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.

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

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:_____

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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Patient Medical History

Name:_____ Date: _____
Height:_____ Weight:_____ Age:_____
Reason for Visit:_____
How long ago did your symptoms start? _____
What do you think caused your symptoms? _____
What treatment have you had so far (injections, chiropractic, self treatment etc)? _____
_____
Has this ever happened before? yes no When?_____
Have you had any of the following:
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?_____
Physical therapy yes no If yes, when, where, results?_____
Please list any surgeries or conditions for which you have been hospitalized (include dates):_____
_____

General Health

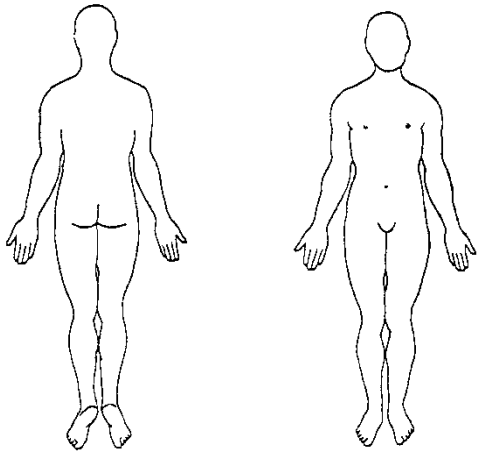
1) Do you smoke? yes no If yes, how many packs per day?_____
2) How many days per week do you drink alcoholic beverages? _____
   How many drinks per day on average? _____
3) Do you use recreational drugs? (marijuana, cocaine, amphetamines) yes no
   If yes, what, how much, how often? _____
4) How much caffeine do you consume daily? (include soft drinks, coffee, tea) _____
5) For women: Are you currently pregnant or think you might be pregnant? yes no
6) Have you had any recent illnesses? yes no What?_____
7) 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:_____
8) Do you have a normal exercises routine? yes no If yes please explain:_____
   _____
9) Do you have any allergies (include food, environmental factors, medications, etc) yes no
   If yes, what? _____
   _____

Have you recently noted:

Unexplained weight loss/gain	yes	no	Shortness of breath	yes	no
Changes in skin color/texture	yes	no	Headaches	yes	no
Fatigue	yes	no	Dizziness/lightheadedness	yes	no
Fever/chills/sweats	yes	no	Heartburn/indigestion	yes	no
Change in balance/falls	yes	no	Difficulty swallowing	yes	no
Muscle weakness	yes	no	Persistent cough	yes	no
Numbness or tingling	yes	no	Changes in bowel/bladder	yes	no
Nausea/vomiting	yes	no			

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

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

Work Environment

Occupation: _____ Part time Full time
Are you on work restrictions from your doctor? yes no If yes please describe:_____
_____
Does your job require: (please check all that apply)
Prolonged sitting ____ Prolonged standing ____
Prolonged walking ____ Climbing/crawling ____
Lifting/bending/twisting ____ Chemical exposure ____
Large equipment use (e.g. Forklift) ____ Small equipment use (e.g. Drill press, cash register) ___
Other: (please describe) _____
Do you use any special support equipment: (please check all that apply)
Back/neck cushion _____ Back brace/corset _____
Other: (please describe) _____

Medications

Please list **all** medications including all prescriptions, vitamins, supplements, herbals, over-the-counter, minerals, dietary and nutritional supplements

Medication Name	**Purpose**	**Dosage**	**Frequency**	**Administered: Oral, Injection, Other**

Past Medical History

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

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