PRIME CARE PHYSICAL THERAPY, P.C.
NEW PATIENT INFORMATION

Patient Name: ____ ( ) Male ( ) Female
Last First MI

Address: ____
Street City State Zip Code

Home Phone: ( ) _____________ Cell Phone: ( ) _______________ Email Add: ________________

Do you prefer to receive calls at: ( ) Home ( ) Cell phone Do you want appointment reminder? Yes No

Birth Date: _____/____/_____ Age: ________ ( ) Single ( ) Married ( ) Minor

Patient's Employer: ______________________________ Work Phone: ( ) ___________________

Employer Address: ____
Street City State Zip Code

Spouse or Parent/Guardian's Name: ______________________________ Phone: ( ) ____________

Person to contact in case of emergency: ____________________________ Phone: ( ) ____________

Whom may we thank for referring you? ______________________________

INSURANCE INFORMATION

Primary Insurance: ________________________ ID #: ____________________

Name of Principal Card Holder: __________________________________ Birth Date: ___/ ___ /_____
Last First MI

Relationship to patient ( ) Self ( ) Spouse ( ) Parent

Secondary Insurance: ________________________ ID #: ____________________

Name of Principal Card Holder: __________________________________ Birth Date: ___/ ___ /____
Last First MI

Relationship to patient ( ) Self ( ) Spouse ( ) Parent

AUTHORIZATION AND RELEASE
I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

______________________________ _____/ _____ / __________
Signature of Patient (Parent/Guardian) Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ Date of request: ____/_____/______

Address:

____

Street City State Zip Code

Date of birth: _____/______/______

As required by the Privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following persons: *(you may write doctor's name and/or family member's name)*

____

____

____

____

Patient Health Information to be disclosed: *(check all that applies)*

( ) Physical therapy reports
( ) Medical tests
( ) Others: ____

Effective dates for this authorization: ______ / ______ / ______ to ______ / ______ / ______
(you may use date of initial visit as your start date and authorization can end up to one year from start date)

____
Signature of Patient / Authorize Representative

ASSIGNMENT OF BENEFITS / RIGHT FOR DIRECT PAYMENT TO PROVIDER

I hereby instruct _____________________________ insurance company to pay Prime Care Physical Therapy, P.C. for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

I have agreed to pay my balance of said professional service charges over and above this insurance payment, including co-pay / co-insurance or deductible as approved by my insurance.

I also understand and agree that I am ultimately responsible for any professional fee due should my insurance refuse to pay my physical therapy provider.

I authorize release of any information pertinent to my case to any insurance company, health care financing administrator, adjustor or attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

______________________________________ ____ / ____ / _______

Signature of patient / Authorized representative Date

____

Name of patient / Authorized representative

NO SHOW / NO CALL CANCELLATION POLICY

Please read & write your initial on the line provided.

______ All patients are required to call 24 hours in advance to cancel or re-schedule an appointment. Our office reserves a one-on-one appointment with the therapist for you and that slot cannot be filled up with another patient if it is a last minute cancellation or no show.

______ Patient will be responsible for a **$25** courtesy fee if you miss your appointment, do not call within 24 hours, or request a last-minute re-scheduling. We cannot bill your insurance for this fee or for any no show appointment.

We understand medical and personal emergencies can happen. We hope you value your therapist's time as much as we value yours. Thank you for your understanding and cooperation!

PRIME CARE PHYSICAL THERAPY
NEW PATIENT HEALTH QUESTIONNAIRE – BALANCE

Patient Name: ____________________________________ Date of Birth: ____/_____/_______

What is your complaint?
Check all that applies

( ) dizziness
- ( ) spinning sensation
- ( ) woozy / cloudy sensation

( ) imbalance
- ( ) walking
- ( ) standing
- ( ) doing usual daily activities

( ) difficulty focusing
- ( ) when reading
- ( ) when looking at something

What medication/s are you currently taking? *Provide copy if you have one* _______________________

Check if you currently have / have history of the following ear symptoms:

( ) ringing / buzzing : ( ) Right ( ) Left ( ) Both
( ) pressure / clogged sensation: ( ) Right ( ) Left ( ) Both
( ) difficulty hearing ( ) Right ( ) Left ( ) Both

Check if you currently have / have history of the following medical conditions:

( ) Back / Neck Pain ( ) Heart problem ( ) Hypertension ( ) Sleep problem
( ) Hip/knee/ankle pain ( ) Diabetes Type ____ ( ) Joint Replacement / Surgery ( ) Sinus problem
( ) Headache ( ) Other: ______________________________________

Rate the following activities as it is affected by your problem:

Use this scale to rate each activity
0 = not affected
1 = mildly affected
2 = moderately affected
3 = severely affected
NA = not applicable

_____ Bed mobility (laying down, getting up, turning over)
_____ Transfer and turning activities (sit to stand, bending over, turning head / body)
_____ Walking (indoor, outdoor, in the dark, on carpet, ramps, stairs, on uneven surfaces)
_____ Shopping (checking grocery items while walking, walking in the mall / open space)
_____ Household chores
_____ Self-care activities (bathing, dressing up, grooming)
_____ Driving (checking traffic, reading signs)
_____ Transportation (as a passenger in a vehicle)
_____ Reading (book, newspaper, in front of the computer)
_____ Social (going out for leisure activities, meeting with people)
_____ Cognitive (ability to think and concentrate)
_____ Work / School activity: ____

Other activities you want your clinician to know: ___________________________________

Patient Name: ____________________________ Date: _________________

DIZZINESS HANDICAP INVENTORY

This 25 - item questionnaire will help your therapist to identify the difficulties you may be experiencing because of your vertigo, dizziness or unsteadiness. Please check your appropriate answer for each question. *If your symptom is better now, answer the questions based on when your symptom was still active.*

	YES	NO	SOMETIMES
P 1. Does looking up increase your problem?	( )	( )	( )
E 2. Because of your problem, do you feel frustrated?	( )	( )	( )
F 3. Because of your problem, do you restrict your travel for business or recreation?	( )	( )	( )
P 4. Does walking down the aisle of a supermarket increase your problem?	( )	( )	( )
F 5. Because of your problem, do you have difficulty going into or out of bed?	( )	( )	( )
F 6. Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing or parties?	( )	( )	( )
F 7. Because of your problem, do you have difficulty reading?	( )	( )	( )
P 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	( )	( )	( )
E 9. Because of your problem, are you afraid to leave home without having someone accompany you?	( )	( )	( )
E10. Because of your problem, have you been embarrassed in front of others?	( )	( )	( )
P11. Do quick movements of your head increase your problem?	( )	( )	( )
F12. Because of your problem, do you avoid heights?	( )	( )	( )

	YES	NO	SOMETIMES
P13. Does turning over in bed increase your problem?	( )	( )	( )
F14. Because of your problem, is it difficult for you to do strenuous house or yard work?	( )	( )	( )
E15. Because of your problem, are you afraid people might think you are intoxicated?	( )	( )	( )
F16. Because of your problem, is it difficult for you to go for a walk?	( )	( )	( )
P17. Does walking down a sidewalk increase your problem?	( )	( )	( )
E18. Because of your problem, is it difficult for you to concentrate?	( )	( )	( )
F19. Because of your problem, is it difficult for you to walk in the dark?	( )	( )	( )
E20. Because of your problem, are you afraid to stay home alone?	( )	( )	( )
E21. Because of your problem, do you feel handicapped?	( )	( )	( )
E22. Has your problem placed stress on your relationship with members of your family or friends?	( )	( )	( )
E23. Because of your problem, are you depressed?	( )	( )	( )
F24. Does your problem interfere with your job or household responsibilities?	( )	( )	( )
P25. Does bending over increase your problem?	( )	( )	( )

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***This part to be completed by your therapist*

Yes = 4 *Functional Scale = ________ / 36*
Sometimes = 2 *Emotional Scale = ________ / 36*
No = 0 *Physical Scale = ________ / 28*

TOTAL SCORE = ________ / 100