PATIENT INFORMATION

How did you choose this clinic? *Facility:*

Today's Date:

Name, Last: First: M.I. Male / Female

E-mail:

Address: Apt # City: State: Zip:

Cell Phone #: Home #: SS#:

Age: Date/Birth: Marital Status: S M D W Student Other

Emergency Contact: Name Phone:

EMPLOYMENT INFORMATION

Employer: Address:

Full Time / Part Time Work #:

MEDICAL INFORMATION

Have you had any therapy provided to you within the last year? Yes No Where:

Injured Body Part: Date of Injury/Onset of Symptoms:

Work Related: Yes No Accident: Yes No Auto: Yes No If Auto, what State:

Referring Physician Name: (Last) (First) Phone:

Primary Care Physician: Phone:

Date of Next Physicians Visit: Date of Prescription:

MEDICARE PATIENTS

Have you had any therapy of nursing services in your home? Yes No Name of Agency:

Medicare ID#

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Phone:	Phone:
Subscriber Name:	Subcriber Name:
Subscriber Date of Birth:	Subcriber Date of Birth:
Relationship to Patient:	Relationship to Patient:
Subscriber Employer:	Subcriber Employer:
ID/Claim #:	ID/Claim #:
Group #:	Group #:

ACCIDENT

Accident?: ☐ Work Related ☐ Auto ☐ Other _____

Date of Accident: State Accident occurred:

Current Occupation:

Insurance Company:

Address: Phone:

ID/Claim #: Adjuster Name: Phone:

Employer: Phone:

Address:

Rehabilitation Nurse/Case Manager Company Name:

CONSENT FOR TREATMENT

I heareby authorize and give my consent to Therapy Consultants to provide me with physical therapy services. Initial _____

FINANCIAL POLICY

Thank you for choosing Therapy Consultants as your physical therapy provider. We will work closely with you and your physician to provide you with treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship.

Cancellation/No show policy: A 24 Hour notice must be received or a fee will be assessed.

1. *All co-pays and deductibles are due at the time of service.*
2. *Payment of patient balance is due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss this with our Patient Care Advocate.*
3. *If any portion of your account balance exceeds 60 days you will be responsible for this amount, plus interest here in at 1 1/2% per month, regardless of your insurance.*

We accept cash, checks, Visa, MasterCard, Discover and American Express

INSURANCE

We accept Medicare, all major insurance and numerous PPO and managed care contracts. Please be aware that some, and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges. Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Therapy Consultants will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral, please ask our Patient Care Advocate.

To guarantee payment for services rendered, we request documentation of a major credit card. Please provide the following information:

Credit Card Type: Master Card / Visa / Discover / American Express

Name on Card _____

Card # _____ **Exp Date:** _____

For your convenience, if you would like your credit card debited weekly for co-pay portion or total charges, please initial here: _____

Date: _____. **Select One: Co-pay Total charge**

Please be advised that if you are paying by check, Therapy Consultants charges a $35 fee for returned checks.

Thank you for understanding our financial policies. If you have any questions or concerns, our Patient Care Advocate will be happy to discuss them with you.

I authorize payment of benefits directly to Therapy Consultants for services provided.

Signature of Patient (Parent / Guardian, if necessary) ***Therapist Signature***

_____ **Date:** _____ _____

* QUOTATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.

I hereby authorize Therapy Consultants to release any information necessary to secure the payment of benefits. I also authorize direct payment to Therapy Consultants for any payments due. I authorize the use of this signature on all my claims submissions. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I am fully responsible for any collection fees necessary to collect this account.

Patient / Responsible Party ***Patient Care Advocate / Facility Manager***

_____ **Date:** _____ _____

HANS HUMBERGER PHYSICAL THERAPY

at

THERAPY CONSULTANTS

Patient Medical History and Intake Questionnaire

Patient Name:_____ Age:_____ Sex: F____ M____ Weight:_____ Height:_____
Why did you choose this location: _____
What is your main complaint and in what area is it located?_____
Occupation: _____
Are you presently working? Yes ____ No ____ If no - Last day worked: _____
Have you ever had these symptoms before? Yes ____ No ____ If so, when? _____
Check all of those which apply to your current condition:

____Work Related Injury ____ Sports Injury ____Fall ____Motor Vehicle Accident ____Aggravation of Pre-Existing Injury
____Causes Unknown ____Injury Recurrence ____Lifting Injury ____Other: _____
What have you been doing to decrease your pain? _____
On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? _____
Are your symptoms getting worse / better / the same / since your injury? _____
Are you currently taking any medications? (Please list) _____
Are you allergic to any medications? (If yes, please list) _____

Please circle tests you have had performed:

None X Rays MRI CT Scan Bone Scan Other (Explain) _____

Check any of the following activities which you have difficulty with due to your injury:

____Housekeeping ____Lifting ____Driving ____Shopping ____Reaching ____Dressing ____Cooking

____Climbing Stairs ____Child Care ____Bending ____Yard Work ____Sit to Stand

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	____	____	Cancer	____	____	Metal Implants	____	____
Chest pain	____	____	Asthma	____	____	Dizziness	____	____
Heart Disease	____	____	Arthritis	____	____	Fractures	____	____
Pacemaker	____	____	AIDS/HIV	____	____	Skin Allergies	____	____
Headaches	____	____	Allergies to Heat	____	____	Nausea/Vomiting	____	____
Kidney Problems	____	____	Allergies to Cold	____	____	Ear Ringing	____	____
Are you Pregnant	____	____	Seizures	____	____	Hypoglycemia	____	____
Bladder Problems	____	____	High Blood Pressure	____	____	Respiratory Problems	____	____

List all of your surgeries: _____
_____

Is there any other information about your present health that we should know about? _____
_____

_____ _____ _____

Date Patient or Guardian Signature PT/OT Initials

HANS HUMBERGER PHYSICAL THERAPY

at

THERAPY CONSULTANTS

"The Results Team"

Hans C. Humberger, PT
Nancy Humberger, PT

Jill Selby, Office Manager

INFORMATION FOR PATIENT

Welcome to Therapy Consultants!

Personal Items & Clothing:
Patients are encouraged to wear comfortable clothing when receiving therapy treatments. We have shorts and gowns, at the clinic, for your use during treatment. Appropriate attire typically includes shorts, t-shirts, and gym shoes. Tank tops or halter tops are better for neck and shoulder injuries. Please make sure that the involved body part and surrounding areas are easily exposed. A wash-room is available for clothing changes. Please secure all personal items. Therapy Consultants is not responsible for any lost or stolen items. If items need to be secured, please see the facility manager prior to treatment.

Workers' Compensation Patients:
We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your workers' compensation adjuster and/or rehabilitation case manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

Billing/Payments:
All patients' co-pays are to be paid on the same day of treatment session unless other arrangements are made with the front office coordinator. All billing questions should be addressed to our front office coordinator. Please inform us immediately if you have made any changes in your address, phone number or insurance carrier. The patient is ultimately responsible for all outstanding balances.

Cancellations/No Show Appointments:
In order to treat your injury in a timely and efficient manner, you are expected to attend all scheduled therapy visits. All cancellations are to be at least 24 hours in advance, and rescheduled within the same business week whenever possible. There will be a $ 35.00 charge to all patients who cancel their appointments with less than 24 hour notice, unless that appointment is rescheduled. There will be a $ 35.00 charge to all patients who do not show up for their scheduled appointments.

Three consecutive no shows appointments may result in a discharge.

_____ _____

Patient or Guardian Signature **Date**

As a courtesy to other patients, please do not bring children and spouses into the treatment area.

Thank you for choosing Therapy Consultants as your physical therapy provider. Our highly skilled staff is looking forward to helping you accomplish your rehabilitation goals in a safe and timely manner.

2255 Center Street, #104 * Chattanooga, TN 37421 * Phone 423-855-0745 * Fax 423-855-7898
E-mail: Therapyconsultants@comcast.net

HANS HUMBERGER PHYSICAL THERAPY

at

THERAPY CONSULTANTS

"The Results Team"

Hans C. Humberger, PT
Nancy Humberger, PT

Jill Selby, Office Manager

Doctor: _____
Address: _____
_____
_____

REQUEST FOR MEDICAL RECORDS

Please forward any written reports of x-rays, MRI's and CAT scans. This will help us focus the treatment and help in billing. Thank you for your help.

Name: _____ Date: _____
DOB: _____
SSN: _____

Signature: _____

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INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At Therapy Consultants, we use a variety of procedures and modalities to help us to try and improve your function. As with all form of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality of procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Therapy Consultants, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

(print) Patient Name	Patient Signature	Date
	PT Signature	Date

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Nancy Humberger, PT

Jill Selby, Office Manager

Patient Name (Print): _____

Privacy Practices

I received a copy of the NOTICE OF PRIVACY PRACTICES. (HIPPA) Initial _____

Where can I call to remind you of appointment?
I authorize the release of appointment information left on the voicemail or message center at:

☐ Home Phone Number: _____
☐ Cell Phone Number: _____
☐ Work Phone Number: _____ Initial _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Therapy Consultants to use and/or disclose certain protected health information (PHI) about me to the following doctors:

1. _____
Name and address of entity to receive this information

2. _____
Name and address of entity to receive this information

The information will be used or disclosed for the following purpose:
To keep additional doctors informed of current therapy treatment.

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on the date of discharge from Therapy Consultants.

I do not have to sign this authorization in order to receive treatment from Therapy Consultants. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at:

2255 Center Street, Suite # 104 * Chattanooga, TN 37421

Signed By: _____ _____
Signature of Patient or Legal Guardian — Date

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at

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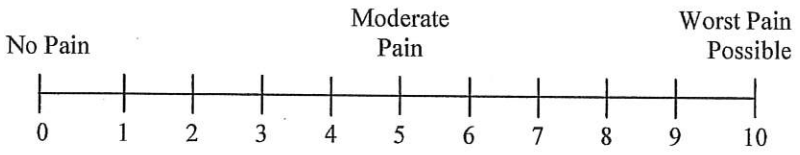
Hans C. Humberger, PT
Nancy Humberger, PT

Jill Selby, Office Manager

Name: _____ **Date:** _____

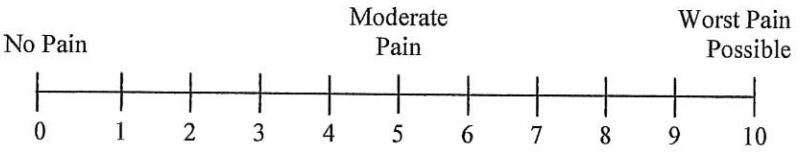
Numeric Pain Rating Scale

1. Over the past 24- Hours: "How bad has your pain been?"



Pain Intensity-Numerical Rating Scale

2. On average over the past 2 days: "How bad has your pain been?"



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Nancy Humberger, PT

Jill Selby, Office Manager

Name: _____ Date: _____

The Patient- Specific Functional Scale

This questionnaire is used to document activity limitation that you may have. This will help to document and measure functional outcomes.

Please list below **at least 5** activities that you are unable to do or are having difficulty doing.

Please rate your ability to do the following activities over the last week. Please circle the number that best represents your level of difficulty.

List at least 5 activities below	No Difficulty			Mild Difficulty			Moderate Difficulty			Severe Difficulty	Unable
1. _____	0	1	2	3	4	5	6	7	8	9	10
2. _____	0	1	2	3	4	5	6	7	8	9	10
3. _____	0	1	2	3	4	5	6	7	8	9	10
4. _____	0	1	2	3	4	5	6	7	8	9	10
5. _____	0	1	2	3	4	5	6	7	8	9	10
6. _____	0	1	2	3	4	5	6	7	8	9	10
7. _____	0	1	2	3	4	5	6	7	8	9	10

Total score = sum of the activity scores / number of activities
Minimum detectable change (90%CI) for average score = 2 points
Minimum detectable change (90% CI) for single activity score = 3 points

Total Score: _____

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Nancy Humberger, PT
Markettia Duncan, PT

Jill Selby, Office Manager
Rebecca Otis, PTA
Karsin Dalton, PTA

Example Activities for Patient - Specific Functional Scale

- Pick up an item off the floor
- Walk up and down the stairs
- Sweep the floor
- Mop the floor
- Walk around the grocery store
- Carrying laundry
- Stepping up into a large vehicle
- Climb on a step ladder or step stool
- Walking without stumbling
- Sitting down on the toilet
- Getting up from the toilet
- Pushing open a heavy door
- Carrying a shopping bag
- Carrying a purse
- Walking on even ground
- Stepping onto or off a curb
- Squatting
- Rising up on your toes
- Balancing when you first stand up
- Standing for 5 minutes
- Standing for 10 minutes
- Standing for 20 minutes or more
- Walking for 5 minutes
- Walking for 10 minutes
- Walking for 20 minutes or more minutes
- Getting up or down without assistance
- Turning around while walking
- Getting out of a chair
- Sitting for 1 hour
- Putting on socks/shoes/hose/etc.
- Balancing on one leg
- Lifting an object from the floor
- Grab an object off a shelf
- Dust furniture
- Vacuum
- Put on a coat
- Wash your back
- Unhook bra straps
- Comb hair
- Lift 10 lbs. above your shoulders
- Stir a pot
- Lift a frying pan
- Wash dishes
- Put dishes in dishwasher
- Hold a cup of coffee
- Pick up money
- Opening a jar
- Writing
- Turning a key
- Changing a light bulb
- Do heavy household chores
- Make a bed
- Wash or blow dry your hair
- Put on a pullover sweater
- Use knife to cut food
- Play cards
- Drive your car
- Rolling over in bed
- Transitioning from sitting to standing
- Getting into and out of bed
- Showering
- Getting into or out of the bathtub
- Doing your usual work activities
- Cooking
- Dressing yourself
- Pushing something
- Pulling something
- Riding in a car for a short ride
- Riding in a car for a long time
- Taking food out of the refrigerator
- Walking slowly
- Walking quickly
- Kneeling down
- Cleaning around the house
- Moving furniture
- Take something out of your back pocket
- Laying on your side
- Sleeping through the night without waking
- Reaching out to grab an item while standing
- Walking without holding onto nearby walls or flat surfaces
- Handling objects with a tingling sensation and/or numbness in your hands

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Jill Selby, Office Manager

Name: _____ Date: _____

Today's Pain Drawing and Visual Analog Scale

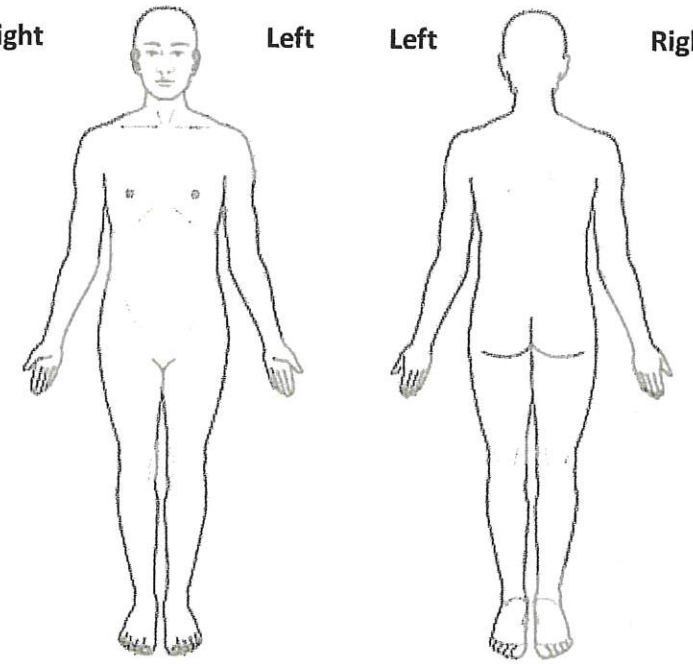
0 (Zero) is NO pain "Normal" **10** (Ten) is the WORST Pain "Emergency Room"

Since your last visit: Please Mark Average Pain to Highest Pain

Head	0	1	2	3	4	5	6	7	8	9	10
Jaws	0	1	2	3	4	5	6	7	8	9	10
Chest	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Shoulders	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Wrist	0	1	2	3	4	5	6	7	8	9	10
Hands	0	1	2	3	4	5	6	7	8	9	10

Upper Back	0	1	2	3	4	5	6	7	8	9	10
Lower Back	0	1	2	3	4	5	6	7	8	9	10
Stomach	0	1	2	3	4	5	6	7	8	9	10
Hips	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10
Knees	0	1	2	3	4	5	6	7	8	9	10
Ankles	0	1	2	3	4	5	6	7	8	9	10
Feet	0	1	2	3	4	5	6	7	8	9	10

Please draw where your pain is located:



1. What's Better? _____
2. Do you have any problems with your exercises? ____ If so which ones? _____
3. Areas the therapist needs to focus on: _____

* **Remember** * Pain improvements occur with your exercises done at home. Talk to the staff if your rating is not going down. Hans, Nancy, and your Doctor want you to improve steadily and consistently.

Thanks, Hans Humberger