F.R.O.G.S. Physical Therapy

Functional Rehabilitation for Orthopedic, Golf and Spine

Patient Information Sheet

Welcome to *F.R.O.G.S.* Physical Therapy. Please print all information and complete all sections.

PATIENT NAME ____ DOB ______________ SEX _____ MARTIAL STATUS _______

ADDRESS ____ CITY ___________________ STATE _____ ZIP ___________

HOME PHONE (   ) _____________________________________ CELL PHONE (   ) ___________________________________

ARE YOU EMPLOYED? YES ☐ NO ☐ EMPLOYER NAME _________________________________ WORK (   ) ____________________

ADDRESS ____ CITY ____________________ STATE _____ ZIP __________

EMAIL ____ ARE YOU A STUDENT? YES ☐ NO ☐ SCHOOL _____________

EMERGENCY CONTACT _________________________________ PHONE (   ) _______________ RELATIONSHIP ______________

HAVE YOU EVER HAD PHYSICAL THERAPY BEFORE? ☐ YES ☐ NO IF YES, WHERE & WHEN? _________________________________

WHAT IS YOUR CURRENT INJURY? ___________________________ HOW DID IT HAPPEN? __________________________________

DATE OF INJURY AND SYMPTOM ONSET___________________________________ ; _______________________________________

HAVE YOU HAD SURGERY RELATED TO THIS INJURY? YES ☐ NO ☐ IF YES, WHEN? ______________________________________

INSURANCE CARRIER ___________________ ID#_________________ GROUP#____________ COMPANY NAME_________________

INSURANCE CARRIER ___________________ ID#_________________ GROUP#____________ COMPANY NAME_________________

PRIMARY CARD HOLDER _________________________________ DOB __________________ RELATIONSHIP ___________________

HOW DID YOU HEAR ABOUT FROGS? _____________________ WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER? YES NO

RELEASE OF INFORMATION

I GIVE PERMISSION TO FROGS PHYSICAL THERAPY TO RELEASE INFORMATION TO MY INSURANCE COMPANY, ATTORNEY, ASSIGNEES AND / OR BENEFICIARIES.

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT DIRECTLY TO FROGS THERAPY FOR SERVICES I RECEIVE.

PAYMENT GUARANTEE

IN CONSIDERATION OF THE SERVICES RENDERED AND TO BE RENDERED TO THE ABOVE NAMED PATIENT BY FROGS PHYSICAL THERAPY. I EXPRESSLY GUARANTEE PAYMENT OF THIS ACCOUNT AND AGREE TO PAY MY WEEKLY COPAYS, OWED DEDUCTIBLE EACH WEEK AND ANY CHARGES LEFT UNPAID IN WHOLE OR IN PART BY THE INSURANCE COMPANY. I AM ULTIMATELY RESPONSIBLE FOR ACCOUNT TOTALS AND BALANCES. I AGREE TO PAY ALL FEES AND COMMISSION INCURRED FOR ANY AMOUNT THAT IS TURNED TO COLLECTION.

____ ____

NAME DATE

Patient Medical History Form

NAME ____

AGE ______________________________ ACCOUNT # ______________________

OCCUPATION ____

TYPE OF WORK, EXAMPLES: LIFTING, PROLONGED SITTING, STANDING, ETC. ______________________

DO YOU HAVE ANY PREVIOUS HISTORY OF?

HIGH BLOOD PRESSURE	YES □	NO □	PACEMAKER	YES □	NO □
HEART CONDITION	YES □	NO □	SEIZURES	YES □	NO □
STROKES	YES □	NO □	CANCER	YES □	NO □
DIABETES	YES □	NO □	OTHER	YES □	NO □

HAVE YOU BEEN ADMITTED TO THE HOSPITAL OR UNDERGONE ANY SURGICAL PROCEDURES DURING THE LAST 5 YEARS? YES □ NO □

WHAT WAS THIS CONDITION? ____

WHAT HOSPITAL? ______________________. IS THIS CONDITION THE REASON YOU WERE REFERRED TO PHYSICAL THERAPY? YES □ NO □

HAVE YOU RECEIVED ANY PHYSICAL THERAPY TREATMENTS DRUING THE PAST 5 YEARS? YES □ NO □ IF YES, PLEASE SPECIFY: ____

DID YOU RECEIVE ANY SPECIAL TESTS WHILE IN THE HOSPITAL OR AS AN OUT-PATIENT? (EXAMPLE: CAT SCAN, EMG, EKG, CARDIAC STRESS) YES □ NO □ IF YES, PLEASE SPECIFY: ______________________

HAVE YOU HAD ANY PREVIOUS ORTHOPEDIC PROBLEMS? YES □ NO □ IF YES, PLEASE SPECIFY: __________

____

MEDICATIONS? WHAT TYPE AND FOR WHAT? ____

EXERCISE/ACTIVITY LEVEL: _____ 0-DAYS/WEEK _____ 1-2 DAYS/WEEK ______ 3-5 DAYS/WEEK _____ 6-7 DAYS/WEEK

WHAT TYPE OF ACTIVITIES? ____

NAME OF YOUR ORTHOPEDIC DOCTOR? ____

NAME OF FAMILY OR PRIMARY DOCTOR? ____

______________________ ______________________

PATIENT SIGNATURE DATE

THERAPIST'S PLAN:

□ WILL SEND IN REQUEST FOR RECORDS ____

□ WILL REVIEW HOSPITAL/OUT-PATIENT/DOCTOR OFFICE RECORDS*

□ NOT NECESSARY AT THIS TIME TO REQUEST/REVIEW RECORDS

COMMENTS: ____

______________________ ______________________

PHYSICAL THERAPIST SIGNATURE DATE

Patient Name: ____ **Date:** ________________

Current Episode of Care

1. Please describe your current injury? ____

2. How did it happen?____

3. Date of injury/symptom onset: ______/______/______ ; _________________________________

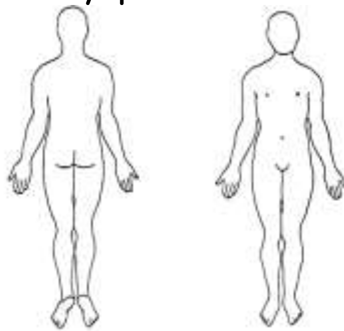
4. Have you had surgery related to this injury? Yes ☐ No ☐ If Yes, When? ____________________

5. Have you had these symptoms previously? ☐ Yes ☐ No

6. Have you received physical therapy previously for this same condition? ☐ Yes ☐ No
   a. If yes, when and where? ____

7. What is your main goal for physical therapy? ____

Please mark the areas where you feel symptoms on the body diagram below:



8. Please check the boxes that best describe what you are feeling: (Check all that apply)
   ☐ Sharp pain ☐ Dull/aching pain ☐ Numbness ☐ Tingling

9. How often do you experience your symptoms:
   ☐ Constantly (76%-100% of the time) ☐ Frequently (51%-75% of the time) ☐ Occasionally (26%-50% of the time) ☐ Intermittently (0%-25% of the time)

10. When do you feel best (have the least symptoms)?
   ☐ Morning ☐ Afternoon ☐ Evening/Night ☐ After exercise

11. When do you feel worst (have the most symptoms)?
   ☐ Morning ☐ Afternoon ☐ Evening/Night ☐ After exercise

12. How are you currently able to sleep due to your symptoms? (Check all that apply)
   ☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Can only sleep with medication

13. What position or activities make your symptoms better? ____________________________________
____

14. What position or activities make your symptoms worse? ____________________________________
____

15. Does coughing, sneezing, or taking a deep breath make your pain worse? ☐Yes ☐No

16. Do activities like bending, sitting, lifting, twisting, and/or turning in bed make your pain worse? ☐Yes ☐No

17. Do you have pain with bowel, bladder, or sexually related activities/functions? ☐Yes ☐No

18. Please rate your average Pain Intensity:

Last 24 hours:

Past Week:

CANCELLATION AND NO SHOW POLICY

We require 24 hours notice in the event of cancellation.
It is your responsibility to keep all your appointments;
When you call in to change it, please have an alternative time in mind that will ensure you to receive the full prescribed number of treatments that week whenever possible.

When you cancel an appointment or are a "no show" three people are hurt:

- **You because you don't get the treatment needed as prescribed by the doctor and/or our staff.**
- **The therapist who will have a "hole" in his schedule since the time was reserved for you personally.**
- **Another patient who could have been scheduled for treatment if the proper notice was given.**

If you CANCEL without a proper notice or NO SHOW
a $25.00 fee will apply.

L&I Patients: Your claims manager will be notified.

Note: After three cancels or no shows your therapy services may be discontinued.

I am aware that there is a 24-hour cancellation policy. If I CANCEL without notice or NO SHOW, a $25.00 fee will apply. If I have an L&I claim, my claims manager WILL BE notified.

____

Patient Signature **Date**

MEDICARE NOTICE

$1,960.00 Therapy CAP/LIMIT

For Services January 1, 2016 to December 31, 2017

Medicare has reinstated their annual therapy cap. Medicare now allows $1,940.00 per year of their allowed schedule; this will include the 20% that is secondary or patient responsibility.

This CAP/LIMIT is for Speech and Physical Therapy combined.

Occupational Therapy also has a CAP/LIMIT of $1,960.00

When this CAP is met, and therapy is still deemed medically necessary and reasonable, you may qualify to get an exception to the therapy cap limits so that Medicare will continue to pay its share for your therapy services after you reach the therapy cap limits. This limit is $3,700.00. If you want to continue therapy past those limits you will have the option to pay out-of-pocket for your services and MUST SIGN an ABN Form.

Please keep in mind that if you went to any other PT facility previous to FROGS, it counts for the CAP/LIMIT too.

We value your patronage to our Physical Therapy Facility and will work with you to see that you receive the therapy you need. We want you to get the maximum therapy necessary for your healing and recovery.

I have been informed of this year's Medicare CAP.

Patient Signature Date