Patient Name:_____

ECRC Physical Therapy - New Patient Information

Welcome to ECRC Physical Therapy! We appreciate the opportunity to guide and assist you towards better health. Here are some guidelines to help make your appointments run smoothly and help us provide you with the care you desire:

- If you have a written referral or prescription for Physical Therapy that your provider gave to you, please bring that with you to the first appointment as well as any other information your physician gave you for this referral (imaging reports like XR findings, operation notes or doctor's office notes, etc.).
- Fill out the New Patient Packet, which you may pick up at the office prior to your scheduled appointment, or downloaded and completed. If you are unable to complete the new patient packet beforehand, or you did not receive the paperwork, please arrive at least 20 minutes earlier than your appointment time so we can assist you in competing the forms.
- Your initial appointment will take approximately one hour.
- At your initial evaluation you will be given the schedule of your follow up appointments. We ask you to review the schedule and let ECRC know if you are unable to make any of the appointments. We will do our best to reschedule those appointments. Please note that there may be some scheduling conflicts and we will do our best to accommodate those times. If there are no convenient times available, we will place you on our wait list and, based on your availability and the clinician's schedule, we will provide alternative dates to attend.
- **Our goal is to help you resolve your condition so your attendance is critical**. If you know you will be late by more than 10 minutes beyond the scheduled time, please call our office as soon as possible. If you arrive more than 12 minutes after your scheduled appointment time, we may need to reschedule your appointment.
- If there are missed appointments without any notification (no call or no excuse for missing the appointments), and it affects our ability to help you resolve your condition, we may have to cancel your remaining visits and refer you back to your referring physical to continue with your Plan of Care.
- **Not only does missed appointments affect your resolution of your condition, but it also affects our ability to schedule all of our patient-clients. A No Show fee of $50.00 may be assessed if you fail to show up for a scheduled appointment AND you have not called to cancel at least 24 hours in advance.**
- We are providers for a wide range of insurance carriers. We make every attempt to assist you in determining your financial responsibility as well as your Physical Therapy benefit as a service to our patients. However, it is your responsibility to know your policy benefits. We encourage you to contact your insurance company via the phone number on your insurance card if you have any questions about your physical therapy benefits.
- Please come prepared to pay your financial portion of the Physical Therapy benefit at the time of service. Under certain circumstances, for example high deductibles or no insurance coverage, we do offer individualized payment plans.

DAYVILLE - 165 Hartford Pike, Dayville, CT 06241 | Ph: 860-779-0150 Fax: 860-774-2371

LISBON - 2B Lee Road, Lisbon, CT 06351 | Ph: 860-376-2564 Fax: 860-376-4812

COLCHESTER - 121 Broadway, Colchester, CT 06415 | Ph: 860-537-6798 Fax: 860-537-5926

Visit us online: www.ecrc-pt.com

Patient Name:_____ DOB:_____

ECRC
PHYSICAL THERAPY

Consent for Care and Treatment

I, the undersigned, agree and give my consent for ECRC to furnish physical therapy care and treatment as considered necessary and proper in the diagnosis and treatment of my illness or injury.

Benefit Assignment / Release of Information

I request that payment of authorized benefits be made on my behalf to ECRC for physical therapy services furnished to me. I authorize any holder of medical information about me to release to my insurance(s) (the "Centers of Medicare and Medicaid Services", formerly the "Health Care Financing Administration" and its agents for Medicare patients) any information needed to determine these benefits or benefits for related services. We ask that you provide your insurance information to us on your initial visit. This includes Primary and Secondary (if applicable) insurance information.

Cancellation / No Show Policy

If you need to cancel/reschedule your appointment, please call at least 24 hours in advance to allow us to offer your appointment time to other patients. **We reserve the right to charge a fee of $50.00 for any no-shows**. **That is, not calling to cancel appointment less than the 24 hours advance notice.**

Agreement to Pay

ECRC will bill your insurance company solely as a courtesy to you. All fees for services provided are your responsibility. We require you pay your estimated share or co-pay, as specified by your insurance carrier for each visit at each visit. We will bill your insurance and if there is any remaining amount due we will bill you. We do offer individualized payment plans. If you are in need of a payment plan, please speak with the front office. We encourage you to contact your insurance carrier to make sure you as a member are being given the same eligibility responsibility information as ECRC. I understand and agree that if I fail to make regular payments as described above, I will be responsible for all costs of collection monies owed, including our costs, collection agency fees and attorney fees.

E-Mail Address

If you would like ECRC Physical Therapy to email you your appointment reminders or information pertaining to your health or any services we provide, please enter your email below:

E-Mail: _____

I have read, understand and agree to the above conditions. I understand my full responsibility for the payment of my account.

_____ _____

Signature of Patient or Legal Representative **Date**

Patient Name:_____ DOB:_____

ECRC
PHYSICAL THERAPY

Authorization to Release Medical Information, Emergency Contacts and Acknowledgement of Privacy Practices

Authorization to Release Medical Information:
I hereby authorize ECRC to disclose my identifiable information to the following: (additional provider, attorney, etc)

1. _____
2. _____
3. _____

I understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above could be re-disclosed by such a person or entity and will likely no longer be protected by federal privacy regulations. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the ECRC staff. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand this revocation does not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

_____ _____
Signature of Patient or Legal Representative **Date**

Emergency Contact:

_____ _____
Name/Relationship **Contact Number**

Acknowledgement of Privacy Practices:
I hereby acknowledge that l have reviewed a copy of ECRC's Notice of Privacy Practices (posted in the waiting room). I understand that if I have further questions or concerns, I may contact ECRC, Wendy Christie, 2B Lee Road, Lisbon, CT 06351; (860) 376-2564. I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy is amended or changed in a material way.

_____ _____
Signature of Patient or Legal Representative **Date**

Patient Name:_____ DOB:_____

ECRC
PHYSICAL THERAPY

Type of Injury / Previous Care

You may be treated at our facility for an injury you sustained or for symptoms related to a disease. Please complete the following information:

The physical therapy that is requested is due to: [check all that apply]

[ ] Work-Related Injury
if so, have you filed a Worker's Compensation claim? [ ] No [ ] Yes Date of Injury: _____

[ ] Not Worker's Compensation
[ ] Auto Accident
[ ] Home Accident
[ ] Other: _____

[ ] Not Motor Vehicle Accident Related
[ ] School Injury
[ ] Disease

For Medicare patients: Medicare will NOT reimburse ECRC for outpatient physical therapy services if you are actively enrolled with a Home Health Care Agency. If Medicare denies payment for services based on the above, member will be responsible for payment.

I have been treated for Physical Therapy / Occupational Therapy / Speech Therapy and/or Chiropractic this year: * THIS INCLUDES HOME THERAPY*****

[ ] No
[ ] Yes, # of visits: _____ Dates Treated: _____

Note: A majority of insurance plans with a combined benefit of physical, occupational, speech and chiropractic therapies will not cover more than one therapy on the same day.

I request payment of authorized benefits be made on my behalf of ECRC for any services furnished me by ECRC staff. I understand my signature requests that payment be made, and I authorize release of my medical information necessary to process this claim.

_____ _____

Signature of Patient or Legal Representative **Date**

Patient Name:_____ DOB:_____

PERSONAL MEDICAL HISTORY

To help us treat you as a whole person instead of just a body part, kindly fill out the information on the following pages. Thank you.

Please check if you have been diagnosed with any of these by a doctor in the past:

[ ] Diabetes / High Blood Sugar
[ ] Hypoglycemia / Low Blood Sugar
[ ] Ulcer / GERD / Stomach Problems
[ ] Rheumatoid Arthritis
[ ] Circulation / Vascular Problems
[ ] Head Injury
[ ] Asthma
[ ] Parkinson's Disease
[ ] Heart Problems
[ ] Cancer
[ ] Depression
[ ] Osteoarthritis
[ ] Lung Problems
[ ] Stroke
[ ] Allergies
[ ] Seizures / Epilepsy
[ ] Anemia
[ ] High Blood Pressure
[ ] Broken Bone / Fracture
[ ] Osteoporosis
[ ] Kidney Problems
[ ] Multiple Sclerosis
[ ] Skin Diseases
[ ] Hepatitis
[ ] Blood Disorder
[ ] Repeated Infections
[ ] Thyroid Problems

Number of falls in the last year: _____

In the last year, have you had any of the following? Please check all that apply:

[ ] Chest Pain
[ ] Shortness of Breath
[ ] Weakness "in.-Arms or Legs
[ ] Joint Pain or swelling
[ ] Difficulty Swallowing
[ ] Urinary Problems
[ ] Headaches
[ ] Heart Palpitations
[ ] Dizziness
[ ] Loss of Balance
[ ] Difficulty Sleeping
[ ] Nausea / Vomiting (not Flu)
[ ] Weight Loss/ Gain
[ ] Hearing Problems
[ ] Cough
[ ] Coordination Problems
[ ] Difficulty Walking
[ ] Loss of Appetite
[ ] Tingling
[ ] Fever / Chills / Sweats
[ ] Vision Problems
[ ] Hoarseness
[ ] Pain at Night
[ ] Numbness
[ ] Bowel Problems
[ ] _____

For <u>MEN</u> only:

Have you ever been diagnosed with prostate disease? [ ] No [ ] Yes
Do you have difficulty beginning to urinate? [ ] No [ ] Yes
Do you have difficulty continuing to urinate? [ ] No [ ] Yes
Do you have pain with urination? [ ] No [ ] Yes

For <u>WOMEN</u> only:

Have you seen a doctor for any pelvic problems? [ ] No [ ] Yes
Are you pregnant or trying? [ ] No [ ] Yes
When was your last Pap Smear:_____ last Breast Exam:_____
Do you ever have any urinary leakage? [ ] No [ ] Yes

Surgery (for <u>ALL</u>):

Have you ever had surgery? [ ] No [ ] Yes _____
if yes, please list approximate date(s): _____

Patient Name:_____ DOB:_____

Are you currently seeing anyone else for the problem that brought you here? Please check all that apply:

[ ] Acupuncturist	[ ] Podiatrist	[ ] Dentist
[ ] Neurologist	[ ] Primary Care Physician	[ ] Cardiologist
[ ] Obstetrician I Gynecologist	[ ] Rheumatologist	[ ] Orthopedist
[ ] Occupational Therapist	[ ] Pediatrician	[ ] Osteopath
[ ] Massage Therapist	[ ] Chiropractor	[ ] _____

Are you allergic to latex? [ ] No [ ] Yes

Are you allergic to oils, lotions, or creams? [ ] No [ ] Yes

Do you smoke or chew tobacco? [ ] No [ ] Yes

if yes, Packs per day: _____ For how long: _____

How many days each week do you drink alcohol? _____

If 1 drink equals 1 beer or 1 glass of wine, how much do you drink in an average sitting?_____

How much caffeinated coffee [or caffeine-containing beverages] do you drink each day?_____

Do you ever feel unsafe at home or has anyone hit you or tried to hit you in any way? [ ] No [ ] Yes

Anything else we should know about?

_____

_____

_____

Medications:

IF YOU HAVE A FULL LIST OF MEDICATIONS, WE CAN COPY IT IF THIS IS EASIER FOR YOU.

Current medications (prescription and over-the-counter) with dosages:

_____

_____

_____

_____

_____

Patient Name:_____ DOB:_____

SOCIAL

With whom do you live? [check ALL that apply]

[ ] Alone
[ ] Spouse / Significant Other Only
[ ] Child
[ ] Spouse / and Other(s)

Does your home have: [check ALL that apply]

[ ] Stairs, no railing
[ ] Uneven Terrain
[ ] Assistive Devices in Bathroom (please list below)
[ ] Obstacles (please list below)
[ ] Stairs, Railing
[ ] Scatter Rugs
[ ] Ramps
[ ] Elevator

_____

_____

Do you use: [check ALL that apply]

[ ] Any Assistive Devices:_____
[ ] Hearing Aids
[ ] Glasses / Contact Lenses
[ ] Other:_____

Do you have difficulty with: [check ALL that apply]

[ ] Moving in Bed
[ ] Walking on Stairs
[ ] Getting Dressed
[ ] Toileting
[ ] Preparing Meals
[ ] Moving from Bed to Chair
[ ] Walking on Ramps/Hills
[ ] Bathing
[ ] Household Chores
[ ] Driving
[ ] Walking on Level Ground
[ ] Walking on Uneven Terrain
[ ] Eating
[ ] Shopping
[ ] Participating in Sports

FAMILY HISTORY: [check ALL that apply]

	Mother	Father	Any Brother/Sister	Any Grandparent
Heart Disease	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]
Psychological	[ ]	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]	[ ]
Other:_____	[ ]	[ ]	[ ]	[ ]

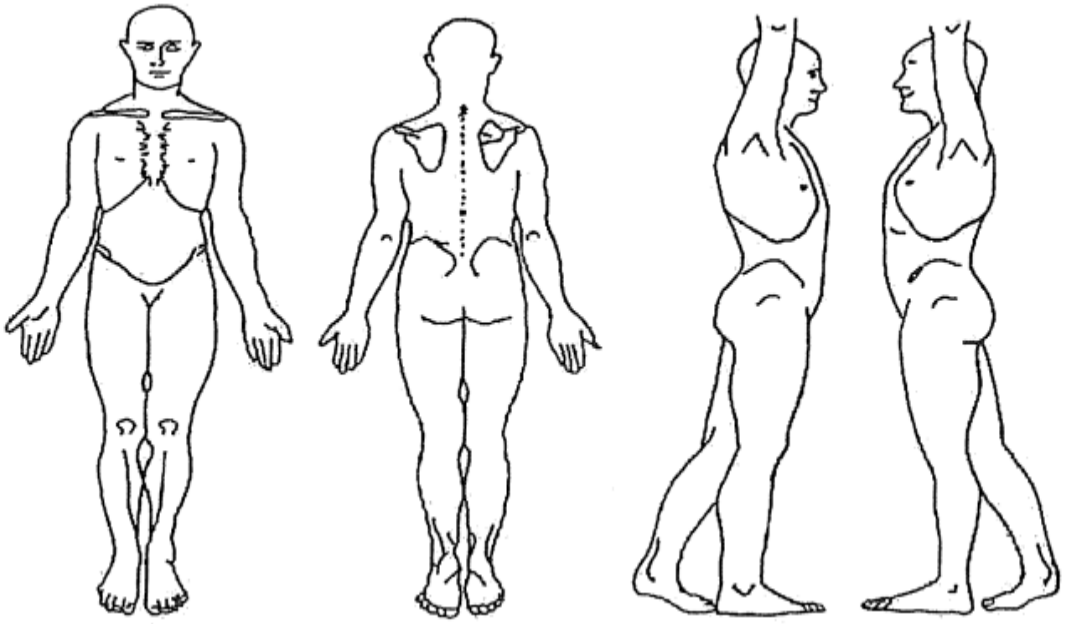
The above is true to the best of my knowledge

[ ] No [ ] Yes

Patient Name:_____ DOB:_____

System Questionnaire

Please circle/mark on the below image the location(s) of your pain:



Does your pain come and go? [ ] No [ ] Yes

Using the below scale, please mark letters B, W and A regarding the INTENSITY of your pain:
In the last week, **when you were feeling your BEST (B**), how low was your pain?
In the last week, **when you were feeling your WORST (W),** how high was your pain?
What has been your **AVERAGE (A)** pain over the last 24 hours?