Name: _____ Age: _____Occupation: _____

Are you having pain? ☐ Yes ☐ No; Rate your pain today on a scale of 0-10, with 0 being no pain and 10 being severe pain:

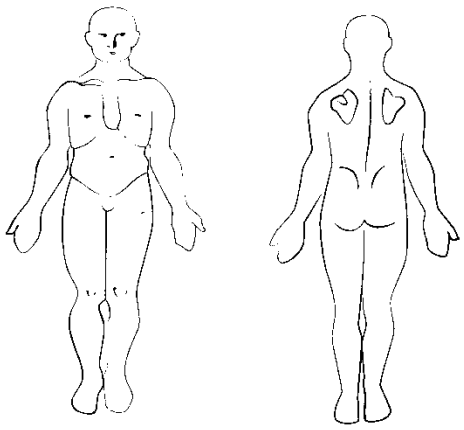
0 1 2 3 4 5 6 7 8 9 10

Do you have any other symptoms (i.e., numbness tingling)? ☐ No ☐Yes: _____

Please mark the specific area of the body below where pain/discomfort occurs:

Height: _____ ft _____ in

Weight: _____ lbs



Check any of the diagnostic tests you have had for this condition: ☐ X-Ray ☐ CT scan ☐ MRI ☐ EMG ☐ Other: _____

Personal Medical History (*check Yes or No)*

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Fractures	☐	☐	Received physical therapy before	☐	☐
Congestive Heart Failure	☐	☐	Diabetes	☐	☐	Surgeries	☐	☐
Prior Heart Attack	☐	☐	Seasonal Allergies	☐	☐	Blood-borne condition	☐	☐
Pacemaker	☐	☐	Latex Allergy	☐	☐	Artificial joints or prosthesis	☐	☐
Peripheral Vascular Disease	☐	☐	Osteoporosis	☐	☐	Unexplained weight loss or gain	☐	☐
Stroke	☐	☐	Parkinsons Disease or MS	☐	☐	Night sweats, fevers or chills	☐	☐
Seizures	☐	☐	Respiratory Problems	☐	☐	Migraines	☐	☐
Currently Pregnant	☐	☐	Gastrointestinal Disease	☐	☐	Asthma	☐	☐
Cancer	☐	☐	HIV, AIDS, or Hepatitis	☐	☐	Kidney, Liver, or Prostate issues	☐	☐

If yes to any of the above, please explain: _____

_____

_____

_____

Please list any disease, condition, or surgery not listed above: _____

_____

Please list any medications you are presently taking. Please list if known, dosage, frequency, and how medication is taken (i.e. 200 mg orally, twice per day):

Prescription: _____

Over the counter: _____

Vitamins and herbal supplements: _____

1. **How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?**
   At least three (3) times a week Once or twice a week Seldom or never

2. **Have you received treatment for this condition before?**
   Yes No

3. **Are you taking prescription medication for this condition**
   Yes No

4. **How many surgeries have you had for the problem for which you are being treated?**
   None 1 2 3 4 or more

5. **How many days ago did your condition begin?**
   0-7 days 8-14 days 15-21 days 22-90 days 91days – 6 months Over 6 months

Social History (check Yes or No):

	Yes	No		Yes	No
Incontinence	☐	☐	Frequent loss of balance or falls	☐	☐
Anxiety or Panic Disorders	☐	☐	If yes, how many falls in the past year?	_____	
Depression	☐	☐	Loss of bladder control or function	☐	☐
Other Psychological Disorders:	☐	☐	Use of illicit or recreational drugs	☐	☐
Sleep Dysfunction	☐	☐	Do you drink alcoholic beverages?	☐	☐
Hearing Impairment	☐	☐	If answered yes:		
Visual Impairment (e.g., cataracts or glaucoma)	☐	☐	FEMALE: number of days in the past year you have had 4 or more drinks:	_____	
Back Pain, Neck Pain or Back Disorder	☐	☐	MALE: Number of days in the past year you have had 5 or more drinks:	_____	
			Do you use tobacco products? (i.e. cigars,	☐	☐
Previous Accidents	☐	☐	cigarettes, pipes, vapes)		
Any major stress change	☐	☐	If answered yes, how much per day?	_____	

Welcome Letter

Dear Patient:
Welcome to Three Lakes Physical Therapy & Wellness Center. We are honored that you have chosen us as your therapy provider and we look forward to assisting you with your rehabilitation. In order to better serve you, we ask that you please take a few minutes to read the following polices specific to our practice and your insurance.

Attendance and Cancellation Policy
In order to meet the needs of all our patients, we request at least 24 hour notice for cancellations. If less than 24 hour notice is given, a **$40 fee** may be charged. If you do not show for an appointment an **$80 fee** may be charged. Should you have 2 "same day" cancellations, no show appointments, or are unable to attend your scheduled appointments consistently, we may discharge you from therapy. You will need to see your referring doctor to obtain a new order for therapy. Please remember that your consistent attendance is essential in obtaining optimal benefit from therapy.

_____initials

Insurance Benefits
Please check your benefits regarding copays, deductibles, and any limitations to the number of therapy visits allowed. The back of your insurance card has a member services phone number which you may call to inquire about and verify the necessary information. You are providing your insurance information and are contractually obligated to your insurance carrier's fees, including copay, coinsurance and deductible. We will file your claim with your insurance carrier and collect any fees associated with your care. Please notify the front desk of any changes in your insurance coverage.

_____initials

Authorization / Financial Responsibility
I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. I agree that in the event that my account is not paid in full, I will be responsible for all reasonable collection and/or attorney fees.

Card on File Agreement for Minors **_____initials**
For patients under 18 years of age, a credit card on file is required for their treatments if the parent/guardian wishes to leave the minor unaccompanied throughout their therapy session. Only kids 12 years of age and over may be left unaccompanied. Parents/guardians must attend treatment sessions if under 12 years of age unless discussed with therapist.

Payment Due at Time of Service **_____initials**
Please be prepared to pay any required copay amount at the time of each appointment. If for any reason you are not able to pay at the time of each visit, please see the front desk to set up an automatic payment plan.

Thank you for your understanding and assistance. We wish you much success in your therapy.

Three Lakes Physical Therapy, LLC

My signature below indicates I have read, understand and am in agreement with the above information

_____ _____
Signature Date

THREE LAKES
physical therapy & wellness center

Patient Compliance Handout

It is important for you to realize that active participation in your treatment is vital to the success of your overall rehabilitation progress. One of the most important things you can do to speed up your recovery is **attend your scheduled appointments**. Your therapist will determine the number of visits that will be required for proper recovery from your diagnosis. Through our past experience, we have learned that the more compliant you are with attending your scheduled appointments, the better and faster your chances of a speedy and full recovery. We understand that situations will arise that make it difficult to keep all of your appointments; however, it is in your best interest to follow through and attend all treatment sessions.

Therapy sessions must be consistently attended in order to see true effective results!

TOP 3 REASONS TO ATTEND YOUR PHYSICAL THERAPY VISITS

1. **Reduce Pain** in the near future and long term

   Both exercise and manual techniques have been shown through research to effectively manage and decrease pain levels. Patients who attend physical therapy have also been shown to be less dependent on pharmaceuticals.

2**. Improve**

Function	Strength	Movement	Endurance
Flexibility	Balance	Coordination	Range of Motion

3**. Learn** ways to improve and maintain body longevity.

   By regularly attending physical therapy sessions, you can lose weight, improve circulation, improve cardiovascular endurance, decrease fall risk, increase sensory acuity and improve muscle tone. The combination of these will help to enhance the body's ability to fight diseases and extend the body's ability to function at its highest level.

My signature below indicates that I have read and understand the above statements regarding my physical therapy appointments.

_____ _____

Patient Signature Date

THREE LAKES
physical therapy & wellness center

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received the attached Privacy Notice.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect our databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs. At this office, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policy describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations. Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment; means of communication among the many health professionals who contribute to your care; legal documents describing the care you received; means by which you or a third party payer can verify that services billed were actually provided; tool in educating health professionals; source of date for medical research; source of information for public health officials charged to improve the health of the State and Nation; source of date for our planning and marketing; tool by which we assess and continually work to improve the care we render and outcomes we achieve.

Although your health record is the physical property of this office, the information belongs to you. You have the right to: obtain a paper copy of this notice of privacy policies upon request; inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with State law); amend your health record as provided by 45 CFR 164.526; obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528; request confidential communications of your health information as provided by 45 CFR 164.522(b) and request restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522(a) – (however, we are not required by law to agree to a requested restriction).

Our practice is required to: maintain the privacy of your health information; provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you; abide by the terms of this notice; notify you if we are unable to agree to a requested restriction; accommodate reasonable requests you may have to communicate your health information. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request. We will not disclose your health information in a manner other than described in the section regarding Examples of Disclosure for Treatment; Payment and Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

Examples of Disclosure for Treatment, Payment & Health Operations: *We will use your health information for treatment*. We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care. *We will use your health information for payment*. We may disclose your information so that we can collect or make payment for health care services you receive. *We may disclose your health information for our routine operations*. These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions. *Consistent with applicable law, we may disclose medical information for the following:* to provide appointment reminders; to coroner, medical examiner or funeral directors; workers' compensation or other similar programs established by law; to public health or legal authorities charged with preventing or controlling disease, injury or disability; to researcher when their research has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal; to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation and transplant; as required by law for reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process or complying with the health oversight activities, such as audits, investigations and inspections necessary to ensure compliance with government regulations and civil rights laws; for military and veterans affairs or national security and intelligence activities; for services provided in our organization through contacts with business associates (i.e. transcription services) due to the nature of business associates' services, that must receive your health information in order to perform the jobs we've asked them to do and to protect our health information we require the business associate to appropriately safeguard your information; to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement; for practice marketing to provide information about treatment alternatives or other health related benefits and services that may be of interest to you; to your personal representative or person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care; when we believe in good faith that your information is necessary to prevent a serious threat to your safety or that of another person (i.e. abuse, neglect, or domestic violence; to family member or close personal friend health information relevant to that person's involvement in your care of payment related to your care, we may notify these individuals of your location/general condition; to an organization assisting in a disaster relief effort. For *all non-routine operations,* we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.