# QUANTUM PHYSICAL THERAPY

Patient Information/This Information Is Confidential

Please have your insurance card(s) and photo I.D. available so we may make a photocopy.

NAME_____

ADDRESS_____
Street Apt./Lot #

_____
City State ZIP Code

Home Phone_____

Cell Phone_____

E-Mail_____

Date of Birth_____

Social Security #_____

Parent (If patient is a minor)_____

Occupation _____

Employer _____

Business Phone_____

Sex: ☐ Male ☐ Female Race_____

Marital Status: ☐ Single ☐ Married_____ (Spouse's Name)

☐ Widowed ☐ Divorced ☐ Separated

Emergency Contact _____
(Name)

_____
(Phone#) (Relationship)

Date of Injury_____ Claim #_____

Employer_____ Self Ins.? ☐ YES ☐ NO
If Work Injury

Attorney_____ Tel #_____
If Applicable

☐ Auto Accident ☐ Other_____

_____
Primary Insurance

_____
ID# Group#

_____
Subscriber's Name Relationship to Patient

_____
Subscriber's Date of Birth Subscriber's Social Security #

_____
Secondary Insurance

_____
ID # Group #

_____
Subscriber's Name Relationship to Patient

_____
Subscriber's Date of Birth Subscriber's Social Security #

## Notice of Privacy Practices

When you receive care at Quantum Physical Therapy, Inc., we are legally required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICES.** You will be offered a copy at our front desk at the time you check in.

☐ I have received a copy of the Notice of Privacy Practices

☐ I have been offered but decline to receive a copy of the Notice of Privacy Practices

## MEDICAL INFORMATION

Diagnosis_____

Referring Physician_____
(Name) (Address) (Date of Last Visit)

Present Medications_____

Recent Operations or Injuries_____

## MEDICAL PROBLEMS

| Yes | No | | Yes | No | | Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Diabetes | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stroke | ☐ | ☐ | Muscle Weakness | ☐ | ☐ | Lung Disease | ☐ | ☐ | Neck/Back Problems |
| ☐ | ☐ | Pacemaker | ☐ | ☐ | Pregnant (Currently) | ☐ | ☐ | Arthritis | ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ | Heart Disease | ☐ | ☐ | Cramps/Numbness |
| ☐ | ☐ | Circulation | ☐ | ☐ | Metal Implants | ☐ | ☐ | Cancer | ☐ | ☐ | Phlebitis | ☐ | ☐ | Other _____ | | | |
| ☐ | ☐ | Allergies_____ | | | | | | | | | | | | | | | |

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignment. All patients must also sign on reverse.

Signature_____ Date_____

# Quantum Physical Therapy, Inc. Office Policies

Quantum Physical Therapy, Inc. is concerned first with the health and rehabilitation of the patients under our care. We understand payment for services can be difficult under some circumstances. In order to provide services we ask you to read and sign this document.

I hereby acknowledge my responsibility for full payment of this debt and waive my rights of defense under the statute of limitations. I also understand it's my responsibility to obtain any referrals, pre-authorization, benefits and network provider information, and provide them to Quantum Physical Therapy, Inc. I authorize payment of insurance benefits and or settlements covering these services directly to Quantum Physical Therapy Inc.

Medicare Patients Statement to permit payment to the provider for therapy services. I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Administration or its intermediaries or carriers, any information needed for this or related Medicare claim. I request that payment authorized benefits be made on my behalf. This authorization shall apply to the period covering these services.

Quantum Physical Therapy, Inc. will bill Workers Compensation claims with the proper insurance company. Caseworkers will be kept up to date on progress, and any missed appointments. If Workers Compensation denies my claim, Quantum Physical Therapy, Inc. will file with my insurance company. I will be responsible for payments not covered or approved by Workers Compensations.

In the case of legal settlements pending or otherwise regarding this injury, I agree to make the full payment for this debt regardless of the settlement decision. I understand if a legal settlement cannot be reached I will be required to make payments of this debt, in a designated amount of time set by Quantum Physical Therapy, Inc.

Please call to cancel appointments within 24 hours. Failure to do so or no show will result in a $10 fee.

I have read and understand the above policies and agree to adhere by them.

Signature: _____ Date: _____

1. On a scale of 0 (NO PAIN) to 10 (EXCRUTIATING PAIN, REQUIRING HOSPITALIZATION) please indicate your pain level today by circling a number:

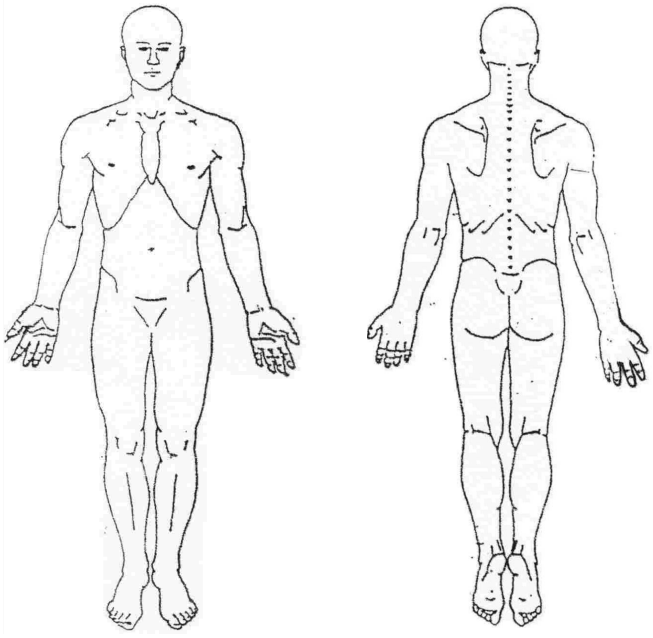
0 1 2 3 4 5 6 7 8 9 10

2. Please circle your pain symptoms:

| | | |
|---|---|---|
| CONSTANT | COMES & GOES | SHIFTS |
| THROBBING | SHOOTING | BURNING |
| SHARP | DEEP ACHING | TINGLING |
| NUMBNESS | LOCALIZED/ONE AREA | |

OTHER_____

Use the diagram below to shade in areas where you feel your symptoms.



3. What relieves your pain?

_____

_____

_____

4. What activities or positions increase your pain?

_____

_____

_____

5. What tests or examinations have been performed (i.e. X-ray, MRI)?

_____

_____

_____

# QUANTUM PHYSICAL THERAPY, INC.

1 Elizabeth Place, West Medical Plaza
Gray Level, Suite A
Dayton, OH 45417
(937) 277-2077 Fax (937) 277-1600


## Patient Compliance Form

Dear Patient,

The therapists at Quantum Physical Therapy, Inc. are here to provide you with the care you need in the best way possible. You have been prescribed visits by your physician to help you recover and get well. It is important for you to be at your appointment for us to provide you with the excellent care you deserve. We are obligated to report your attendance to your physician. We understand weather and other unforeseen events occur that require you to reschedule. When these happen it is very important that you reschedule as soon as possible.

I have read and understand the above information and I agree to make every effort to attend my scheduled appointments.

Patient Signature: _____ Date: _____

**QUANTUM PHYSICAL THERPAY, INC.**
**7271 N. Main Street, Suite 6**
**Dayton, OH 45415-2561**
**Phone: (937) 277-2077**
**Fax: (937) 277-1600**

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION CONCERNING YOU AS A PATIENT CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

**USES AND DISCLOSURES:** We may use and disclose your Protected Health Information (PHI) as follows without your signed authorization.

**Treatment:** Doctors, nurses, and healthcare providers who are administering any medical treatment, lab work as ordered and referrals to other healthcare providers assisting in your care while a patient at this office.

**Payment:** To collect payment on services rendered to you provided by healthcare professionals and facilities.

**Health Care Operations:** To evaluate the quality of care for clinical review and improvement, professional peer review, business management, and accreditation and licensing.

**Disclosures Required by Law:** Judicial settings, law enforcement agencies, and subpoenas by law and health oversight regulatory agencies.

**Emergency Situations:** To avert serious health/safety situations.

**To Medical Examiners:** Coroners or funeral directors to help in performing their duties and for identifying purposes.

**Special Circumstances:** To contact you concerning appointment reminders, treatment alternatives and other health related benefits and services.

**Organ and Tissue Donations:** Upon or proximate to your death to help facilitate in organ and tissue donations.

**Alcohol and Drug Abuse Records:** These records are protected by federal law. This information may not be disclosed without written consent given by you, by court order; or disclosure is made to medical personnel; or in a medical emergency to help aid in the treatment of you.

**YOU HAVE THE FOLLOWING RIGHTS CONCERNING YOUR PHI:**

**Confidential Communications:** To receive confidential information concerning you by alternative means of usual communication. To do this you may be required to contact the office coordinator or sign appropriate consent forms.

**Access**: To inspect or receive a copy of your PHI. To do this you must contact the office coordinator at this office. We are not required by law to grant this request.

**Restrictions:** To request restricted access to all or part of your PHI you must contact the office coordinator at this office. We are not required by law to grant this request.

**Accounting:** To receive an accounting of the disclosures by the office of your PHI. All requests can be no longer than six years from the date of request. In order to obtain an accounting and disclosures you must request in writing to the office coordinator. We are not required by law to grant this request.
**Amendments:** You may ask for an amendment of your PHI if you believe it to be incorrect or incomplete. You must make this request in writing to the office coordinator. We are not required by law to grant this request.

**Copy of this notice:** You have the right to a copy of this notice upon request.

**Complaints:** You may file a complaint at any time with the office coordinator if you feel that your privacy rights have been violated. You may also file a complaint with the U.S. Dept. of Health and Human Services in Washington, D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing your complaint.

**IT IS OUR DUTY AND COMMITMENT, AS REQUIRED BY LAW, TO UPHOLD, PROTECT, AND MAINTAIN THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION.**

**QUANTUM PHYSICAL THERAPY, INC.**
1 Elizabeth Place
West Medical Plaza
Gray Level, Suite A
Dayton, OH 45417-3445
PHONE: 937-277-2077
FAX: 937-277-1600

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**I, _____, authorize the release of my medical records, X-ray results, to Quantum Physical Therapy, Inc.**

**I understand that these records are confidential and will only be released to Quantum Physical Therapy, Inc. with my consent and witnessed signatures for continuing care. I understand I have a right to revoke this authorization in writing at any time, and also my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. By signing below, I hereby consent to the release of my medical records to Quantum Physical Therapy, Inc.**

**Patient's Name: (F)_____(MI)_____(L)_____**

**D.O.B.:_____/_____/_____ S.S. Number:_____-_____-_____**

**Signature of Responsible Party:_____**

**Witnessed:_____**

**Date Signed:_____/_____/_____** (Authorization effective one year from date signed)

**Date of Records To Be Sent:_____/_____/_____ to _____/_____/_____**

**Please Send Records From:_____**

**Street Address:_____**

**City:_____ State:_____ ZIP Code:_____**

**Phone Number: ( )_____-_____**

**Fax Number: ( )_____-_____**

**Requesting the following information:**
**( ) X-ray, MRI, CT Reports**
**( ) Pathology Reports**
**( ) Copies of Pertinent Information**
**( ) Progress Notes**
**( ) Consultations**