Grey Physical Therapy and Sports Medicine Center

Body Made Better by Grey… A Tradition of Caring Since 1984

101 Phoenix Ave, 2D
Enfield, CT 06082
Ph (860) 741-2541
F (860) 745-5264

Patient Information

First Name:	Last Name:	MI:	Date:
Address:			
City:	State:	Zip:	
Email:			
Birth Date: / /	Age:	† Female † Male	S.S. #: – –
Home #: ( ) –	Work #: ( ) – x		Cell #: ( ) –
Please circle 1st choice for phone contact: Home Work Cell			
Marital Status: † single † married † divorced † widowed † other:			

Work Information

Employer:	Occupation:
Employment Status: † Full time † Part Time † Retired † Not Employed	Student Status: † Full time † Part time

Care Provider Information

Referring Physician:	Primary Care Physician:

Emergency Contact Information

Name:	Relationship:	Phone: ( ) –

Primary Insurance Information

Insurance Name:		
Subscriber's Name (if different):		Birth Date: / /
ID#:	Group/Policy #:	Employer:
Patient's Relationship to Subscriber: † self † spouse † child † other		

Secondary Insurance Information

Insurance Name*:*		
Subscriber's Name (if different):		Birth Date: / /
ID#:	Group/Policy#:	Employer:
Patient's Relationship to Subscriber: † self † spouse † child † other		

Auto or Work Injury Claim

Insurance Name:			
	Auto: † yes		Work: † yes
Adjustor/Case Manager:	Phone:		Ext:
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Employer:	

I hereby provide consent for treatment by Grey Physical Therapy. I hereby authorize payment to be made directly to Grey Physical Therapy. I also understand that as a part of treatment, my records may be shared with other providers to whom I am referred from or referred to and/or my insurance company. I have been made aware of the Notice of Privacy Practices for Grey Physical Therapy.

Signature of Patient or Parent/Guardian

Date

Grey Physical Therapy and Sports Medicine Center of Enfield

Financial Policy Agreement

As a patient at Grey Physical Therapy your insurance coverage is verified to determine available benefits. Even though this information is reliable, it is not guaranteed. You are responsible for knowing the benefits, limitations, and/or restrictions that your policy may stipulate.

We base our information regarding your insurance coverage on what we are given by your insurance company when we verify your coverage. The exact determination of benefits occurs at the time your insurance company pays the claim.

We must emphasize that as medical providers, our relationship is with you. While the filing of insurance claims is a service we extend to our patients, it is your responsibility to see that your charges are paid in full. Any known deductions including deductibles, copays, co-insurance, or non-covered services/supplies are due at the time of service. Accounts unpaid are considered delinquent. Delinquent accounts will be referred to our collection agency.

I understand and agree that I am financially/legally responsible for full payment of my bill and that any failure of my insurance carrier to pay for all or any part of my bill does not constitute a reason for me not to pay. I understand that my insurance policy is a contract between myself and my insurance carrier, and that Grey Physical Therapy is not responsible for settling disputed claims. Grey Physical Therapy will provide the necessary information regarding my treatment in order to facilitate payment of your claims.

In addition, I have been advised that my failure and/or denial to provide accurate information prior to, or upon my initial visit constitutes my classification as a self-paying uninsured cash patient. This classification will cause me to forfeit and/or relinquish all subsequent discounts, agreements, adjustments, benefits and arrangements that Grey Physical Therapy may have contractually accepted with any or all third party insurance carriers. This will supersede and replace any prior obligation that Grey Physical Therapy may have. If it is determined I am a self-pay, cash patient the following rates apply: $145.00 for the first visit (initial evaluation) and $90.00 for each subsequent visit which payment will be expected at the time service is rendered.

In the unlikely event that your insurance carrier determines that care provided to you is “not medically necessary”, you hereby have been provided prior notice that you are fully responsible for any charges not paid by your insurance carrier based on their decision.

I also understand that Grey Physical Therapy requires ***24 hours*** notice for cancellation of scheduled appointments and I may be financially responsible (not my insurance carrier) for missed appointments (no shows) in the form of a $25 per visit fee. I understand the Grey Physical Therapy Financial Policy and my responsibility for my account.

_____ _____ _____

Patient/Responsible Party Signature Date Time

Notice of Privacy Practices

I hereby acknowledge that I have been given the opportunity to review and request a printed copy of the Privacy Practices of Grey Physical Therapy. **Please check one of the following**:

□ I hereby authorize Grey Physical Therapy to disclose my Protected Health Information (PHI) to the following people:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____Phone:_____

□ I hereby authorize Grey Physical Therapy to disclose my Protected Health Information (PHI) to no one other than myself.

Authorization to leave message on voice mail/answering machine: Yes_____ No_____

_____ _____

Patient or Patient Representative (print) Patient or Patient Representative (sign)

Date Signed:_____ Expiration Date: 1 year from date signed

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101 Phoenix Avenue, Suite 2D
Enfield, CT 06082

Patient Medical Screening Questionnaire

Name:_____ **Date**:_____

D.O.B____/____/_____ **Age**:_____ **Height**:_____ **Weight:**_____

Current Symptoms:

What is your reason for this visit?_____

How long ago did your symptoms begin?_____

How did your symptoms begin?_____

Are your symptoms currently: Getting better / About the same / Getting worse

Have you had these symptoms before? Yes / No If so, when?_____

If so, how treated?_____

How are you able to sleep at night? Fine / Moderate Difficulty / Only with medication

Have you had any of the following for your condition:

X-ray Yes / No If yes, when, where, results?_____

CT scan Yes / No If yes, when, where, results?_____

MRI Yes / No If yes, when, where, results?_____

Urinalysis/ Blood Test Yes / No If yes, when, where, results?_____

General Health:

Do you smoke? Yes / No If yes, how many packs per day?_____

How many days per week do you drink alcoholic beverages? _____ How many drinks per day on average?_____

Do you use recreational drugs? Yes / No If yes, what, how much, how often? _____

If a woman, are you pregnant or think you may be pregnant? Yes / No

Do you take blood thinners? Yes / No

Does coughing, sneezing, or taking a deep breath make your pain feel worse? Yes / No

Are you allergic to latex? Yes / No List other known allergies:_____

Have you sustained any falls in the last year? yes no If yes, how many? _____ Were there any injuries sustained during these falls? yes no Please explain:_____

Please list regular exercise routine:_____

Please list any recent illnesses:_____

Please list any recent surgical or needs for hospitalization:_____

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes / No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes / No

Is this something with which you would like help? Yes / Yes, but not today / No

Have you recently noted any of the following:

☐ Unexplained weight loss	☐ Shortness of breath	☐ Headaches
☐ Changes in skin color/texture	☐ Dizziness/ Lightheadedness	☐ Fever/chills/sweats
☐ Heartburn/Indigestion	☐ Change in balance/falls	☐ Difficulty swallowing
☐ Muscle weakness	☐ Persistent cough	☐ Fatigue
☐ Numbness or tingling	☐ Changes in bowel/bladder	☐ Nausea/ vomiting
☐ Increased pain at night/rest	☐ Depression	☐ Changes in appetite

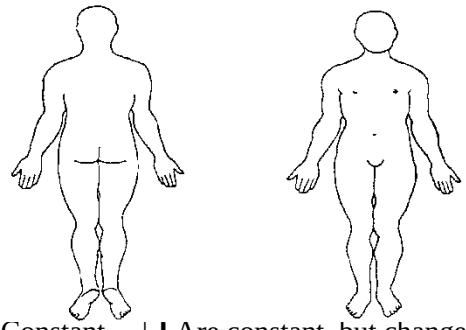
Medications: Please list all medications including all prescriptions, vitamins, supplements, herbals, over-the-counter, minerals, dietary and supplements.

Medication Name	Purpose	Dosage	Frequency	Administered: Oral, injection, other

Body Chart:
Please mark the areas where you feel symptoms using the following symbols:

↓ **Shooting/sharp pain**

O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Past Medical History:
Have you or anyone in your immediate family ever been diagnosed with:

Diagnosis	Yes	No	Relation to Patient	Diagnosis	Yes	No	Relation to Patient
Anemia				High Blood Pressure			
Arthritis				Kidney disease/stones			
Asthma				Lung problems			
Bleeding tendencies				Lyme disease			
Blood clots				Migraine headaches			
Bone or joint infection				Multiple sclerosis			
Cancer (type)				Organ transplant (which)			
Chemotherapy				Osteoporosis/Osteopenia			
Radiation				Pacemaker			
Chemical Dependency				Parkinson's Disease			
Chest pain/Angina				Pelvic inflammatory disease			
Circulation problems				Psychiatric disorders			
Cirrhosis/Liver disease				Rheumatoid arthritis			
COPD				Shortness of breath			
Dementia				Stroke			
Diabetes: Type I / Type II				Thyroid problems			
Epilepsy				Tuberculosis			
Fibromyalgia				Ulcers			
Gout				Urinary incontinence			
Hearing loss				Urinary tract infection			
Heart attack/Heart disease				Vision loss			
Hepatitis/Jaundice				Other:			