Your **Physical Therapy** Experts

Center for Physical Rehabilitation

754 North College Road, Ste D, Twin Falls, ID 83301
(208)734-5313
1015 Main, Buhl, Id 83316
(208) 543-8887

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address _____ City _____ State _____ Zip Code _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security # _____ Date of Birth: _____ Patient Sex: ☐ Male ☐ Female

Age: _____ Height: _____ Weight: _____

Occupation: _____ Currently Working: ☐ Yes ☐ No Employer _____

Spouse/Parent: _____ Employer of Spouse/Parent: _____

Email Address: _____

How did you hear of us (please check all that apply):

☐ MD ☐ Friend/Relative ☐ Phone Book ☐ Web Page ☐ Location ☐ Prior Patient ☐ Insurance ☐ Other

In case of emergency please contact:
Name: _____ Phone # _____ Relationship: _____

INSURANCE INFORMATION: (Please Provide copy of insurance card)

Primary Insurance Information:

Name of Insurance: _____ Subscriber Number: _____

Group Number: _____ Insured's Name: _____ Relationship to Patient: _____

Insured Birth Date: _____ Insured SS#: _____ Insured Employer: _____

Secondary Insurance Information:

Name of Insurance: _____ Subscriber Number: _____

Group Number: _____ Insured's Name: _____ Relationship to Patient: _____

Insured Birth Date: _____ Insured SS#: _____ Insured Employer: _____

For Office Use Only:

Treatment Diagnosis _____

Medical Diagnosis _____

Date of Injury _____ Date of Surgery _____

Plan of Care End Date _____

Entered by _____ Return to Dr visit _____. Therapist _____.

Date of Eval _____

*********CONTINUED********

INJURY / CONDITION INFORMATION

What problem or diagnosis brings you to physical therapy?

_____

Date Of Injury_____Injury related to: ☐Auto Accident ☐Workers Comp ☐Accident ☐Sports ☐Unknown

Did you have surgery: ☐Yes ☐No Date of Surgery: _____ Type of Surgery: _____

Referring Physician: _____ Family Physician: _____

Work Restrictions per MD: ☐ Yes ☐ No Attorney: ☐ Yes ☒ No Attorney Name: _____

The following tests have been performed for this problem: ☐X-ray ☐MRI ☐CAT ☐EMG ☐None ☐Other_____

Please explain how this condition happened:

_____

INJURY / CONDITION INFORMATION (CONTINUED)

Please rate your pain on a scale from 0 (no pain) to 10 (worst pain)

Your pain is currently (circle) 0 1 2 3 4 5 6 7 8 9 10 0

Is your pain affecting your ability to sleep? ☐ Yes ☐ No

Does coughing/sneezing increase your symptoms? ☐ Yes ☐ No

What makes your symptoms BETTER? _____

What makes your symptoms WORSE?_____

Prior PT /OT/Chiropractic Care this year? ☐Yes ☐No Are you receiving Home Health Services? ☐Yes ☐No

What do you hope to gain from physical therapy?_____

_____

MEDICAL HISTORY

I CURRENTLY have or have had a HISTORY of: (Please check all that apply)

Yes No		Yes No		Yes No	
☐	High blood pressure	☐	Currently Pregnant	☐	Allergies
☐	Heart trouble/angina	☐	Seizures	☐	Metal implants
☐	Pace maker	☐	Osteoporosis	☐	Sensitive to heat/ice
☐	Diabetic	☐	Headaches	☐	Vision problems
☒	Smoking/tobacco use	☐	Dizziness	☐	Hearing problems
☐	Cancer/ tumor	☐	Asthma/shortness of breath	☐	Major injury to neck/spine/back
☐	Severe night pain	☐	Kidney problems	☐	Black outs
☐	Bowel/bladder problems	☐	Nervous disorder	☐	Bruising easily

☐ ☐Major illness/disease: Hepatitis, Aids, HIV, TB, Fibromyalgia, Arthritis Other_____

Please check CURRENT MEDICATION use:……

☐Steroids (cortisone)	☐Anti-inflammatory	☐Pain killer
☐Heart medication	☐Blood pressure medication	☐Anti-coagulants (blood thinners)
☐Muscle relaxants	☐Insulin (diabetes)	☐Other:_____.

Please list PREVIOUS SURGERIES and their dates:

Surgery_____ Date:_____

Surgery_____ Date:_____

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CPR
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PATIENT AUTHORIZATION

- ✓ **Payment** of your deductible and co-pay amount is required at time of service. We accept check, cash and credit cards. We will file Medicare, primary and secondary insurance if all information is furnished to us. Should financial problems arise, we encourage you to contact our office for assistance in the management of your account. Financial arrangements can be made; we are here to help you.

- ✓ **Insurance is a contract between you and your insurance company**. We are not a party to this contract. We will file claims on your behalf from the information that you furnish us. If payment is made directly to you from your insurance you are responsible for sending us that payment.

- ✓ **I authorize CPR to release my records** to my insurance company, my referring physician and my attorney. I understand that these records will be held in strict confidence and will not be released to any unauthorized person.

- ✓ **I authorize payment** of medical benefits to undersigned physician or supplier for services rendered. Please let us know if you have any questions or concerns. Your signature below signifies your understanding and willingness to comply.

- ✓ **I give Center for Physical Rehabilitation my consent** to perform physical therapy services according to the recommended plan of treatment as discussed by my therapist.

- ✓ **HIPPA notification**: Our Notice of Privacy Practices describes how Center For Physical Rehabilitation, LLC may use and disclose protected health information. It also describes rights to access and control of protected health information. "Protected health information" is information about a person, including demographic information that may identify a person and that relates to their past, present or future physical or mental health or condition and related health care services. CPR, its employees, business associates and contractors are required to abide by the terms of this Notice of Privacy Practices. A full copy of our policy is available to you at any time. By signing below, you are giving us permission to disclose in written, electronic and oral formats as it is related to your medical needs, insurance requirements and payments to your account.

_____ _____

SIGNATURE DATE

CPR will not discriminate on the basis of Race, Color, Religion, National Origin, Handicap or Age.

PARENTAL CONSENT NEEDED IF **PATIENT IS UNDER THE AGE OF 18**
I hereby give my consent as a Parent/Guardian of _____ for physical therapy evaluation and treatments rendered by the Center for Physical Rehabilitation.(sign here)_____.

The Center for Physical Rehabilitation offers a wide variety of services. If you would be interested in services other than what you were referred for, please ask your therapist for more information.

- Adaptive Equipment Needs
- Pediatric Therapy
- Aquatic Exercise Program
- Weight Loss/Exercise Program
- Wound And Burn Care
- Sports Performance
- Amputee Program
- Pre/Post Partum Program
- Home Safety Evaluation
- Neurological Rehab, For Stroke Or Brain Injury
- Incontinence Management
- Post Offer Job Screens
- Ergonomic Assessment
- TMJ / Headaches
- Hand Therapy

Attendance Policy

Center for Physical Rehabilitation is committed to improving the lives of our patients by exceeding expectations in the field of rehabilitation. We strive to be known as the best physical therapy practice in our community by achieving excellent results with the most friendly and most efficient staff.

To make the largest gains in the shortest period of time, we expect that you will make every attempt to adhere to the plan that you and your therapist have discussed during your initial examination.

Except in the case of a serious emergency, it is expected that you keep all your appointments. If you need to cancel an appointment, we require 24 hours notice. **In the instance of a cancellation without 24 hours notice or a no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.** Payment for this is due in full from you prior to your next appointment. Exceptions to this policy include inclement weather or sudden illness. **We also reserve the right to discharge patients who routinely cancel or miss their scheduled appointments.**

Our staff works very hard to help you meet your goals. Keeping your scheduled appointments is the key to a successful outcome. We trust that you will make every attempt to assist us in helping you and look forward to providing you with the highest quality of rehabilitation services.

I acknowledge that I have read the "Attendance Policy" and understand that I may ask questions about this policy at any time.

Patient/Parent/Guardian Signature: _____

Date: _____