SYMMETRY
PHYSICAL THERAPY

270 Main Street
Portland, CT 06480-1859
860-788-7976 phone
877-532-7987 fax
www.symmetryusa.net

Patient Name: _____ DOB: _____ Date : _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail: _____Do you want e-mail appointment reminders? ☐ Y ☐ N

Employer: _____Work Phone: _____

Emergency Contact_____ Phone: _____ Relation? _____

Attorney Name: _____ Phone Number: _____

Have you had any prior Therapy this past year? ☐ Y ☐ N How many visits? _____

How did you hear about us? ☐ Friend/Family ☐ Newspaper ☐ Internet ☐ Doctor ☐ Insurance ☐ Prior Patient

☐ Other, please describe: _____

.....Please answer highlighted only.....

Referring Physician: _____ **NPI #:** _____

Primary Insurance Co: _____ WC HMO PPO MC Other_____

Address: _____

City_____ State_____Zip_____

Phone: _____ Billing F a x : _____

Policy/claim#: _____Group#: _____

Effective date of insurance: _____Pre-Cert Required? #: _____

Insured's Name: _____Insured's DOB: _____

Insured's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

In Network: Deductible: $_____ Co-Pay: $_____Co-Insurance (% covered): _____%

Out of Network: Deductible: $_____ Co-Pay: $_____ Co-Insurance (% covered): _____%

Visit Limit per Dx: _____ Per Year: _____ F i s c a l Limit per Dx: $_____ P e r Year: $_____

Out of pocket Max: _____. Deductible Met: ☐ Y ☐ N Remaining amount: _____

Secondary Ins: _____

Policy/claim#: _____Group#: _____

Effective date of insurance: _____Pre-Cert Required? #: _____

Insured's Name: _____Insured's DOB: _____

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PATIENT MEDICAL HISTORY

Name: _____ Date of Injury:_____

Family Physician:_____Phone: _____

Referring Physician:_____Body Part:_____

Medications:_____

Allergies: _____

Did you have surgery? Date of Surgery: Procedure:_____

Have you had any of the following for your condition? ☐ PT ☐ X-ray ☐ MRI ☐ Chiropractic ☐ Injections

MEDICAL HISTORY QUESTIONNAIRE

☐ Arthritis
☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes
☐ Osteoporosis
☐ Cancer: Type:_____
Year:_____
☐ Stroke
☐ Depression
☐ Smoker
☐ Liver Disease
☐ Fibromyalgia
☐ Chronic Fatigue Syndrome
☐ Multiple Sclerosis
☐ Thyroid dysfunction Hypo Hyper
☐ HIV/AIDS

☐ Recent weight GAIN / LOSS
☐ Numbness/tingling
☐ Night Sweats
☐ Rheumatoid Arthritis
☐ Kidney Dysfunction
☐ Dialysis
☐ Blood Disorder
☐ Total Joint Replacement

☐ Type:_____
Headaches
☐ Heart Disease
☐ Pacemaker
☐ Shortness of Breath
☐ Angina

☐ Spinal cord injury

☐ Chest pain
☐ Dizziness/Lightheadedness
☐ Lyme Disease
☐ Asthma
☐ Emphysema
☐ COPD
☐ Tuberculosis
☐ Seizures/Epilepsy
☐ Back injury
☐ Neck Injury
☐ Hernia
☐ Pregnant?_____ mos.
☐ Liver Dysfunction

☐ Hepatitis A B C (circle)
☐ Traumatic brain injury

Other, not listed above:

Please check your current pain level, 0 = no pain, 10 = emergency room pain:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain when it is at it's worst:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Patient Authorization Record

Initial here

	Authorization for Treatment ➢ I hereby authorize Symmetry Physical Therapy to provide physical therapy treatment and/or procedures that have been described to me. The inherent risks and benefits of such procedures have been explained, as well as alternate treatment options. I understand that my decision to allow Symmetry Physical Therapy to provide such treatment and/or procedures is completely voluntary and I have the right to refuse any such treatment and/or procedures at any time.
	Authorization for Release of Information ➢ I agree that Symmetry Physical Therapy may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Symmetry Physical Therapy for services rendered. ➢ I agree that Symmetry Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read or been offered the "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Symmetry Physical Therapy for services rendered.
	Patient Agreement ➢ I agree to pay Symmetry Physical Therapy charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Symmetry Physical Therapy collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Symmetry Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Symmetry Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to Symmetry Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Symmetry Physical Therapy may give intermediary's information necessary to process claims.

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Cancellation and No Show Policy

Failure to keep your scheduled appointments hinders our ability to provide the best possible care to all of our patients. *Symmetry Physical Therapy* asks that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient. ALL missed appointments MUST be made up the same week so you may fully recover from your condition.

Our Cancellation Policy is:

∞ **Failure to give 24 hours notice prior to cancellation will result in a "No-Show Appointment Fee" of $25.**

This fee cannot be billed to your insurance company and will be your direct responsibility.

∞ Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and our other patients, therefore:

3 late cancellations or no shows will result in discontinuing physical therapy.

I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

Patient/legal guardian INITIAL HERE: _____

RELEASE OF INFORMATION

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.
I authorize Symmetry Physical Therapy to disclose my health information that is directly related to my current treatment at Symmetry Physical Therapy to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

NAME	RELATIONSHIP

I attest that all of the above information has been documented accurately and to the best of my knowledge, and I agree to adhere to all policies and procedures outlined above,

Patient/Legal Guardian/LPOA signature:_____ Date:_____

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may not be calculated if there is greater than 1 missing item. Score: