Maxim Physical Therapy

Patient Name: First _____ MI _____ Last _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Mobile: _____ Work: _____

Email: _____

What is your date of birth (Format xx/xx/xxxx): _____ Age: _____ Sex: _____

Marital Status: _____ Injury: _____ Date of injury: _____

Employer: _____

If the patient is under the age of 18, please fill out section below:

Responsible party: _____ Date of birth: _____

Relationship to Patient: _____

Is the responsible party's address the same as the patient? Y / N (If no, fill out question below)

Responsible party's address: _____ City _____ State _____

Zip: _____

Insurance Information:

Primary Insurance Carrier: _____

Policy #: _____ Group #: _____

Secondary Insurance Carrier (If applicable): _____

Policy #: _____ Group #: _____

Emergency Contact/Transportation Contact:

Name: _____ Relationship: _____

Phone number: _____

Consent for Medical Treatment:

Signed: _____

(I hereby authorize Maxim Rehab and all persons acting as agents thereof, as well as all medical; personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventative, therapeutic and medical treatment to me)

MAXIM
PHYSICAL THERAPY

HIPAA – CONSENT FORM

Maxim Rehab Inc. has always exercised safeguards, pertaining to your personal health information. Now, with the new HIPAA regulations in effect, we are to provide each patient With our specific safeguards spelled out in writing and have you sign a Consent that you have reviewed and understand the Notice of Health Information Practices.

- I understand that Maxim Rehab Inc., reserves the right to change and/or revise their Notice of Practices and those changes/revisions will be posted in their lobby for me to review.
- I understand that Maxim Rehab Inc., may convey messages or phone calls, while I am here as a patient, if and when another calls to check on me. However, a full release to anyone regarding my "specific" health information requires me to personally sign a Medical Records Release (Authorization). Please request this form if you want to authorize us to speak with a spouse, relative or any other person.
- While at the clinic, inadvertently I may hear another person's name when they are called to the back office, I may accidentally see a computer screen or chart, or additionally, I may overhear Physical Therapists or Staff speaking of another patient. I understand and respect that this information is "Protected Health Information" and I am requested by Maxim Rehab Inc., to not retain or disclose of this information.
- I have the right to request restrictions on the use and disclosure of my Protected Health Information to carry out treatment, payment or healthcare operation 45CRF164.522.
- I have the right to revoke, in writing, my Consent to use or disclose health information except to the extent that action has already been taken.
- I may revoke or refuse to sign the Consent form. However, by doing so, Maxim Rehab Inc., is NOT required to see and/or treat me, as a patient.

Patient Name (Please Print): _____

_____ _____

Patient Signature (or Legal Representative) Date

_____ _____

Maxim Rehab Inc. Rep-Witness "Notice" Effective Date

For Office use ONLY – Requests: _____

_____

_____

_____ _____ _____

Maxim Rehab Inc., Rep – Signature Title Date

___ Accepted ___ Denied

Financial Payment and Attendance Policy

We find that communication with our patients regarding our financial and attendance policies assists us in providing the best service to you. Here are the answers to the most commonly asked questions.

1. FINANCIAL OBLIGATIONS: As a courtesy to our patients, we will bill your health insurance company for any treatments performed. If after 90 days your insurance has not paid, we will request payment from you. Because the therapist's service is provided directly to you and not to the insurance company, you are ultimately responsible for payment of the account.

2. REGARDING INSURANCE: Any co-payments, co-insurance amounts or annual deductible amounts required by your insurance must be paid at the time of service. We accept cash, personal checks, Visa, Mastercard and Discover. Because we are the provider of service, benefits are assigned to and will be paid to us by the insurance company.

3. APPOINTMENTS: Our first priority is to make sure our patients are taken care of. We strive to ensure all patients are able to be seen in a timely manner. If you are unable to attend your appointment please call to reschedule 24 hours in advance. If we do not receive a phone call we will be calling you within 15-20 minutes after your scheduled appointment time. **If you no-show for a scheduled visit, you will be charged $25.** If we do not hear from you within 24 hours your future appointments (if any are scheduled) will be canceled. Thank you for understanding and working with us to keep our clinic running smoothly!

WE ARE HERE TO HELP!

I acknowledge full financial responsibility for services rendered by Maxim Physical Therapy. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance such as co-pays, co-insurance and deductibles at the time of service. I agree to all responsible attorney fees and collections costs in the event of default of payment of my account. Any holder of this medical debt contract is prohibited by section 1785.27 of the Civil code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Signed_____ Date_____

MAXIM PHYSICAL THERAPY

Date: _____

PATIENT INTAKE SHEET / EVALUATION

Name: _____ **Age:** _____ **Male / Female**

Current Condition: _____

When did symptoms start? _____

- ☐ 1 week ago
- ☐ Greater than 1 week but less than 4 weeks
- ☐ Greater than 1 month but less than 3 months
- ☐ Greater than 3 months

height: _____

weight: _____

Mechanism of Injury / Current condition:

- ☐ Fall
- ☐ Carrying object
- ☐ Movement
- ☐ Motor Vehicle Accident
- ☐ Work Injury
- ☐ Sports
- ☐ Overuse
- ☐ Other: _____

Primary concern / complaint:

- ☐ Loss of function
- ☐ Pain
- ☐ Difficulty with Average daily activities
- ☐ Other: _____

Current pain level as it relates to you current condition:

Pain Scale 0 - 10 (0 = No pain, 10 = extreme pain):

Worst (0 1 2 3 4 5 6 7 8 9 10) circle one
Current (0 1 2 3 4 5 6 7 8 9 10) circle one
Best (0 1 2 3 4 5 6 7 8 9 10) circle one
Is your pain Constant or intermittent (circle one)

Aggravating factors:

- ☐ Lying on back
- ☐ Lying on side
- ☐ Lying on stomach
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Stairs
- ☐ Dressing
- ☐ Hygiene
- ☐ Lift / Carry
- ☐ Reaching
- ☐ Other: _____

Function prior to current condition:

- ☐ Independent
- ☐ Needed some assistance
- ☐ Needed moderate assistance
- ☐ Unable to function

Pain Relief with any of the following?:

- ☐ Sitting
- ☐ Lying down
- ☐ Walking
- ☐ Standing
- ☐ Heat/Ice
- ☐ Medication
- ☐ Other - Massage, Acupuncture, etc..

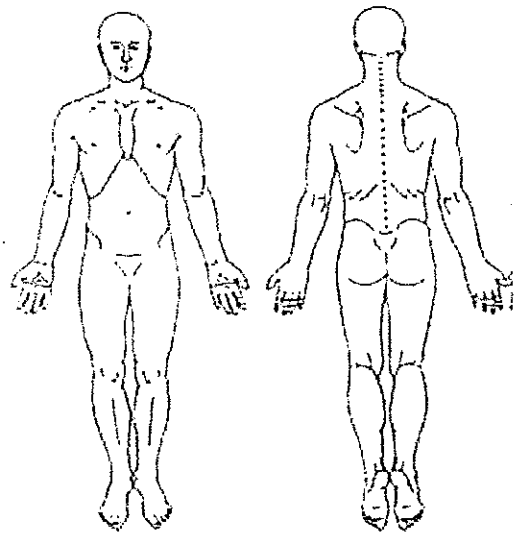
Restrictions:

Difficult / Unable to

- ☐ Lift
- ☐ Sit for a period of: _____ minutes.
- ☐ Stand for a period of: _____ minutes.
- ☐ Walk for a period of: _____ minutes.
- ☐ Sleep for a period of: _____ hours.

Current condition only!

Please mark where you hurt.



Patient (your) goals:

- ☐ Increase range of motion
- ☐ Increase strength
- ☐ Decrease pain
- ☐ Return to prior function
- ☐ other _____

Previous injury to this area?

- ☐ Yes
- ☐ No

When? _____

Previous Therapy for this area?

- ☐ Yes
- ☐ No

When? _____

Overall general health?

- ☐ Good
- ☐ Fair
- ☐ Poor

Please list all Surgeries and Dates

_____

_____

_____

_____

_____

Medical History:

- ☐ Diabetes
- ☐ Heart issues / pacemaker
- ☐ Stroke
- ☐ High blood pressure
- ☐ Osteoarthritis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Cancer _____
- ☐ Other _____

Recent medical tests (on current condition)

- ☐ X-ray
- ☐ MRI
- ☐ CT-Scan
- ☐ Injections
- ☐ Nerve conduction test
- ☐ Bone scan

Where were these tests performed?:

_____

Medication Log - Prescriptions, Over-the-counters, herbals, and vitamin/mineral/dietary (nutritional supplements)

Name					Date	
Name of Medication	**Date Started**	**Dosage**	**Frequency**	**Route of Admission**	**Prescribing Physician**	**Physician Phone Number**