CRANE
PHYSICAL THERAPY

Welcome to Crane Physical Therapy!

We're happy you have chosen us to provide your outpatient physical therapy. We are committed to helping you meet your personal health goals through physical therapy via a customized clinical process as well as to educate you on you condition to help you prevent reoccurrence.

What to Expect:
As part of your orientation, your first visit will consist of a complete Physical Therapy evaluation. We will discuss your physical history, current condition and perform a complete physical examination. The physical examination will consist of specialized tests designed to assess your body mechanics as well as your strengths and weaknesses. This will enable our therapists to develop an individualized program specifically designed to treat your diagnosis limitations.

You will be asked to complete periodic evaluation forms so that we can accurately assess your progress, and we will provide your doctor with a report of your progress.

What to Wear:
Be prepared to move around a lot during your first physical therapy session. With that in mind, we recommend that you wear looser-fitting clothing and sneakers for maximum comfort.

Please complete the attached forms and bring them to your initial appointment.

Please also bring the following:
- Your referral or prescription from your doctor for physical therapy
- Your driver's license or other photo ID.
- Your insurance card(s)

Appointments:
- Please be sure to arrive at least 15 minutes prior to your initial evaluation to complete intake paperwork.
- It is important to the recovery process that you keep all your prescribed appointments. Should you need to cancel, kindly notify our office **at least 24 hours** in advance.
- Should you arrive past your appointment time, we will do everything we can to ensure you receive the maximum benefit from your program. Please understand our commitment to outstanding service extends to all our clients and you may be asked to reschedule your appointment if you arrive more than 10 minutes late.

If you have any questions or need to change the date or time of your appointment, please call our office and we will be happy to make the adjustment for you.

Thank you for choosing Crane Physical Therapy; we look forward to working with you!

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Patient Intake Form

Patient's Name: _____ **Date of Birth**: _____
(last) (first) (MI)

Mailing Address: _____
(number and street) (city) (state) (zip)

Cell # (_____) _____ **Home #** (____) _____ **Email:** _____

Emergency Contact: _____**Phone #** (____) _____

Relationship of Emergency Contact: _____

What is your reason for seeing us (circle one)? Auto Injury Work Injury Surgery Other

Referring Physician: _____**Date of Injury:** _____

Primary Care Physician: _____

Are you currently receiving home health, or have you received it in the past 60 days? YES / NO

If yes, please provide the name of the home health agency. _____

Have you recently been discharged from home health? YES / NO

If yes, what was the date of your last home health visit? _____

_____ **Please initial to acknowledge that if at any point during your treatment at this facility you start to receive home health services (or other Medicare Part A services), you will notify this facility immediately.**

Authorization & Consent

- I understand that I am responsible for all charges incurred regardless of insurance or third-party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize ***Crane Physical Therapy*** to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to ***Crane Physical Therapy.***

_____ _____

Signature **Date**

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Patient History Form

Note: This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth ____ /____ /____ **BMI:** Height _____ Weight _____

Today's Date ____ /____ /____ **Date of last Physician exam** ____ /____ /____

History of Present Problem

What is the main reason for your evaluation today?

_____

_____

Have you had surgery related to this condition? ___YES ___NO
If yes, type of surgery: _____ Date of Surgery: _____

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable) circle the number that best describes your average pain. 0 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem? (circle)
days ago weeks ago months ago years ago
Other _____

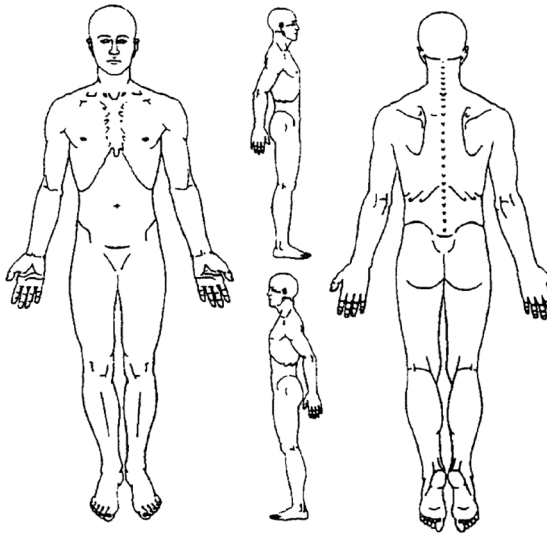
Problem worsens with: (circle all that apply)
Movement Inactivity Standing Lying Sittin
Other _____
_____

Problem improves with: (circle all that apply)
Movement Inactivity Standing Lying Sittin
Rest Medication Heat Ice
Other _____

How frequently are you bothered by this problem? (circle one)
Constant Occasional/Variable
Other _____

How would you describe the problem? (circle one)
Dull Sharp Dull then Sharp Very sharp then stops
Other _____

Please mark the location of the pain on the diagram below.



Do you have any other symptoms?
NO YES (please explain): _____

Does the problem interfere with daily functions?
NO YES (please explain): _____

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Medical History

Do you now or have you ever had (please check all that apply):

_____Allergies
_____Anemia
_____Angina
_____Anxiety/Panic Disorders
_____Arthritis (rheumatoid/osteoarthritis)
_____Asthma

_____ Back Pain (neck pain/back pain/ degenerative disc disease/spinal stenosis)
_____Cancer (Type:_____)
_____CHF/Any Heart Disease/Heart Murmur
_____Chronic Headaches
_____Colitis
_____Convulsion
_____COPD/ARDS/Emphysema
_____Crohn's Disease
_____Depression
_____Diabetes
_____Epilepsy/Seizures
_____Fractures
_____Gastrointestinal Disease (ulcer/hernia/reflux/bowel/liver/gallbladder)

_____Goiter
_____Headaches
_____Hearing Impairment/Hearing Aids
_____Heart Attack
_____Hepatitis/AIDS/HIV
_____High Blood Pressure
_____High Cholesterol
_____Hypothyroidism
_____Incontinence
_____Jaundice
_____Joint Pain/Swelling
_____Kidney/Bladder/Prostate/Urination Problems
_____Multiple Sclerosis / Parkinson's/ Any Neurological Disease
_____Leukemia
_____Osteoporosis
_____Other Disorders
_____Paralysis
_____Rheumatic Fever
_____Pneumonia
_____Previous Accidents
_____Prior Surgery
_____Prosthesis/Implants
_____Psoriasis
_____Pulmonary Embolism
_____Visual Impairment (cataracts/glaucoma/macular degeneration)
_____Sinus Problems
_____Sleep Dysfunction
_____Stomach or Peptic Ulcer
_____Stroke/TIA
_____Tuberculosis
____ PVD (Peripheral Vascular Disease)

Do you wear dentures? YES / NO

Do you wear glasses/contacts? YES / NO

Do you have a pacemaker? YES / NO

Do you have any skin allergies? YES / NO

Have you experienced any falls in the last 12 months? YES / NO **If yes, how many?** _____

Have you been injured from a fall during the last 12 months? YES / NO

Do you have any discomfort/shortness of breath/pain with exercise? YES / NO

Do you smoke? YES / NO If yes, how much do you smoke?_____

If you quit smoking, when did you quit? _____

Is there a chance that you may be pregnant at this time? YES / NO

List any allergies to medication:_____

List any hospitalizations/reasons/dates:

_____

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Financial Policy & Consent to Treat

This is an agreement between ***Crane Physical Therapy*** and (print name) _____.

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to ***Crane Physical Therapy***.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

Collection Policy: If you allow your patient balance to go 120 days without making payment arrangements, you will be sent to a collection agency. If your balance is sent to collections, you will also be responsible for a 30% fee in addition to your balance.

Payment options if you have insurance:

1. If you have a deductible to meet, you choose to pay by check or credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for any additional patient responsibility, if any, which is determined by your carrier.

2. You choose to pay your co-payment, determined by your insurance carrier, by check or credit card at the time services are rendered. If there is a balance on your account at the end of the month, we will bill you accordingly

3. **Payments:** Unless other arrangements are approved, the balance of your statement is due and payable when the statement is issued and is past due if not paid by the end of the month. If extenuating circumstances should arise, you can discuss a payment plan with our Billing Department **866-496-8541** or inquiries@lincolnrs.com.

Consent For Care & Treatment

I, the undersigned, do hereby agree and give my consent for ***Crane Physical Therapy*** to furnish medical care and treatment to _____that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____
Parent or Authorized Representative (if applicable)

_____ _____

Signature **Date**

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Insurance & Fee Notice

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your coverage eligibility. Our billing company will verify your benefits with your insurance company and determine if a preauthorization is required.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your coverage eligibility. You agree to pay any portion of the charges not covered by insurance.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

Returned Checks: There is a $25 fee for any checks returned by your bank.

Missed Appointments: If you find that you cannot keep your scheduled appointment, we ask that you cancel at least 24 hours in advance. **Failure to cancel with at least 24 hours' notice or "no shows" will result in a cancellation fee of $50.00 per appointment.** This charge must be paid in full before receiving further treatment.

Workers Compensation: We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Motor Vehicle Accidents: If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____
Patient Name (please print)

_____
Parent or Authorized Representative (if applicable)

_____ _____
Signature **Date**

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HIPAA Notice of Privacy Practices

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosure of Health Information:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:
Except as stated below, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____
Patient Name (please print)

_____
Parent or Authorized Representative (if applicable)

_____ _____
Signature **Date**

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Patient Talent Release

I grant permission to ***Crane Physical Therapy*** to publish, distribute, create, copy, reproduce or exhibit my written testimonial and/or photographic image/video. I understand that the above uses may include, but are not limited to print, websites, social media, film, photographs, multi-media programs or other types of promotional medium existing now or in the future.

I further understand that by granting this permission I am giving up all rights and claims to monetary compensation for any future use of this material by ***Crane Physical Therapy.***

Signature: _____

Date: _____

Patients under the age of 18:

A parent or guardian signing is doing so individually and on behalf of the minor and warrants he/she has the authority to sign on behalf of the minor.

Signature: _____
(Signature of parent or guardian individually and on behalf of the minor)

Date: _____

How Did You Hear About Us?

Please place a check mark next to one of the below

Physician _____ Name of Physician: _____

Repeat Patient _____

Friend/Family _____ Name of Friend/Family Member: _____

Google/Search Engine _____

Website _____

Social Media _____

Advertisement _____

Event _____

Other _____

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Medical Records Individuals Authorization Form

I hereby authorize ***Crane Physical Therapy*** to release any protected health information (PHI) regarding my treatment, payment or any administrative operations related to my treatment and payment to the below individuals.

If you do NOT wish to share your PHI with anyone, please write **"NONE"**, sign, and date.

_____	_____
First and Last Name	**Relationship to Patient**
_____	_____
First and Last Name	**Relationship to Patient**
_____	_____
First and Last Name	**Relationship to Patient**

Signature: _____

Date: _____