TUDOR PHYSICAL THERAPY CENTERS
PATIENT INFORMATION PACKET

Date: _____

Patient/Insurance Information:

Name: _____
Phone Number: _____ E-mail address: _____
Date of Birth: _____ Social Security Number:_____
Emergency Contact: _____ Phone Number: _____
Workers Comp. Claim: Y or N Date of injury: _____Claim#_____
Motor Vehicle Claim: Y or N Date of Injury: _____Claim #_____
Have you received Physical Therapy in the past 12 months: Y or N?
If yes, how many visits? _____
Are you currently receiving home health services? Y or N Agency: _____
****

☐ **WebPT demographics are attached and reviewed.** **If box is not ✓ please fill out below:**

Address: _____City:_____State:_____Zip:_____
Gender: M or F Marital Status:_____ Student: Yes or No
Primary Insurance: _____ Policy ID#_____
Secondary Insurance: _____Policy ID#:_____
Referring Doctor Name: _____ Phone: _____
Custody Status if pediatric?_____
Attorney Name & City: _____
Employer Name & City: _____
Job Title: _____Full time status ◯ Part time status ◯
****

Health History:

Please circle all that apply:

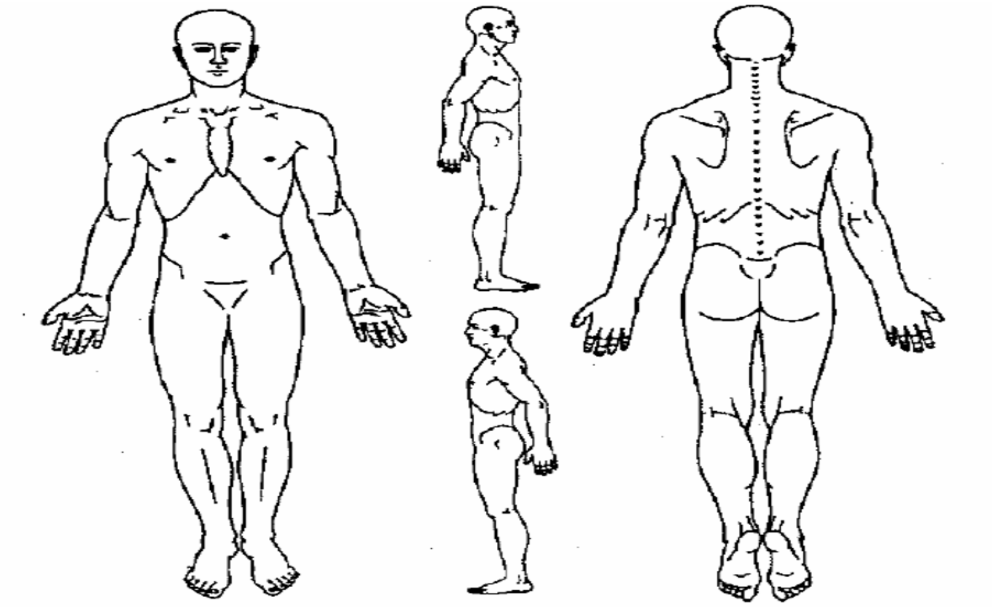
Stroke Diabetes Arthritis TB Cardiac Lung Problems
High BP Cancer Headaches Fractures Seizures Autoimmune Disorder
Asthma Vision/Hearing Problems Sinus problems Osteoporosis
How were you injured: _____Date of Injury:_____
Was Surgery Performed? Y or N If Yes/When:_____Surgeon :_____
List any surgeries/hospitalizations related to your problem:_____
_____
List any Medications presently taking:_____
List any allergies:_____
Do you have a pacemaker? Y or N
(Females only) Is there a chance of pregnancy? Y or N

Patient Name: _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



NAME _____ DATE _____

No Pain |—————————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

Please list pain level based on Pain Scale 0-10:_____

Please list pain aggravating activities: _____

_____

Please list pain alleviating activities:_____

_____

What are your goals for therapy?_____

Patient Name:_____

Consent to Treat and Insurance Authorization:

1.) I have presented myself for physical, occupational, and/or speech therapy treatments to this facility and consent to diagnostic procedures and care provided by my therapist/assistant.
2.) I have the right to have diagnosis, treatment, benefits, risks, alternatives, and prognosis explained to me.
3.) I have the right to refuse any treatment or procedures.
4.) I understand that medicine is not an exact science, and that no guarantee or warrantee can be made to me regarding the results of any treatment to this facility.
5.) I understand that information from my record kept by this facility may be used for medical, administrative, and/or facility approved purposes with my personal identity not being revealed.
6.) I have the right to obtain physical, occupational, and/or speech therapy at the facility of my choice, when it is recommended by my physician.

Insurance:

As a courtesy, TuDor Physical Therapy Centers will bill your insurance. I fully, accept responsibility for any charges not covered by my insurance or its intermediaries. I hereby authorize TuDor to furnish the completed information to my insurance carrier or its intermediaries regarding services rendered. I also hereby authorize TuDor to submit a claim to my insurance carrier or its intermediaries for all services rendered by the therapist and authorize and direct my insurance carrier or its intermediaries to issue payment check directly to TuDor. If at any time, for any reason, I am unable to pay, "when due" and if any action is brought to enforce collection, the laws of the State of Ohio shall govern and "TuDor Physical Therapy Centers" shall be entitled to recover all costs of collections, including but not limited to, interest rate of 18% per annum from the day of default, and court costs and suit fees, including attorney fees, up to 50%.

Attendance Agreement:

Your rehabilitation program is an ongoing process that requires regular attendance to be effective. If you do not attend scheduled sessions, you will be hindering your progress. **Please call** if you must cancel and provide a 24 hour notice. All cancellations and no-shows are recorded in the patient's chart. If you do not show for three appointments, we may require you to follow up with your physician before returning to therapy in order to determine if further services are recommended. Missing sessions may also affect your disability status, and/or disability benefits. TuDor holds the right to charge a fee of $25.00 to appointments that are not cancelled with in the 24 hour window. Your insurance will not pay for this charge, and it will be your responsibility. *We understand there are unforeseen circumstances that may not allow you to give a 24-hour notice, the $25 fee at that time, will be at the discretion of management.

I have read and fully understand the above general information regarding attendance, and consent to treat and insurance authorization.

Print Name: _____Signature: _____ Date: _____

Patient Release of Medical Records/Health Insurance Portability and Accountability Act: HIPAA

I, _____, allow TuDor Physical Therapy Centers to receive, send, or fax my records to/from my physician of record, DME companies to obtain equipment necessary for my care, and to home healthcare and other health care companies that TuDor is contracted with, if it is necessary for my care. **I have reviewed and understand TuDor's Notice of Protected Health Information Practices**. I understand and consent to the uses and disclosures of my health information according to the articles outlined in the **Notice of Protected Health Information Practices.**

Print Name: _____Signature:_____ Date: _____