Riverside Physical Therapy
Admissions Form

Last First Middle

Street Address City State Zip Code

Home Phone Cell Phone Email

Birthdate Sex

Occupation Employer Name Work Phone

Would you like appointment reminders? **Yes** **No**
Home Phone or Cell Phone Text or Voice

Please Present Insurance Card

Name of card holder Birthdate of card holder

Primary Insurance Secondary Insurance

Referring Physician Name if referred by friend or family member.

Is prescribed therapy due to an **accident (automobile or work related)**? Yes No

Have you had any type of therapy at any other clinic this year? (PT. OT. ST) Yes No
If so, where? ____

Authorization

I hereby authorize the physical therapist to administer treatment and/or a qualified technician to participate in any treatment as may be deemed necessary or advisable in his/her diagnosis and treatment. I also authorize the release of such information as may be necessary the the completion of insurance claims. I agree to pay Riverside Physical Therapy in full for services rendered not covered by insurance.

Signed Date Relationship

Witness Date

Riverside Physical Therapy

47581 815th Road
Ord, Ne 68862

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review, read, and request a copy of the Riverside Physical Therapy **NOTICE OF PRIVACY PRACTICES.**

Patient Signature: ______________________________ Date:______________

Signature of Patient Representative: ____________________Date:_____________

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby authorize Riverside Physical Therapy to furnish information to insurance carriers concerning my illness and treatment for purposes of payment of my claims. This information may include the following data: appointment date and time, account information, and evaluation/testing and daily treatment notes.

Patient/Patient Representative signature: ____________________Date:_________

Other than insurance purposes, I hereby authorize the following people to have access to my protected health information and/or account information for purpose of payment.

_____ Spouse Name:_________________________________
_____ Child Name:_________________________________
_____ Parent Name:_________________________________
_____Other Name:_________________________________

By the following forms of communication:

_____Phone _____Voice Mail _____Fax
_____Other (describe)_________________________________

Patient/Patient representative signature:

____**Date:**_________

Riverside Physical Therapy

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At Riverside Physical Therapy, we strive to provide the highest quality of care for our patients.

In order to do this we depend on prompt payment from the insurance companies and patients. Please present your most current insurance information at your first visit. Then, if you receive a new insurance card during your treatment, please bring that with you to your next visit. This will help prevent you from incurring any unnecessary charges.

If at any time you have questions about your bill, please feel free to contact our office. We are here to help ensure that our billing is clear and understandable. We can give you an idea of how your insurance coverage will cover your visits. We can explain balances, actions taken by insurance companies, and our statements. We can also help set up payment plans when needed.

If there are ever any questions about your treatment or bill, please feel free to contact us. We are here to provide you with the quality care you deserve.

Cancellation Policy

We understand that there are times that you cannot make a scheduled appointment. We ask that you please notify us 24 hours in advance when you will be unable to make a scheduled time. Appointments are in very high demand, and your early cancellation allows us to schedule someone that may be waiting. Your consideration is greatly appreciated.

Late cancellations may be subject to a $25 charge.

I have read and understand the Cancellation Policy.

____ ____________________

Signature Date

Riverside Physical Therapy

Name: ______________________________ Date: ________________

Age: __________ Weight: __________ Height: __________

Referred by: ______________________________

Please complete the following:

List the area(s) of the body to be treated: ______________________________

What is the primary problem? ______________________________

What date did it begin? ______________________________

Have you had this problem before? ________

If so, what treatment helped? ______________________________

Was there a particular incident or accident involved, or did it come on gradually?

____

Briefly describe what happened:

____

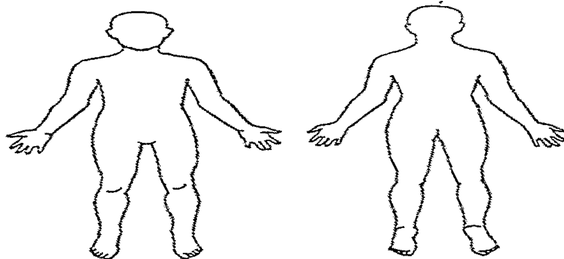
If it was a car accident, were you the driver or passenger?

____

Circle all that describe your pain:

dull	sharp	stabbing	burning	pins & needles
constant	on & off	aggravating	numbing	pinching
shooting	radiating	night pain	tinglingthrobbing	

On the body diagram, draw the location of your pain/discomfort.



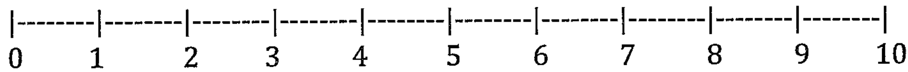
Which activities, positions, or treatments (if any) aggravate our problem the most, or are the **most painful**? ______________________________

____

Which activities, positions, or treatments give you the **most relief**?

____

Rate your pain level on a scale from 0 to 10. Place an "X" anywhere along the following scale to rate your pain level when your condition is the **most painful**. Then draw another "X" to rate your pain level when you have the **most relief**. (A "10" means you have to go to go to the emergency room NOW.)



0 1 2 3 4 5 6 7 8 9 10

No pain — Emergency Room pain

Please list three activities which are now more difficult or more painful than before this condition occurred:

1.) ______________ 2.) ______________ 3.) ______________

Do you have a history of falls? ________

Please list dates: ______________________________

Circle all the following you have had *since this condition started: (even if they seem unrelated)*

Unexplained weakness	Diarrhea	Loss of appetite	Fever
Change in bowel or bladder	Irritability	Nausea/vomiting	Fatigue
Unexplained weight loss/gain	Headaches	Night sweats	

Circle if you have had any of the following and if so explain:

heart problems: ______________ lung problems: ______________

cancer: ______________ diabetes: ______________

high blood pressure: ______________ fibromyalgia: ______________

arthritis: ______________ metallic implant: ______________

osteoporosis: ______________ pacemaker: ______________

currently pregnant: ______________ Hepatitis: ______________

HIV: ______________

latex Allergy: ______________ other allergies (list): ______________

Please list current medications: ______________________________

____

Circle all surgeries you have had, and list dates:

gall bladder ________ appendectomy ________ hernia ________

mastectomy ________ hysterectomy ________ c- section ________

heart surgery ________ bowel restriction ________

List other surgeries with dates:

____

Have you had an x-ray, MRI, or a CT scan for your problem? If so, where was it done?

____

What do you hope to be able to do when you have completed your therapy?

____

Are you currently receiving Home Health Services? ______________

Signature: ______________ Date: ______________

Riverside Physical Therapy Medication Form

Name ______________________ Date __________ Pharmacy ______________

Please list all medications you are currently taking. Please include all prescribed, over-the-counter, vitamins, and herbal supplements.

Medication	**Prescribed (RX) or Over the Counter (OTC)**	**Dosage**	**Strength**	**How taken: Pill, tablet, injection, IV, etc.**	**Frequency**
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				
	RX OTC				

__________ At the current time I am not taking any type of medication, prescribed or over-the-counter.

____
Signature