CT Physical Medicine

physical therapy ✦ physiatry ✦ orthopedic surgical consultations

Name ____________________ Date ____________________

Social Security # ____________________ Date of Birth ____________________ Home Tel ____________________

Address ____________________ Work Tel ____________________

City ____________________ State ________ Zip ________ Cell # ____________________

Email Address ____________________

Marital Status M S W D # Children ____________________

Spouse's Name ____________________ Your Occupation ____________________

Emergency Contact Name and Tel # ____________________ (   ) ____________________

HEALTH INFORMATION

Main complaint ____________________

____

Other complaints ____________________

How long have you had this condition? ____________________

Other Doctors seen for this condition ____________________

Have you had similar conditions in the past? Yes / No If yes, please list. ____________________

____

Are you taking any medication? Yes / No If yes, please list. ____________________

____

____

Have you had any previous surgeries? Yes / No If yes, please list. ____________________

____

____

Pregnant? Yes / No If yes, # of weeks ____________________

Who is your Primary Care Physician? ____________________

Name ______ **Date of Birth** ______

HEALTH INSURANCE INFORMATION

Do you have Health Insurance? Yes / No

Insurance Company ______ Member ID # ______

Is this condition due to:

work-related injury? Yes / No **automobile accident?** Yes / No **slip or fall?** Yes / No

Date of Injury ______ In what state is the car you were driving/riding registered? ______

FOR WORKER COMPENSATION INJURY

Date of Injury ______

Description of Injury ______

Worker Comp Insurance Carrier ______ Claim # ______

Adjuster's Name ______ Tel # ( ) ______

Employer's Name ______ Tel # ( ) ______

Do you have an attorney? Yes / No ______

Attorney's Name ______ Tel # ( ) ______

FOR MOTOR VEHICLE ACCIDENT

Name of Auto Insurance (for the vehicle you were in) ______

Has a medical claim been filed? Yes / No ______ Claim # ______

Adjuster's Name ______ Tel # ( ) ______

Do you have an attorney? Yes / No ______

Attorney's Name ______ Tel # ( ) ______

FOR SLIP & FALL INJURY

If slip & fall, place of injury ______

Has a medical claim been filed? Yes / No ______ Claim # ______

Do you have an attorney? Yes / No ______

Attorney's Name ______ Tel # ( ) ______

Name ______________________ Date of Birth ______________________

REVIEW OF SYMPTOMS

Please check yes or no to the following conditions or symptoms you currently have or have had in the past:

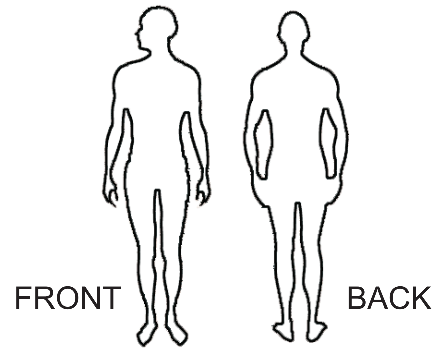
YES NO

☐☐ *Abdominal Pain*
☐☐ *Anemia*
☐☐ *Arm or Shoulder Pain*
☐☐ *Arthritis: rheumatoid, gout, osteoarthritis*
☐☐ *Back Pain*
☐☐ *Bladder Problems*
☐☐ *Cancer (Where):* ______________
☐☐ *Chest Pain*
☐☐ *Diabetes*
☐☐ *Digestive Disorder*
☐☐ *Dizziness*
☐☐ *Eyes or Blurred Vision*
☐☐ *Headaches*

YES NO

☐☐ *Heart Problems*
☐☐ *High or Low Blood Pressure*
☐☐ *Hip or Leg Pain*
☐☐ *Immune System Problems*
☐☐ *Kidney Problems*
☐☐ *Liver/Jaundice/ Hepatitis*
☐☐ *Lung or Bronchial Disorder*
☐☐ *Neck Pain*
☐☐ *Neurological: Strokes, Seizures, Numbness*
☐☐ *Thyroid*

Please mark on the diagram where you are having pain, numbness or tingling.



☐☐ *Allergies: Medications* ______________________________

☐☐ *Other Allergies:* ______________________________

SOCIAL HISTORY

Are you employed? Yes / No ______________________________

Do you smoke? Yes / No ______ If yes, how long? ______ How much? (   ) pack(s) per day

Do you use recreational drugs? Yes / No ______ If yes, how long? ______ How much? ______

Do you drink alcohol? Yes / No ______ How much per day? ______ Per week? ______ Per month? ______

Name ______________________ **Date of Birth** ______________________

FAMILY HISTORY

Any cancer in your immediate family? Alive / Deceased

Mother: Yes / No What kind? ______________________ ❑ ❑

If deceased, cause of death: ______________________

Father: Yes / No What kind? ______________________ ❑ ❑

If deceased, cause of death: ______________________

Brother: Yes / No What kind? ______________________ ❑ ❑

If deceased, cause of death: ______________________

Sister: Yes / No What kind? ______________________ ❑ ❑

If deceased, cause of death: ______________________

PLEASE REVIEW & SIGN

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to Connecticut Physical Medicine, LLC and be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immedicately due and payable. By signing this form I further understand that I'm giving Connecticut Physical Medicine, LLC permission to send me their monthly newsletter. If I do not wish to receive this newsletter I can inform the office at any time and/or I can unsubscribe at any time. All of the above information being provided by me on this form is true.

Patient's Signature ______________________ Date ____________

Guardian's Signature ______________________ Date ____________

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NOTICE OF PRIVACY PRACTICE

This notice of privacy practice discloses how health information about you may be used.

Connecticut Physical Medicine, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Connecticut Physical Medicine, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Connecticut Physical Medicine, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Connecticut Physical Medicine, LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Connecticut Physical Medicine, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

This notice of privacy practice will stay in effect until the patient revokes it in writing to this office.

If you have any questions or complaints please contact our practice manager @ 203.437.7229.

Patient’s Signature: ______________________________________ Date: _________________

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MEDICAL RELEASE

I, ______________________________, DOB _________, authorize ___________________________________ to release my Protected Health Information, as described below, to:

Please fax all records to:
Connecticut Physical Medicine, LLC
Fax (203) 504-7700

Connecticut Physical Medicine, LLC
PO Box 1105
Enfield, CT 06083-1105

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

❏ Complete Medical Record on or after DOI:_____________

❏ Consultation Documentation ❏ X-ray Reports ❏ Medical History, Evaluation Records

❏ Surgical Reports ❏ Laboratory Reports ❏ Hospital Records including Reports

I also specifically authorize that any sensitive information be released to the above referenced recipients regarding (CHECK ALL THAT APPLY):

❏ HIV/AIDS ❏ Substance Abuse (alcoholism or drug abuse) ❏ Mental Health

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/ eligibility for benefits on my decision to sign this form. I understand that I may revoke my Authorization or to receive a copy of my revocation, I am to contact the practice manager @ 203.437.7229. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes. This release will be in effect until the patient notifies the office in writing to terminate the release.

Patient's Signature:____ Date:______________

Guardian's Signature (if applicable):____

Description of Guardian's Relationship: ____

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FINANCIAL AGREEMENT
Personal Injury and/or Worker's Compensation

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available to you for your personal injury and/or work-related injury.

Payment Arrangements:

Personal Injury Responsibility for Payment

As a courtesy to you, we will gladly submit your medical bills to your auto insurance carrier and/or your attorney; however, all services rendered by this office will be charged directly to you, and, ultimately, you will be responsible for payment for these bills regardless of any settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If you have further questions about your care, please don't hesitate to ask.

Workers' Compensation Injury:

If you are being treated for a work related condition, we would like for you to understand how your case will be handled by our office. The first thing that you need to know is that the insurance carrier for your employer, by law, is fully responsible for payment of your care in our office. When a person is treated for a condition which is solely the result of an industrial accident or employment-related incident, your Workers' Compensation insurance will pay for treatment which restores your health to a pre-injury status of a permanent and stationary condition.

Notification of Employer:

When you have suffered a work-related injury or illness, the law requires that you notify your employer within 30 days of injury. If you do not report your injury as required, you may be responsible to pay for the charges incurred in our office.

Prior Symptoms:

If you are currently experiencing symptoms or problems that you suffered prior to your work-related injury, these may be considered "contributory factors" to your present condition. We will evaluate these symptoms to determine if, and to what extent, these factors are related to your present condition. Once this has been determined, we will notify your Workers' Compensation insurance carrier to apportion or allocate some part of your care to treatment of those symptoms.

Your Responsibilities

This office specializes in the treatment of Personal Injuries and Workers' Compensation patients, so it is very important for you to follow our recommendations and to keep your scheduled appointments with this office in order to achieve maximum benefits for your condition. For Workers' Compensation claims the law states that if you choose not to receive the care that is necessary for treatment of your condition, your Workers' Compensation benefits will be discontinued and your case will be closed.

Termination of Care

When your condition has reached a "pre-injury status", or is determined to be "permanent and stationary." We will notify you, your attorney and/or your Workers' Compensation insurance carrier, and close your case in our office.

We thank you for the opportunity to serve you and welcome any questions you may have concerning your case.

I have read and agreed to the above.

Patient's Signature: ______________________________________ Date: _________________

CONSENT TO TREAT

Medical Visit and/or Treatment

I hereby request and consent to the treatment plan as explained to me for my medical symptoms, complaints, illness. If I am referred for physical therapy services, I understand it is part of this practice and consent.

Chiropractic / Physical Therapy

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and physical therapy procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the chiropractors and physical therapists who now or in the future work at the clinic or office listed above or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of physical therapy and chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor and/or physical therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor/therapist to exercise judgment during the course of the procedure which the doctor/therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. By signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

All procedures (medical, chiropractic and physical therapy) will be covered by this consent and will be in effect until the patient revokes the consent in writing to this practice.

I understand that results are not guaranteed.

Patient Signature____ Date __________________

Parent/Guardian Signature ___________________________________ Date __________________

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Attorney Name____

RELEASE OF MEDICAL RECORDS AND DOCTOR'S LIEN

I do hereby authorize Connecticut Physical Medicine, LLC to furnish you, my attorney, a full report of their examination, diagnosis, treatment, prognosis, etc, of myself in regards to the accident/injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current basis.

D.O.I___________ Patient Name (print)____

Date___________ Patient Signature____

The undersigned, being attorney of record for above patient, does hereby agree to observe all the terms above, and agree to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor which is named above.

Date____________ Attorney Signature____

Please fax the signed lien form to us at (203) 504-7700.