Capitol Physical Therapy

Wisconsin's PRIVATE PRACTICE OF THE YEAR RECIPIENT
Mount Horeb | Verona | at Associated Physicians | University Ave
Waunakee | Sun Prairie
608.848.6628 | capitolphysicaltherapy.com

First Name: MI: Last Name: DOB:

Address:

CELL HOME CELL HOME Would you like to receive text reminds For your upcoming appointments?

1st Phone: 2nd Phone: ☐Yes ☐No

Employer: Email:

Referring Physician: Injury Type: Left / Right / Both

Primary Physician Name and Location:

How did you hear about us? ☐Doctor's Office ☐Previous Patient ☐Family/Friend recommended ☐Insurance ☐Internet search ☐Personal Trainer ☐Another PT ☐Other: _____

Medical History:

Have you ever been diagnosed with or do you have any of the following conditions? (Check all that apply)

☐ **None of these apply to me**
☐ Cancer
☐ Heart problems
☐ Chest pain/angina
☐ Circulation problems
☐ Blood clots
☐ Stroke
☐ Anemia
☐ Chemical dependency (i.e. alcoholism)
☐ Depression
☐ Anxiety
☐ Lung problems
☐ Tuberculosis
☐ Sexually transmitted disease/ HIV
☐ Rheumatoid Arthritis
☐ Arthritis
☐ Bladder/urinary tract infection
☐ Kidney problems/infection
☐ Cholesterol high/low
☐ Thyroid problems
☐ Diabetes
☐ Osteoporosis
☐ Multiple Sclerosis
☐ Epilepsy
☐ Hepatitis
☐ Ulcers
☐ Liver problems
☐ Allergies/asthma
☐ Pacemaker
☐ Blood thinners
☐ Fibromyalgia
☐ Broken bones
☐ Recent infection /illness (explain)
☐ Other

Past surgical history (Type & Date):

Significant family medical history:

During the past month have you been feeling down, depressed, or hopeless? ☐Yes ☐No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐Yes ☐No

Is depression or anxiety something you would like help with today? ☐Yes ☐Yes, but not today ☐No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? ☐Yes ☐No

If you are over 65, how many falls have you had in the last 6 months? _____

Are you taking any medications? ☐Yes ☐No

If yes, please list the medications you are taking **on the next page**, or indicate that you have attached your own list to this paperwork:

Medication name: Amount: Dose:

Tobacco use: ☐Yes ☐No **Alcohol use:** ☐Yes ☐No **Vitamin D supplement:** ☐Yes ☐No

Current Symptoms:

Problem(s) you are here for:

What date (roughly) did your symptoms start?

What do you think started your symptoms?

Are your symptoms related to a work injury? ☐Yes ☐No --- Or related to a work injury? ☐Yes ☐No

Symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same
☐ Come and go ☐ Constant ☐ Constant, but change with activity

Treatments so far for this problem (injections, chiropractic, etc.):

Have you had an X-ray, MRI, or other imaging for this problem? ☐Yes ☐No

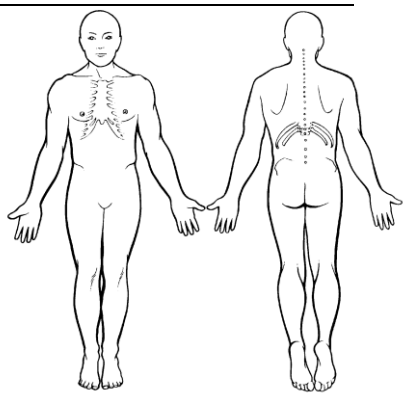
If yes, please list, including date:

Have you ever had this problem before? ☐Yes ☐No

If yes, when and how it was treated:

What is your personal goal for therapy?

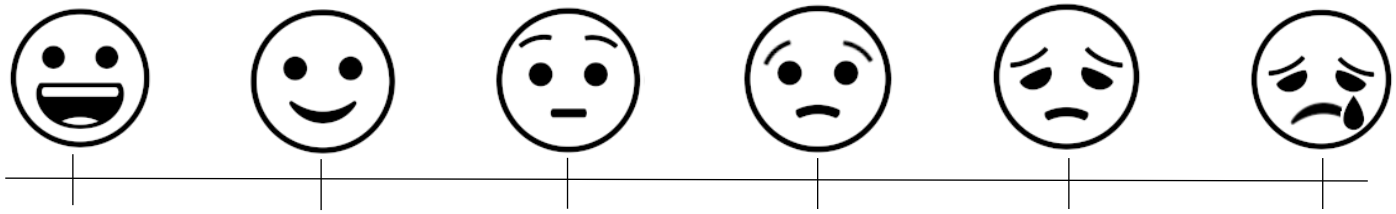
Body chart: Please mark **all** areas where you feel symptoms on the chart to the right



What makes your symptoms **better**?

What make your symptoms **worse**?

On the scale below, please mark the which best represents the severity of your pain over the past 24 hours:



SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following? (Check all that apply)

☐ Skin changes
☐ Fatigue
☐ Generalized muscle weakness
☐ Pain at night
☐ Leg swelling
☐ Weight loss/gain
☐ Changes in appetite
☐ Heart palpitations
☐ Changes in bowel or bladder function
☐ Numbness or tingling
☐ Falls
☐ Shortness of breath
☐ Heartburn/indigestion
☐ Difficulty swallowing
☐ Headaches
☐ Changes in cognition
☐ Other
☐ Fever/chills/sweats
☐ Nausea/vomiting
☐ Abdominal pain
☐ Fainting
☐ Cough
☐ Chest pain especially with sweats
☐ Difficulty maintaining balance when walking
☐ **None of these apply to me**

Describe your usual exercise routine:

How are you able to sleep at night?

Patient Signature **Date**

Consent to Treatment

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by
my therapist.

2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

4. Worker's Compensation - I hereby authorize Capitol Physical Therapy to receive my records related to my work injury.

Photo/Video Authorization

I grant to Capitol Physical Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

☐ Agree or ☐ Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Capitol Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Capitol Physical Therapy representatives.

PT Benefits Provided by Your Insurance Company

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Capitol Physical Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. In the unlikely event your account would be turned over to a collection agency you would be responsible for all filing, collection, and legal fees necessary to obtain full recovery of any unpaid balance due CPT. There will also be interest added to invoices with balances over 30 days. I agree to allow CPT to file my Health Insurance should my worker's compensation, auto, or third-party insurance deny the claim, exhaust the benefits, or fail in any want to pay the claim.

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

_____

Print Patient Name

_____

Patient or Guardian Signature

_____

CPT Employee Signature

_____

Date of Authorization

Capitol Physical Therapy

Patient Name: _____

Date: _____

Clinic: _____

1. Do you receive Veteran's benefits? ☐Yes ☐No
2. Are you receiving benefits under the Black Lung Program ☐Yes ☐No
   - 2.1. If Yes, date benefits began: _____
   - 2.2. If Yes, are the services you will be receiving related to a non-black lung condition? ☐Yes ☐No
3. Was this injury/illness due to a work-related accident/condition? ☐Yes ☐No
   - 3.1. If Yes, date if injury/illness: _____
4. Was this injury/illness related to an automobile accident? ☐Yes ☐No
   - 4.1. If Yes, date of accident: _____
5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending? ☐Yes ☐No
   - 5.1. If Yes, please provide the following:
     Attorney Name and Phone Number: _____
     Address: _____
6. Are you entitled to Medicare based on: ☐Age (65 &over) – go to question 7
   ☐Disability – go to question 7
   ☐End Stage Renal Disease

   Do you have a group health plan (GHP) coverage? ☐Yes ☐No

   Are you with the 30-month coordination period? ☐Yes ☐No
7. Are you currently employed? ☐Yes ☐No – date of retirement: _____
   - 7.1. Is your spouse currently employed? ☐Yes ☐No – date of retirement: _____
   - 7.2. Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current or former employment? ☐Yes ☐No
     - 7.2.1. Does the employed that sponsors your GHP employ 20 or more employees? ☐Yes ☐No

If you answered YES to questions #3, #4 or #7 above, please complete the following information:

Insurance company Name: _____

Address: _____

Policy/Cerf Number: _____ Group Name and Number: _____

_____

Responsible Party **Relationship**

_____

Patient Signature **Date**

Capitol Physical Therapy

APPOINTMENT CANCELLATION POLICY

All appointment cancellations must be made by 12:00 a.m., the night before your scheduled appointment. This can be done either in person, on the phone, or by leaving us a voicemail at the number listed below. If you do not cancel your appointment by 12:00 a.m., or if you do not show for your appointment, you will be charged $25.00 regardless of whether or not you have received reminder(s) from our office.

_____

Signature **Date**

VERONA	608-848-6628
MOUNT HOREB	608-437-0222
SUN PRAIRIE	608-318-1357
WAUNAKEE	608-850-7275
UNIVERSITY AVE	608-467-3537