# PHYSICAL THERAPY PATIENT MEDICAL HISTORY FORM

NAME:________________________________________SEX:_________MARITAL STATUS:__________AGE:_________

ADDRESS:______________________________________CITY:_____________________STATE/ZIP:________________

PHONE:________________________________________DATE OF BIRTH:_______________________________________

EMPLOYER:_____________________________________________________PHONE:___________________________

OCCUPATION:__________________________________REFERRING DOCTOR:_____________________

## MEDICAL INFORMATION

Before you saw the doctor, when did your MOST RECENT injury occur?
Month_________Date__________Year__________

Have you had therapy before? If yes, explain:___________________________________________YES___NO___
Do you have a history of heart trouble?________________________________________________YES___NO___
Do you have a pacemaker?___________________________________________________________YES___NO___
Do you have a history of circulatory problems?___________________________________________YES___NO___
(i.e. thrombosis, clots, increased blood pressure, etc.)
Do you have any respiratory problems?_________________________________________________YES___NO___
(i.e. bronchitis, emphysema, asthma, etc.)
Do you have any metal implants?______________________________________________________YES___NO___
(i.e. pins, shrapnel, etc.)
Do you have diabetes?_______________________________________________________________YES___NO___
Do you have a history of cancer? If yes, explain:_________________________________________YES___NO___
Are you pregnant?___________________________________________________________________YES___NO___
Do you have infectious diseases or a history of such?______________________________________YES___NO___
If yes, explain:_______________________________________________________________________________
Please list any surgeries, including dates:________________________________________________________
_____________________________________________________________________________________________
What medications are you currently taking?________________________________________________________
Is there any additional information you feel would be beneficial for the therapy department to be aware of?
(i.e. tendency to faint, dizziness, seizures, etc.) If yes, explain:__________________________________
_____________________________________________________________________________________________

## VOCATIONAL INFORMATION

Is your injury being affected by stress or other factors?_____________________________________YES___NO___
Has your injury resulted in financial or job difficulties?____________________________________YES___NO___
If yes, would you like to learn skills to help you cope with the difficulties?_____________________YES___NO___
Are you currently receiving vocational rehabilitation or other counseling services?_______________YES___NO___

PATIENT SIGNATURE:____________________________________________DATE:___________________________

THERAPIST SIGNATURE:__________________________________________DATE:___________________________

WELLNESS PHYSICAL MEDICINE CENTER
Mark J. Brennan, M.D.
Director
(586) 263-0820
Physical Therapy
(586) 263-0820 ext. 501

43650 Garfield Rd.
Clinton Twp., MI 48038

## SCHEDULING POLICY AND PATIENT RESPONSIBILITIES

Wellness Physical Medicine Center thanks you for allowing us to help you with your rehabilitation. Be assured that your Physical Therapy program will be individualized to suit your special needs.

For a successful Physical Therapy experience the following is recommended:

- Attendance is crucial for optimal recovery. Each session builds on the previous one. Please attend all scheduled appointments without interruption.
- Complete required home exercise programs prescribed to insure a stable outcome in a timely manner.

In order to provide you with the best possible physical therapy *please* arrive on time. Late arrivals, cancellations, or simply not showing will affect all patient care. If you are more than 15 minutes late you maybe rescheduled, thus jeopardizing a successful rehabilitation. We also understand that circumstances arise beyond control, please notify our office prior to your scheduled appointment to cancel and reschedule as soon as possible.

*Failing to show or canceling any twp consecutive physical therapy appointments* will result in an immediate discharge from Wellness Physical Medicine Center. You will be referred back to your physician/family practitioner for further treatment and medications.

We at Wellness Physical Medicine Center take pride in our facility and will work hard to help you with a successful and favorable recovery.

Wellness Physical Medicine Center

*I have read and understand the above policies as stated above.*

______________________________ ______________

PATIENT SIGNATURE DATE

# WELLNESS PHYSICAL MEDICINE

## AUTHORIZATION FOR TREATMENT

I HEREBY CONSENT TO AND AUTHORIZE WELLNESS PHYSICAL MEDICINE CENTER TO ADMINISTER TREATMENT TO ME. I UNDERSTAND THAT I WILL BE FULLY INFORMED AS TO THE NATURE OF THE TREATMENT TO BE PERFORMED OR ADMINISTERED BY WELLNESS PHYSICAL MEDICINE CENTER. I ACKNOWLEDGE THAT THERE MAY BE ADDITIONAL PROCEDURES THAT ARE CONSIDERED NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID TREATMENT AND CONSENT TO SUCH PROCEDURES AFTER EXPLANATION OF THEIR NATURE.

I FURTHER ACKNOWLEDGE THAT RESULTS ARE NOT GUARANTEED. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT.

_______________________________________ _____________________

SIGNATURE DATE

...............................................................................

IF THE PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR______AGE OF PATIENT__________

PATIENT IS UNABLE TO SIGN BECAUSE:_______________________________________

______________________________________________________________________

PERSON WHO IS AUTHORIZED TO FOR PATIENT:

_______________________________________ _____________________

NAME RELATIONSHIP

ADDRESS OF PERSON SIGNING:

_________________________________ ___________________________

STREET CITY/STATE/ZIP CODE

_________________________________

PHONE NUMBER

WITNESS:______________________________ DATE:_____________________

ACCT # _______

NEUROSURGERY GROUP
NEUROLOGY SPECIALISTS
SLEEP AND LIVE WELL DIAGNOSTIC CENTER
WELLNESS PHYSICAL MEDICINE

Each time you are seen by a medical professional, a written report is generated detailing your visit and treatment recommendations. We need your signed authorization to release medical information. Please complete the information below.

1. Who referred you to our office? Please note, if this area is completed, a written report MUST be sent.
   NAME ______________________________
   ADDRESS ______________________________
   ______________________________
   PHONE NUMBER ______________________________

2. Do you have a primary care ( family) physician? Do you want our report sent ? ___
   NAME ______________________________
   ADDRESS ______________________________
   ______________________________
   PHONE NUMBER ______________________________

3. Can we speak to family members/other individuals regarding your medical condition?
   YES __________ NO __________
   NAME ______________________________ RELATIONSHIP __________
   NAME ______________________________ RELATIONSHIP __________

4. By initialing here, you do NOT want medical information released to anyone _____

( Please note: By law, we must sent our reports to Workers Compensation or Auto insurance carriers if your care is related to a work or auto injury.)

This authorization will stay in effect until revoked by you.

PRINT NAME ______________________________ DATE __________

SIGNATURE ______________________________ DATE __________

WITNESS ______________________________ DATE __________

**AKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE**
**HEALTHCARE INFORMATION DISCLOSURE**
**Wellness Physical Medicine**

By signing below, I acknowledge that I have received a notice of the privacy practices of The Neurosurgery Group, Neurosurgery Specialist, Wellness Physical Medical Center and Sleep and Live Well Diagnostic Center located on the back of this sheet.

**Patient Declined ______________________ Date _____________ _________Initials**

I understand once (the above named organizations) has disclosed the healthcare information I have authorized to be disclosed, (above named organizations) has no control over the information. The person or organization I have authorized to receive the information might also disclose the information, and it may no longer be protected by privacy laws. This request is effective until revoked by the beneficiary. By declining to sign you will be required to pay for treatment in full at time of service.

**Patient Declined ______________________ Date ______________ __________Initials**

I consent (the above named organizations) to disclose and receive pharmacy clearinghouse healthcare information. This request is effective until revoked by the beneficiary.

**___________Initials**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers, as well as all insurance companies, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payments to medical insurance benefits to the party who accepts the assignment for services rendered by this provider. This request is effective until revoked by beneficiary. I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

The Neurosurgery Group, P.C, Neurosurgery Specialist, Wellness Physical Medical Center and Sleep and Live Well Diagnostic Center have my consent through routine use and disclosure of health records whether communicated electronically, on paper, or orally.

______________________________________________ ________________________

Signature (Patient or Authorized Representative) Date

______________________________________________ ________________________

Signature (Patient or Authorized Representative) Date

______________________________________________ ________________________

Witness (Staff Member) Date

**Patient's Right to Privacy**
The Neurosurgery Group. P.C.
Neurology Specialist
Sleep and Live Well Diagnostic Center
Wellness Physical Medicine

## Healthcare Privacy

Each time you visit a hospital, physician or other healthcare provider, a written electronic record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. Protecting your privacy is very important to us. All of our patients have the right to considerate and respectful care.

## Privacy Practices for Protective Health Information

The provision of high-quality healthcare requires the exchange of personal, often sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patient's ability to trust that the information shared will be protected and kept confidential. Yet, many patients are concerned that their information is not protected.

## Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner in the facility that complied it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of our information.
- Obtain a paper copy of this notice upon request.
- Inspect a copy of your health record.
- Request to amend your health record.
- Obtain an accounting of disclosures.
- Request communications of your health information by alternative locations
- Revoke your authorization to use or disclose health information except to the extent action has already been taken.
- Receive notification if ever there is a breach of unsecured public health information.

Consent Agreement

Providing "consent" allows for the use and disclosure of protected health information only for treatment, payment, and healthcare operations.

As part of your healthcare, we originate ad maintain health records describing your health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

This Information is a Basis For:

- Planning for future care or treatment.
- A means of communication among many health professionals who contribute to your care.
- A source of information for applying your diagnosis and medical information to your bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Confidentiality

Expect that all aspects of your care will be confidential. Your medical records, both written and electronic, will not be released without your written permission, unless it is associated within our healthcare operations. These operations include but are not limited to; evaluation and review of healthcare professionals, quality reviews, assessments, improvement and training activities, licensing and credentialing activities, and certification and accreditation programs. Our office many use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment to you. Your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you.

You Have the Right to:

- Take part in decisions about your care. Before agreeing to any treatment, your doctor will tell you about your plan of care in terms you can understand.
- Refuse further medical care. If you make this decision, it is important that you understand the risks and how it can affect your health. If you refuse care, you become responsible for your future health outcome. If you and your doctor cannot agree about your care, which meets ethical and professional standards, you may be asked to seek treatment elsewhere.
- Pay out of pocket for a service and the right to require that we not submit PHI to your individual health plan.

This notice describes how medical information about you may be disclosed and how you obtain access to the information. Please review it carefully. It is the right of this office to change this policy any time as long as the changes are in accordance with applicable laws. If you receive this notice via our website or by e-mail, you are also entitled to receive this notice in written form from our office.