Jaworski Physical Therapy, Inc.
Patient Medical History Form

Name:	Phone :	Date of Birth:	
Address:	City:	State	Zip Code
Height:_____ Weight: _____	Sex ☐ M ☐ F	Employer:	Occupation:

Past History: Please check if you have or ever had one of these conditions or problems.

☐ Allergies	☐ Circulation problems	☐ Hepatitis	☐ Neck/arm pain
☐ Aneurysm	☐ Currently pregnant	☐ High Cholesterol	☐ Open Wound (current)
☐ Anxiety	☐ Depression	☐ High Blood Pressure	☐ Osteoporosis
☐ Arthritis	☐ Diabetes	☐ HIV/AIDS	☐ Parkinson's disease
☐ Asthma	☐ Dizzy Spells	☐ Incontinence	☐ Rash (current)
☐ Autoimmune disorder	☐ Emphysema/Bronchitis	☐ Kidney Problems	☐ Rheumatoid arthritis
☐ Back Pain/leg pain	☐ Falls	☐ Joint Replacement	☐ Seizure/epilepsy
☐ Balance problems	☐ Fibromyalgia	☐ Incontinence	☐ Smoking
☐ Blood Clots	☐ Fractures	☐ Low blood pressure	☐ Speech problems
☐ Cancer	☐ Gallbladder Problems	☐ Lupus	☐ Strokes
☐ Cardiac conditions	☐ Headaches	☐ Metal implants	☐ Thyroid Disease
☐ Cardiac pacemaker	☐ Head Injury	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Chemical Dependency	☐ Hearing impairment	☐ MRSA	☐ Vision problems

Please list any relevant surgeries including date: _____

_____

We are required to document your level of function or ability that was present *prior to the onset of the condition* for which you are seeking treatment. Please check the answer the following questions to the best of your ability.

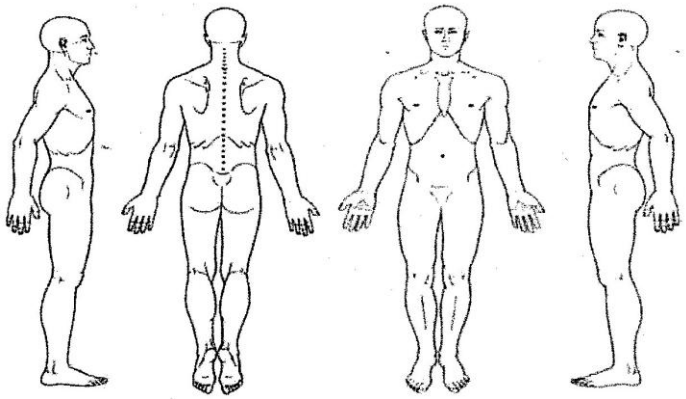
Answer level of activity prior to onset of current condition	No Difficulty	Mild Difficulty	Moderate difficulty	Severe Difficulty	Unable
Walk without support or assistive device					
Walk 1 mile					
Stand for more than 1 hour					
Go up or down 10 stairs (about 1 flight)					
Sit for more than 1 hour					
Reach arms overhead					
Put on clothing					
Complete housekeeping tasks					
Complete work related tasks					

Please briefly describe the problem(s) for which you are seeking treatment _____

_____

When did the problem start: _____?

What is your current pain level? 0_____5_____10
No Pain Worst Pain



Please mark an X on the picture over any place that you are having pain and shade any area of tingling or numbness

Emergency Contact: _____ Phone _____Relationship to Patient: _____

Consent to Release

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Jaworski Physical Therapy, Inc. ("The Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use or disclosure. I understand that I may request a copy of the Notice of Privacy Practices at any time for my personal use. *By signing this consent, I understand and acknowledge that I have reviewed the "Privacy Notice" before signing this consent. I authorize employees of Jaworski Physical Therapy, Inc. to discuss my health information with the following persons: (Please list)*

_____ _____ _____

Phone Messages: I give permission to leave a message (verbal or text) on my telephone: ____Yes ____No

General: I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said benefits. The assignment will remain in effect until revoked by me in writing.

Authorization for Treatment: I know that I am suffering from a condition(s) requiring physical/occupational/speech therapy/ massage therapy and/or athletic training. I hereby voluntarily consent to such treatment and procedures to be performed by employees of Jaworski Physical Therapy, Inc.

Permission to take Photograph: I hereby consent for Jaworski Physical Therapy, Inc. to take a photograph of me only for the purpose to use in my medical chart and will not be disclosed for any other reason without additional permission from me.

Self Referral: If you have not been referred for therapy by your physician and you would like to have him/her receive a copy of your evaluation, progress and discharge reports, please provide the following information:

Name:_____ Address: _____ City_____ State: _____ Zip Code: _____

_____ _____

Patient's signature Signature other than patient (if patient is a minor)

_____ _____

Date Relationship

_____ _____

Date Witness

(rev 2/3/2014)

Jaworski Physical Therapy, Inc.

Patient Name:_____Date:_____

Private Health Insurance

Name of Private Health Insurance:_____

Address:_____City:_____State:_____Zip:_____

ID#:_____Group#:_____

Cardholder Name:_____ Cardholder Date of Birth:_____

Relationship to Patient: _____ Phone: _____

Address (if different): _____

Worker's Compensation (complete the following)

Place of Employment at Time of Injury:_____

Address:_____City:_____State:_____Zip:_____

Date of Injury:_____ Claim Number: _____

If you have an attorney, please complete the following:

Attorney Name:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Liability/Motor Vehicle Accident (complete the following)

Responsible Auto Insurance Name:_____

Date of Accident:_____Claim#:_____

Address:_____City:_____State:_____Zip:_____

Adjuster Name:_____Adjuster Phone:_____

If you have an attorney, please complete the following:

Attorney Name:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Jaworski Physical Therapy Inc.
MEDICARE SECONDARY PAYER QUESTIONNAIRE
Completed by all Patients Covered Under Medicare

	YES	NO
1. Should this illness or injury be covered by a past Workers Compensation Claim or will you be filing a new claim with the Bureau of Workers Compensation		
2. Are you covered under the Federal Black Lung Program		
3. Are you entitled to benefits through the Veteran's Administration? Do you want us to contact the VA for authorization of these services?		
4. Are these services a result of an accident?		
5. Do you feel someone else is responsible for this illness or injury?		
6. Are these services covered by a Public Health Service (other than Medicare or Medicaid)		
7. Are you entitled to Medicare due to End Stage Renal Failure- If yes please answer the following a. Are you covered by an Employee Sponsored Group Health Plan? b. Are you within the 18 month Coordination of Benefits period?		
8. If you or your spouse are actively employed, are you covered by that Employee Group Health Plan		
9. Are you entitled to Medicare solely due to a disability other than End Stage Renal Failure?		
10. If you answered yes to question number 9, are you are your family member actively employed and covered by that Large Group Health Plan?		
11. Are you currently receiving Home Health Services (for example, nurse, aide, therapist)		

Please Explain any Yes answers:

_____

_____

_____

_____

Signature: _____ Print Name: _____ Date: _____

Name of person who supplied information if different then the patient: _____ (print name)

Relationship to patient: _____ Signature: _____ Date: _____

JAWORSKI PHYSICAL THERAPY, INC.

IMPORTANT- SCHEDULING AND FINANCIAL POLICIES

SCHEDULING

At Jaworski Physical Therapy, we strive to provide excellent care with treatment provided on a one- on- one basis by your therapist. The appointments you make will be reserved specifically for you. To receive the maximum benefit of treatment, it is important that you attend each of your scheduled appointments and that you arrive on time for your appointments.

Providing one- on- one care to each patient requires that we do not overbook or double book our appointments. Unfortunately, missed appointments result in open slots in our therapists' schedules and are a lost opportunity for them to help other patients. Although we understand that emergencies happen and there will be times that you have to cancel an appointment, **we reserve the right to charge a $25 fee for treatments that are not cancelled within 24 hours of the scheduled appointment time or if you fail to show for an appointment.** This fee is your responsibility and must be paid **prior** to your next scheduled treatment.

PAYMENT POLICIES

- As a courtesy we will try to verify your benefits prior to your first visit. However, experience has taught us that we can be given incorrect information. We strongly suggest that you personally contact your insurance company for verification of benefits and ask any questions you may have.
- Co-pays and co-insurances, and deductibles are dictated by your insurance company. Our contract with your insurance carrier requires that they be collected.
- Co-pays are due **prior** to the beginning of each treatment session.
- If you have a plan with a co-insurance, we will **estimate** your expected co-insurance and require that it be paid **prior** to the beginning of each treatment session. If you have a deductible that has not been met prior to treatment, you will be required to make a payment toward the deductible at each visit. You will be responsible for any unpaid balance after insurance payment and adjustments.
- You are responsible for any outstanding balance present after insurance has paid their portion and payment is due within 30 days of billing. Interest is accrued at a rate of 1.5% per month on outstanding balances.
- Payment can be made by credit card, check or cash. For your convenience, we can accept pre-authorized payments by credit card.

If you have any additional questions, please do not hesitate to ask us. Our goal is to provide you with the best possible service and to make your rehabilitation go as smoothly and successfully as possible.

Thank you for choosing Jaworski Physical Therapy, Inc.

I have read and understand the above policies.

_____ _____

Signature Date

Jaworski Physical Therapy Inc.

Medication List

To meet regulatory requirements and to assist the therapist in the treatment of your condition it is important that we are aware of all the medications that you are currently taken. This includes prescription medications, over the counter medications, vitamins and/or herbs. Please provide us a list of your medications, including the medication, dosage, frequency, route taken and reason for taking the medication. If you already have this information on a printed list, you may bring it to your appointment and we will make a copy for your file. Thank you for your cooperation.

Patient Name: ____________________________ Date:__________________________

Medication	Frequency	Dosage	Route Taken	Reason for taking