MEDICAL HISTORY/EVALUATION

Date: _____

Name:_____

Email Address:_____

Insurance Type:_____

General Benefits:_____

Patient Responsibility:

CoPay:____Per:_____Deductible:_____%Responsible:_____

_____

Referring Physician:_____Family Physician:_____

Date of Injury/Onset:_____

Current Work Status:_____Last Date worked due to injury: _____

Level of Activity: _____

Is an Attorney involved in this case: **YES** **NO**

Have you had any diagnostic tests for this injury? **YES** **NO**

If so, what type? (I.e. X-rays, MRI, other)_____When?_____

Have you had surgery for this injury? **YES** **NO**

If so, what type of surgery and when?_____

Current Medications:_____

Age:_____ Weight:_____ Height:_____ Avg Blood Pressure:_____

Have you had any falls? **YES** **NO**

How has pain changed since onset?_____

Goals you expect from therapy:_____

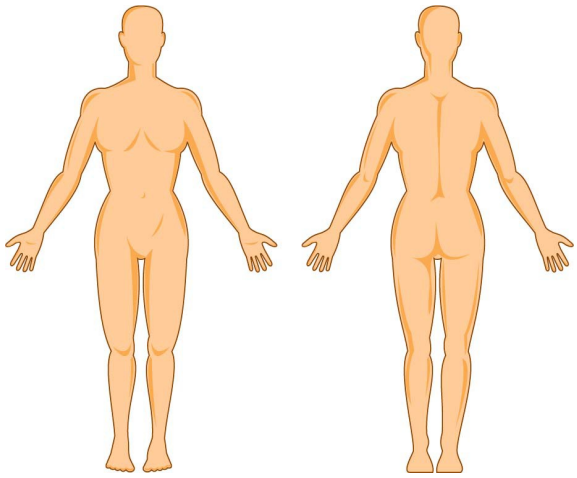
Are you receiving home health services?_____If so, with whom?_____

When were you discharged?_____

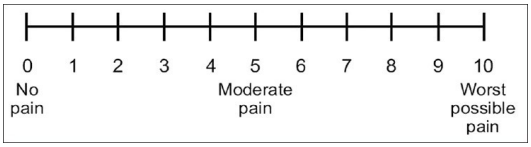
Please check all that apply to you:

- ☐ PAIN
- ☐ SHORTNESS OF BREATH
- ☐ HEART DISEASE/CHEST PAIN
- ☐ DO YOU HAVE A PACEMAKER?
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE/TIA
- ☐ BLOOD CLOT
- ☐ SEIZURES/EPILEPSY
- ☐ THYROID PROBLEMS
- ☐ INFECTIOUS DISEASE
- ☐ OSTEOPOROSIS
- ☐ DIABETES
- ☐ CANCER - if so, where and When:_____
- ☐ ARTHRITIS
- ☐ GOUT

Indicate where pain is:



Best:____Current:____Worst: _____



- ☐ DRINK ALCOHOL
- ☐ SLEEPING PROBLEMS
- ☐ SEVERE/FREQUENT HEADACHES
- ☐ EMOTIONAL PROBLEMS
- ☐ VISION/HEARING PROBLEMS
- ☐ POOR ENDURANCE
- ☐ DIZZINESS/FAINTING
- ☐ WEAKNESS: if so, where:_____
- ☐ ALLERGIES
- ☐ DO YOU SMOKE? If so, how often?_____
- ☐ ARE YOU PREGNANT?

CONSENT TO TREAT:

I hereby agree and give consent to medical treatment and I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to ESPT regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent Signature:_____ Date:_____

HIPPA:

I acknowledge that I have seen the "**Notice of Privacy Practices**." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent Signature:_____ Date:_____

Eastern Shore Physical Therapy

No-Show / Same-day Cancellation Policy

At Eastern Shore Physical Therapy, we expect you to get the most out of your physical therapy visits. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you meet your goals. A recently published study found that patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. It is extremely important that you attend your scheduled appointments.

Our schedule is very full and certain time slots are not always available for patients who need them. If you need to cancel or change a scheduled appointment, for any reason, we require a day's notice of the cancellation. When you call we will assist you in rescheduling this appointment because helping you recover is very important to our team.

Please read our policy and sign at the bottom indicating you understand our same-day cancellation / no-show policy.

1. As experts, we know that **you will not get better if you do not attend your appointments**. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
2. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for late notice. If you are ill, providing at least a days' notice will allow us to help someone else and will help you avoid our missed visit fee.
3. For all appointments, we expect that you will arrive on time, dressed for your session, and ready to begin at your scheduled treatment time.
4. While traffic can be unpredictable, we need you to call us immediately if you're running late for your scheduled appointment, so we can be prepared for your late arrival.
5. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
6. Please note: when you need to change or cancel an appointment, we need 24 hours' notice so we have enough time to help someone else who needs that appointment time. Same-day cancellations or no-shows are not permitted and there is a **$50.00 fee if you do not provide at least a days' notice of your appointment change or cancellation. This is your responsibility as insurance will not cover it.** To avoid our missed visit fee, call our office during business hours - at least a day in advance for any appointment changes or cancellations. This will allow us to reschedule you for another time and help other patients get the care they need by offering that appointment time.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records.

We look forward to working with you to meet your physical therapy goals.

Martin Weinstein, PT, MPT, COMT
President

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

Patient Signature	Patient Name	Date