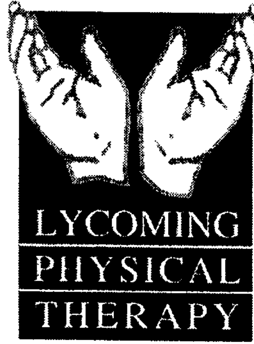

DATE:_____/______/______

NAME:____AGE:__________ GENDER: M / F

ADDRESS:____

CITY____STATE:_______________________ZIP:__________

CELL PHONE:(_____)___________________ HOME PHONE:(_____)_______________________

EMAIL:_______________________________________ DATE OF BIRTH:___/___/___

MARITIAL STATUS:___________ SPOUSE'S NAME:_____________________________ PHONE #:___________________

EMER. CONTACT:_____________________________ RELATIONSHIP:______________ PHONE#:___________________

EMPLOYER:____☐FULL-TIME / ☐PART- TIME

ADDRESS:________________________________ CITY/STATE:______________________ ZIP:____________

OCCUPATION:________________________________

STUDENT: ☐YES / ☐NO ☐FULL-TIME / ☐PART-TIME

REFERRING PHYSICIAN:____LAST DOCTOR VISIT:________________

FAMILY PHYSICIAN:__________________________________

HAVE YOU HAD HOME HEALTH CARE: ☐YES / ☐NO IF YES, DATE OF DISCHARGE: ____/____/______

WHO CAN WE THANK FOR YOUR REFERRAL?

☐FRIEND ☐SOCIAL MEDIA ☐RADIO ☐PHYSICIAN ☐NEWSPAPER ☐WEB PAGE

5/2/2023

PLEASE PRESENT ALL INSURANCE CARDS FOR PHOTOCOPY

MEDICAL INSURANCE:______________________________

NAME OF POLICY HOLDER:______________________ DATE OF BIRTH:___/___/____

RELATIONSHIP TO PATIENT:__________

SECONDARY MEDICAL INSURANCE:______________________________

NAME OF POLICY HOLDER:______________________DATE OF BIRTH:___/___/____

RELATIONSHIP TO PATIENT:__________

WAS YOUR INJURY DUE TO AN ACCIDENT? ☐YES / ☐NO

IF YES: ☐AUTO ☐WORK RELATED ☐LIABILITY ☐OTHER DATE OF ACCIDENT:___/___/___

PLEASE DESCRIBE ACCIDENT:____

____

____

AUTO OR WORK INJURY CLAIM

PRESENT INSURANCE CARD FOR PHOTOCOPY

INSURANCE COMPANY:____________________________ CLAIM #:____________________

CLAIM REP:____________________________ PHONE#:__________________

IS THERE AN ATTORNEY INVOLVED: ☐YES / ☐NO

IF YES, NAME OF FIRM AND ATTORNEY'S NAME:____

ADDRESS:__________________________CITY/STATE:________________ _____ZIP:________

MEDICAL CONDITIONS (PLEASE CIRCLE ALL THAT APPLY)

NEUROMUSCULAR	CARDIOVASCULAR	GASTROINTESTINAL
☐ STROKE OR TIA	☐ HYPERTENSION	☐ REFLUX/GERD/HEARTBURN
☐ PARKINSON'S DISEASE	☐ HEART ATTACK	☐ CHRON'S DISEASE
☐ DEMENTIA/MEMORY LOSS	☐ ARRHYTHMIA/PALPITATIONS	☐ GI BLEEDING
☐ NEUROPATHY	☐ PERIPHERAL VASCULAR DISEASE	☐ CONSTIPATION
☐ MUSCLE DISEASE	☐ CONGESTIVE HEART FAILURE	☐ ULCERS
☐ RESTLESS LEG SYNDROME	**ENDOCRINE**	**RHEUMATOLOGY**
☐ MULTIPLE SCLEROSIS	☐ THYROID DISEASE	☐ RHEUMATOID ARTHRITIS
☐ EPILEPSY	☐ DIABETES	☐ LUPUS
☐ HEARING/VISUAL LOSS	☐ KIDNEY DISEASE	☐ SPINAL STENOSIS
☐ FIBROMYALGIA	☐ EXCESSIVE FATIGUE	☐ OSTEOPOROSIS
☐ SLURRED SPEECH	☐ EXCESSIVE THIRST/HUNGER	**RESPIRATORY**
☐ VERTIGO/DIZZINESS	**PSYCHIATRIC**	☐ ASTHMA
CANCER	☐ ANXIETY	☐ EMPHYSEMA
LOCATION:____________	☐ DEPRESSION	☐ COPD
TREATMENT:____________	☐ BIPOLAR DISEASE	☐ SHORTNESS OF BREATH
☐ **HIV/AIDS**	☐ SCHIZOPHRENIA	☐ PERSISTANT COUGH

OTHER MEDICAL CONITIONS:____
____

ALLERGIES:____

LIST ALL SURGERIES AND DATES THEY OCCURRED

______________________________ DATE:___/___/_____

______________________________ DATE:___/___/_____

______________________________ DATE:___/___/_____

______________________________ DATE:___/___/_____

______________________________ DATE:___/___/_____

______________________________ DATE:___/___/_____

LIST CURRENT PRESCRIPTION MEDICATIONS AND DOSAGES YOU ARE TAKING OR PROVIDE A LIST FOR PHOTOCOPY

MED:______________________________ DOSAGE:______________

MED:______________________________ DOSAGE:______________

MED:______________________________ DOSAGE:______________

MED:______________________________ DOSAGE:______________

MED:______________________________ DOSAGE:______________

HAVE YOU HAD ANY **FALLS** IN THE PAST YEAR: ☐YES / ☐NO HOW MANY:____ WITH INJURY:_____

BRIEFLY DESCRIBE YOUR REASON FOR COMING TO PHYSICAL THERAPY:______________________________

WHEN DID THIS CONDITION BEGIN: ______________________________

HOW DID SYMPTOMS START:____

HAVE YOU HAD OTHER TREATMENT FOR THIS CONDITION: ☐ YES / ☐ NO

IF YES, PLEASE SPECIFY: _____SURGERY _____MEDICATIONS ____CHIROPRACTIC ____INJECTIONS ____OTHER

HAVE YOU HAD PHYSICAL THERAPY FOR ANY CONDITION IN THE LAST YEAR: ☐ YES / ☐ NO

IF YES, PLEASE PROVIDE DATES AND CAUSE FOR THERAPY:___________________________________

____

ARE YOU CURRENTLY INVOLVED IN A REGULAR EXERCISE PROGRAM OR SPORT: ☐ YES / ☐ NO

IF YES PLEASE DESCRIBE:____

DO YOU SMOKE: ☐ YES / ☐ NO _____PACK(S) PER DAY ARE YOU PREGNANT: ☐ YES / ☐ NO

DO YOU DRINK ALCOHOL: ☐ YES / ☐ NO _____DAYS PER WEEK

HEIGHT:_______' _______" WEIGHT:__________LBS

IN GENERAL, WOULD YOU SAY YOU ARE IN: ☐ GREAT / ☐ GOOD / ☐ FAIR / ☐ POOR (CIRCLE ONE) HEALTH?

TODAY I AM FEELING: ☐ GOOD / ☐ FAIR / ☐ POOR (CIRCLE ONE)?

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

1. LITTLE INTEREST OR PLEASURE IN DOING THINGS:

☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY ☐ DECLINE TO ANSWER

2. FEELING DOWN, DEPRESSED, OR HOPELESS:

☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY ☐ DECLINE TO ANSWER

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ DATE: ______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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A2663B 10-04-2005

AGREEMENT TO PAY FOR SERVICE

The financial policies of Lycoming Physical Therapy, Ltd. are as follows:

1) We will offer the most effective physical therapy treatment for our patients; in accordance with APTA Code of Ethics, these services are reimbursable.

2) It is the patient's responsibility to be aware of and knowledgeable of their insurance coverage.

3) Any concerns that the patient may have regarding payment for physical therapy service rendered in our facility should be discussed and settled with the patient prior to discharge.

4) Should the patient be a legal minor, the patient's parent/guardian shall be held responsible for the payment of said physical therapy services-any financial matters will be discussed with the parent/guardian as noted above.

5) Patients responsibility for co-pay, coinsurance, etc. Payment for physical therapy services rendered in our facility is payable on the date of service.

6) Payment for outstanding balances are due at the time you receive an invoice/bill. Payment schedules may be established at the discretion of Lycoming Physical Therapy, Ltd. and agreed to be paid by the responsible party.

7) I understand that my account may be turned over to collection agency after 90 days and that I will be responsible for a 25% collection charge. Our office is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. **Please call our office by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations.** Failure to show up at the time of a scheduled appointment will be recorded in your medical record as a "no-show." Please be courteous to fellow patients who are also seeking our care, by promptly keeping your appointments so we can serve you and allow others to readily schedule appointments. A fee of $25 will be applied to your account after the third and all subsequent "No Show" for an appointment.

8) I understand that any balances over 90 days will incur and finance charges of 1.5% per month.

In consideration of the above policies and procedures, I acknowledge and agree to the above terms and conditions. I hereby agree to consent to treatment and agree that I am responsible for payment of such services, regardless of insurance coverage. I assign all payments and/or medical benefits for the physical therapy services including Medicare, Major Medical, Workers' Compensation, Private Insurance, and/or other health insurance coverage to Lycoming Physical Therapy, Ltd. Further, I authorize Lycoming Physical Therapy, Ltd. to release and/or provide all pertinent and necessary information and records as may be required to secure payment and/or notify physician(s), attorneys, and insurers of my status. I agree that Lycoming Physical Therapy Ltd. And/or its agents may contact me by telephone at any telephone number associated with your account including wireless numbers which could result in charges to you. I agree that we or our agents may contact you by sending text messages or emails. Using any email address you provide to use and by using pre-recorded ot artificial voice-messages and/or an automatic telephone dialing system is applicable.

__________________________ __________________________

Patient Signature Date Parent/Guardian Date

08/05/2024

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ______________________________ Birth Date: ________________

I authorize ______________________________ to release information from my medical records to LYCOMING PHYSICAL THERAPY:

SPECIFIC INFORMATION TO RELEASE		
☐ MRI/X-Ray	☐ History/Clinical Notes	☐ Discharge Summary
☐ Operative Reports	☐ Emergency Room Notes	☐ Lab/Pathology Reports
☐ Itemized Bills	☐ Attendance History	
☐ Other: All records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expenses		
☐ Other (Specify):		
☐ Other (Specify):		

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization A copy of this authorization shall have the same force and effect as the original. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I also understand that this consent will expire 12 months after the date of signature or automatically with the records request requested on this authorization has been released. I understand that the information released may be re-released by the recipient and may no longer be protected by the HIPAA (Federal regulations). I understand that providing authorization for the requested use of disclosure is not a condition of my treatment, payment, enrollment in a health plan or eligibility for benefit except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The above Authorization applies to the release of written documents and permits oral conversation(s) with the entity(ies) indicated above with regard to the release of information from my medical records.

AUTHORIZATION SIGNATURES:

Date: ________________ Patient Signature: ______________________________

If patient is unable to sign authorization form because of physical condition of age, complete the following. Patient is a minor or patient is unable to sign authorization because: ______________________________

____

Date: ____________ Signature: ____________________ Relationship: ________________

NOTE: IF PATIENT IS UNDER 18 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR, THE PARENT OR GUARDIAN MUST SIGN. ******* COPY OF COMPLETED AUTHORIZATION PROVIDED TO PARENTS *******

Social Drivers of Health (SDoH)

This document is based on the Core Questions of the Accountable Health Communities Health-Related Social Needs Screening Tool

Living Situation

1. **What is your living situation today?**
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**
   Choose all that apply
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food - Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true
4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**
   - ☐ Yes
   - ☐ No

Utilities

6. **In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?**
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Safety - Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently
8. **How often does anyone, including family and friends, insult or talk down to you?**
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently
9. **How often does anyone, including family and friends, threaten you with harm?**
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently
10. **How often does anyone, including family and friends, scream or curse at you?**
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently