NEW PATIENT ORIENTATION

- Welcome to Nexus Physical Therapy. Your doctor has prescribed Physical Therapy for your condition. It is important that you understand what to expect from your treatment and what you can do to improve your chances for a successful outcome.

- Your first visit will consist of an evaluation to enable us to design a treatment program for your condition. We will explain what our evaluation findings are and review the recommended treatment program for you.

- PLEASE KEEP ALL SCHEDULED APPOINTMENTS BECAUSE YOUR TREATMENT PROGRAM WILL BE PROGRESSIVE. MISSED APPOINTMENTS MAY REDUCE A SUCCESSFUL RECOVERY.

- PATIENT WILL BE RESPONSIBLE FOR HIS OR HER OFFICE VISIT CO-PAYMENT. CO-PAYMENT CAN BE PAID AT EACH PHYSICAL THERAPY VISIT WITH CHECK OR CASH. Individuals may receive a bill regarding co-payment if applicable.

- MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE WILL RESULT IN A LATE CANCELLATION FEE OF $20.00. Please allow us enough time to schedule another patient in your absence.

- Please sign your name on the sign-in sheet located at the front desk upon arrival.

- Please let us know of all of your upcoming doctor appointments during your treatment here so that we may write the appropriate reports to your referring doctor to update them on your condition.

- During your treatment program you will be given exercises to do at home. It is very important that you follow these recommendations because without your participation, your recovery may be limited.

- Please wear loose-fit, appropriate clothing for your injury allowing easy access to the body part(s) affected. For example, if you have a low back problem, please avoid tight jeans. If you have a knee problem, bring or wear shorts. If you have a shoulder problem, please wear a t-shirt.

I, the undersigned, have read and understand the above information.

Patient signature ___________________________ Date ___________________________
PATIENT INFORMATION FOR MEDICAL RECORDS
PLEASE PRINT CLEARLY

Mr./Mrs./Ms. ________________________________________________________________________________________

Last Name
First Name
Middle Initial

____________________________
___________________________
________________________________
_____________

Patient’s Address
City
State
Zip

____________________________________________________________________________________________________

Cell Phone #
Alt Phone #
Email Contact

Social Security #
Date of Birth
Age
Driver’s License #

Patient’s Employer
Address
City
State
Zip
Phone #

Attorney’s Name
Address
City
State
Zip
Phone #

INSURANCE INFORMATION

PRIVATE | W/C | MEDICARE | AUTO | LIEN | CASH | HMO | PTPN | OTHER
Primary Insurance: ______________________________________________________________________

Address: __________________________ City: ___________ State: _______ Zip: ___________

Phone: __________________________ Claims Adjuster: __________________________ Auth #: __________________________

Policy/ID #: __________________________ Group/Claim #: __________________________ Home Care: YES / NO

Date of Injury: __________________________ Previous PT (this injury) YES / NO # of Visits: ________

Name of Insured/Policy Holder: ______________________________________________________________________

Relationship to Patient: __________________________

Social Security #: __________________________ Effective Date of Coverage: _______ Deductible: _______ CoPay: _______

Plan Limitations: __________________________ Authorized By: __________________________ Date: _______

# Visits Authorized: ______

OFFICE POLICY

I hereby give lifetime authorization for payment of insurance benefits to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

SIGNATURE: __________________________ DATE: __________________________

Please print NAME: __________________________
MEDICAL HISTORY FORM

Name: ________________________________ DOB: _________________ Age: ___________

Email Contact: _________________________________________________________________________________________

Social Security Number: ___________________________ Occupation: _________________________

Referring Physician: _______________________________ Next doctor’s Appointment: ___________________________

What is your condition/injury? _________________ __________________________________________________________

Date of injury/onset: _____________________ Date of surgery, if any: ______________________________________

What happened? __________________________________________________________________________ ____________

What treatment was given? ______________________________________________________________________________

Have you had the problem(s) before? □ Yes □ No

Please list any medications you are currently taking:
(prescription) _________________________________________________________________________________________
(non-prescription i.e. herbs, supplements) ____________________________________ ______________________________

Have you had any tests for this problem? □ X-Ray □ MRI □ EMG □ C.T. Scan □ Other: ___________

Are you presently receiving any other medical or health services? □ Chiropractor □ Acupuncture □ Other: _________

Please shade area of pain

What does the pain feel like?

□ Aching □ Pinching □ Pulsing □ Tender
□ Burning □ Pins & Needles □ Sharp □ Throbbing
□ Deep □ Pricking □ Shooting □ Tight
□ Dull □ Pounding □ Sore □ Other: _______
□ Knot-like □ Pressing □ Stabbing

What makes the pain worse? _______________________________________

What makes the pain better? _______________________________________

Rate your pain on a scale of 0 to 10, 0 being no pain/discomfort and 10 being the worst pain imaginable. Indicate by circling the appropriate number.

Pain at its least: 0 1 2 3 4 5 6 7 8 9 10
Pain at its worst: 0 1 2 3 4 5 6 7 8 9 10

Medical History (check all that you have ever had):

□ Allergies □ Cancer □ Metal Implants □ Seizures
□ Arthritis □ Diabetes □ Multiple Sclerosis □ Stroke
□ Asthma □ Head Injury □ Muscular Dystrophy □ Surgery
□ Back Injury □ Heart Disease □ Osteoporosis □ Tuberculosis
□ Bleeding Disorder □ High Blood Pressure □ Pacemaker □ Other: ___________
□ Broken Bones/Fractures □ Kidney Problems □ Parkinson’s Disease

Are you having any of these symptoms? (check all that apply)

□ Chest Pains □ Dizziness □ Numbness □ Visual Problems
□ Coordination □ Headaches □ Pain at Night □ Weakness
Problems □ Loss of Balance □ Swelling □ Other: _________
□ Difficulty Sleeping

Is it possible you are pregnant? □ Yes □ No

Have you had any physical therapy treatment before? □ Yes □ No When? ____________ Where? ____________

What type of treatment did you receive? ____________________________________________________________________

Patient Signature: ___________________________ Date: __________________

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3.5.1C PATIENT PRIVACY NOTICE

THE FOLLOWING ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE UNUSED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- **For Treatment:** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved in taking care of you.

- **For Payment:** We may use and disclose health information about you so that the services you receive from us may be billed to insurance carriers and payment collected.

- **For Health Care Operations:** We may use and disclose health information about you for operations that are necessary to run our practice.

- **Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to you health and safety or the health and safety of the public or another person.

- **Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.

- **Workers’ Compensation:** We may release health information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order, etc.

- **Law Enforcement:** We may release health information if asked to do so by a law enforcement official.

RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

- **Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care.

- **Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information.

- **Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

I, the undersigned, have read and understand the above information.

Patient signature

Date