Account # _____

Confidential Medical History/Evaluation

Date:_____

How did you hear about ProCare?_____

Patient Information

First Name:_____ Last Name:_____ Middle Initial:_____ M/F Age:_____

DOB:____/____/____ SS#:_____-_____-_____ Home phone#:_____ Cell phone#:_____

Address:_____City:_____State:___ZipCode:_____

Marital status:_____ Email address:_____

Employer:_____ Occupation:_____

Employer address:_____ Work phone#:_____

Insurance Subscriber Information (Person whom insurance is through)

Name:_____ DOB:_____/_____/_____

Employer:_____ Patient's relationship to subscriber: Self Spouse Child Other_____

Primary Insurance Carrier: _____ Secondary Insurance Carrier: _____

Emergency Contact

Name:_____ Relationship to patient:_____ Phone #:_____

Have you received **Home Health** treatment for this or any other condition in this calendar year? YES____ NO____
If YES- what agency provided the services and for how long were you seen? _____
_____

Is this condition the result of a work related injury? Y N	If yes, in which state did the accident occur? _____
Is this condition related to an auto accident? Y N	If yes, in which state did the accident occur? _____
Is this condition related to a motorcycle accident? Y N	If yes, in which state did the accident occur? _____
Is this condition related to a personal accident? Y N	If yes, in which state did the accident occur? _____
Is this condition the result of a school athletic injury? Y N	If yes, in which state did the accident occur? _____

If yes to any of the above, have you retained an attorney? Y N
Attorney Name_____
Address_____
City_____ State_____ Zip_____
Phone number_____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to ProCare PT, LP. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred equaling 25% of my balance due.

Patient/parent/guardian signature:_____
Date:_____

Reviewed by _____

Account # _____

Patient Name_____

Medical History

Referring Physician:_____ Primary Care Physician:_____

Date of Symptoms or Injury:_____/_____/_____ Date of Surgery:_____/_____/_____

Area of injury/condition:_____

Chief Complaint:_____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking:_____

_____

Are you allergic to any medications? _____

Past surgeries:_____

Have you had any diagnostic or rehabilitative services for this injury (MRI, x-ray, etc):_____

Wear glasses / contacts? YES NO _____

Have you fallen in the past year? YES NO If yes, how many times: _____

If yes to falling, did you sustain an injury as a result of the fall? YES NO _____

Do you currently have any "flu-type" symptoms (i.e. fever, coughing)? YES NO If yes, what symptoms: _____

Do you have any open cuts, lesions or wounds? YES NO If yes, where: _____

Do you have any of the following?

	YES	NO
Asthma, bronchitis, or emphysema	____	____
Shortness of breath/chest pain	____	____
Coronary heart disease	____	____
Do you have a pacemaker	____	____
High blood pressure	____	____
Heart attack/heart surgery	____	____
Stroke/TIA	____	____
Blood clot/emboli	____	____
Epilepsy/seizures	____	____
Thyroid trouble/goiter	____	____
Anemia	____	____
Infectious disease	____	____
Diabetes	____	____
Cancer or chemo/radiation	____	____
Arthritis/swollen joints	____	____
Osteoporosis	____	____
Varicose veins	____	____
Gout	____	____
Sleeping difficulties	____	____
Emotional/psychological problems	____	____
Bowel or bladder problems	____	____
Severe/frequent headaches	____	____
Vision/hearing difficulties	____	____
Dizziness or faintness	____	____
Are you pregnant?	____	____

Smoking Daily_____ Weekly_____

Alcohol consumption Daily_____ Weekly_____

Pain when performing the following activities?

	Mild	Mod	Severe	Unable
Bending	____	____	____	____
Care for infirm family	____	____	____	____
Carrying groceries	____	____	____	____
Change pos (sit to stand)	____	____	____	____
Climbing stairs	____	____	____	____
Driving	____	____	____	____
Extended computer use	____	____	____	____
Feeding (self)	____	____	____	____
Household chores	____	____	____	____
Kneeling	____	____	____	____
Lifting children	____	____	____	____
Lifting	____	____	____	____
Pet care	____	____	____	____
Reading (concentration)	____	____	____	____
Self care- bathing	____	____	____	____
Self care- dressing	____	____	____	____
Self care- shaving	____	____	____	____
Sexual activities	____	____	____	____
Sleep	____	____	____	____
Sitting (prolonged)	____	____	____	____
Standing (prolonged)	____	____	____	____
Walking	____	____	____	____
Yard work	____	____	____	____

Sports_____

Recreational Activities_____

Exercise Daily_____ Weekly_____

Other Medical Conditions_____

Are you aware of your diagnosis? YES____ NO____ Are you aware of your prognosis? YES____ NO____

Have you had Physical/Occupational Therapy, Speech Therapy OR Chiropractic treatment for this or any other injury/condition within the past year? YES ____ (please list # of visits and which therapy _____) NO_____

Therapist Signature _____ Date_____

ProCare PT, LP.
Headquarters: 310 Penn St, Suite 103 Hollidaysburg, PA 16648

Consent for Disclosure of PHI

I consent to the use and disclosure of my protected health information (PHI) by ProCare PT, LP. (ProCare) for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for the practice of ProCare. I understand that treatment of me by ProCare may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of the practice. ProCare is not required to agree to the restrictions that I may request. However, if they agree to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that ProCare has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physical or occupational therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices prior to signing this document. The practice's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the practice. The Notice of Privacy Practices for the practice is also provided at the front desk and in the waiting room. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my PHI.

ProCare reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting one in the mail or by asking fore one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Name of Patient or Personal Representative **Description of Personal Representative's Authority**

Form #153
4/24/2013

DISCLOSURE AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

DATE: _____

PATIENT NAME: _____ **PATIENT #:** _____

ADDRESS: _____

_____

COMMUNICATION OF HEALTH INFORMATION

I give permission to ProCare PT LP to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name	**Relationship**
Name	**Relationship**
Name	**Referring Physician**
Name	**Primary Care Physician**

METHOD OF CONTACT

I wish to be contacted in the following manner(s):

_____ **Home Telephone**

[ ] OK to leave a message with detailed information

[ ] Leave message with call-back number only

[ ] OK to leave message with family members or other persons living in the same household

_____ **Work Telephone**

[ ] OK to leave a message with detailed information

[ ] Leave message with call-back number only

[ ] OK to leave message with secretary, assistant or other individual who regularly answers phone

_____ **Cell Phone**

[ ] OK to leave a message with detailed information

[ ] Leave message with call-back number only

RELEASE OF INFORMATION

RELEASE INFORMATION TO: _____

I hereby authorize _____ to release to the above referenced individual(s) or entity(ies), copies of the following medical records, including mental health information and such reports and/or records pertaining to a serious or communicable disease or infection pertaining to myself:

- ☐ Evaluation
- ☐ Daily Notes
- ☐ Discharge Summary
- ☐ Testing
- ☐ Progress Notes
- ☐ All Records
- ☐ Other (describe) _____

Dates of Service Requested _____

- ☐ I would like photocopies mailed to me.
- ☐ I would like to arrange to pick records up in the clinic.

The above identified information is released solely for the following purpose and that purpose only:

_____

_____

_____

This authorization will expire one hundred and eighty (180) days from the date of signature, or sooner if specifically revoked below (except to the extent that action has been taken in reliance on it).

X_____ _____

Signature of Patient or **Date**
Authorized Legal Representative (Describe basis of authority)

_____ _____

Witness Signature **Date**

_____

Printed Witness Name and Relationship to Patient

Authorization Revoked:

_____ _____

Patient Signature **Date**

Revised 06.02.2010kb