ❑ Holding/carrying objects ❑ Grooming

❑ Other:_____

What activities or positions increase your symptoms?_____

What activities or positions decrease your symptoms?_____

What household duties are you currently having difficulty performing? ❑ Cooking ❑ Cleaning

❑ Vacuuming ❑ Laundry ❑ Yard work ❑ Grocery shopping ❑ Other:_____

Do you currently use an assistive device (walker, cane, etc.)? ❑ Yes ❑ No

If yes, explain._____

Did you use an assistive device prior to your current injury/condition? ❑ Yes ❑ No

WORK HISTORY

Therapist Comments

What is/was your occupation?_____ Are you: ❑ currently working? ❑ retired?

If you are currently working, do you have any restrictions or limitations? ❑ Yes ❑ No

If yes, explain._____

What kinds of job duties does/did your occupation require? (Check all that apply.)

❑ Sitting ❑ Computer work ❑ Bending ❑ Heavy lifting ❑ Standing ❑ Traveling
❑ Reaching ❑ Crawling ❑ Twisting ❑ Walking ❑ Pushing/pulling
❑ Gripping/pinching ❑ Other_____

What is your current living arrangement? ❑ Alone ❑ Spouse ❑ Family ❑ Other_____

MEDICAL HISTORY, PRECAUTIONS, AND CONTRAINDICATIONS

Therapist Comments

In terms of your general health, check **ALL** that apply.

❑ **Cancer**	❑ Chest pain/angina	❑ Recent fever	❑ Heat/cold intolerance
❑ **Pacemaker**	❑ Stroke/TIA	❑ Ringing in the ears	❑ Recent fracture(s)
❑ **Diabetes I or II**	❑ Physical abnormality	❑ Recent nausea	❑ Heart Disease
❑ Recent headaches	❑ Hypoglycemia	❑ Recent vomiting	❑ Liver/gallbladder issue
❑ Recent vision change	❑ Night pain	❑ Heart attack	❑ Asthma/breathing issue
❑ Sexual dysfunction	❑ Urine leakage	❑ Allergies	❑ Seizures/epilepsy
❑ Osteoarthritis	❑ Kidney problem	❑ Skin abnormalities	❑ Recent dizziness/fainting
❑ Heart palpitations	❑ Anemia	❑ Osteoporosis	❑ High/low blood pressure
❑ Smoking history	❑ Adhesive/tape allergy	❑ Metal Implant(s)	❑ Unexplained weight loss / weight gain
❑ Numbness/tinging	❑ Pregnancy (currently)	❑ Depression	
❑ Recent change in bowel/bladder habits	❑ Pain with cough /sneeze	❑ Recent unexplained fatigue	❑ **NONE OF THE ABOVE**

Is there is any other information regarding your medical history or are there any other factors that may complicate your ability to participate in therapy? Explain._____

MEDICATIONS

Therapist Comments

❑ See attached list.

Please list ALL the medications you are currently taking, including prescriptions, over-the-counter, vitamins/minerals, and herbals. List the specific **NAME, DOSAGE, FREQUENCY, and ROUTE** (e.g., by mouth) of each medication. If you have a list of your current medications, please provide us with a copy._____

SIGNATURES

To the best of my knowledge, I have fully informed you of the history of my problem and current status.

Patient's Signature:_____ Date:_____

Therapist's Signature:_____ Date:_____

TREATMENT CONSENT AND AUTHORIZATION FORM

PLEASE READ CAREFULLY. INITIAL AND SIGN WHERE INDICATED.

AMBULATORY CARE AUTHORIZATION

I, the undersigned, hereby voluntarily authorize Tri-City Physical Therapy to perform wellness services, outpatient evaluation(s) and/or procedure(s) and to administer such outpatient therapy and/or medical treatment(s) that in the opinion of the physician and/or consulting allied health provider is/are necessary or appropriate. I am aware that medical treatment/therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered. I hereby release Tri-City Physical Therapy and its personnel from any responsibilities for any resulting illness, ill effect, or reaction from treatment. **INITIAL _____**

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, hereby authorize Tri-City Physical Therapy to release medical record information by means of telephone, reproduction, or facsimile transmission relative to any outpatient therapy, treatment(s) or evaluation(s), and/or medical services to referring physician for status of treatment, attorney, family physician providing follow-up care, third party payer(s) to substantiate medical necessity and charge verification, and/or case manager(s) for determining medical necessity or utilization review. This authorization shall be valid during the course of treatment and shall expire 365 days after discharge. **INITIAL _____**

NOTICE OF PRIVACY PRACTICE

I, the undersigned, understand that, under the Healthcare Portability and Accountability Act of 1996 (HIPAA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- Contact, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Contact me in advance by phone call, email or text message to remind me of my appointment with a signed consent providing us with your choice of notification method.

I have received your *Notice of Privacy Practices*, which contains a more complete description of uses and disclosures of my health information, whether in person or by viewing on your Website (www.tricitypt.net). I have read and understood the notice prior to submitting my registration. I understand that Tri-City Physical Therapy has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact Tri-City Physical Therapy at any time to obtain a current printed copy of the *Notice of Privacy Practices.* **INITIAL _____**

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC IMAGES AND/OR TESTIMONIALS

I, the undersigned, authorize the use and disclosure of my (check all that apply):

- ❑ name,
- ❑ photographic images,
- ❑ testimonial including my name, or
- ❑ testimonial including my initials only

for marketing purposes by Tri-City Physical Therapy. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. The image(s) and/or testimonial(s) will be used for social media, our website and advertising.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by Tri-City Physical Therapy VIA REGISTERED MAIL. Revocation affects disclosure moving forward and is not retroactive. This authorization expires in 99 years from the date signed.

I understand that Tri-City Physical Therapy cannot condition treatment on whether or not I sign this authorization.
INITIAL _____

PATIENT OR PARENT/LEGAL GUARDIAN SIGNATURE

Patient Name: _____ Parent/Guardian Name: _____

Date: _____ Date: _____

Patient Signature: _____ **Parent/Guardian Signature:** _____

NOTICE OF PRIVACY PRACTICES

TRI-CITY PHYSICAL THERAPY

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.