3605 College Ave
Conway, AR 72034
Phone (501) 327 - 2235
Fax (501) 327 - 1601

McMASTER
PHYSICAL THERAPY CLINIC

57 S Broadview St
Greenbrier, AR 72058
Phone (501) 679 - 1295
Fax (501) 679 - 6806

Patient's Name_____ Age_____ Date of Birth _____
last first middle initial

Social Security Number _____ Marital Status: □ Single □ Married □ Widowed □ Divorced

Address_____ Email _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Employer _____ Occupation_____ Business Phone _____

If married, spouse's name _____ Date of Birth _____

Social Security Number _____ Spouse's Employer _____

Occupation _____ Business Phone _____

In case of an emergency, call _____Phone_____ Relation _____

If Patient is a Minor, Please Complete the Following

Father's Name _____ Social Security Number _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Occupation _____ Business Phone _____

Mother's Name _____ Social Security Number _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Occupation _____ Business Phone _____

Financial Agreement

As a courtesy, we attempt to verify insurance benefits for our patients. This in no way guarantees that your insurance company will pay exactly as quoted, since they will not guarantee benefits over the phone. This facility is not responsible for attaining or being aware of your policy requirements for referrals from your primary care physician, pre-certifications, or limits with your specific policy. We urge you to familiarize yourself with your health care benefits. Your insurance policy is a contract between you and your insurance company; therefore the responsibility lies with you, the patient, to be aware of this information. We will assist you if necessary to help you obtain this information.
I understand I will be billed and agree to pay any co-pays, deductible, or balances unpaid by my insurance provider.

Signed _____ Date _____|_____

Assignment of Benefits

I request payment and assign benefits of authorized insurance, prepaid medical plan, Medicare or Medicaid benefits to McMaster Physical Therapy Clinic, Inc. for any services provided. A photocopy of this assignment is to be considered as valid as the original.

Signed _____ Date _____|_____

MEDICAL INFORMATION

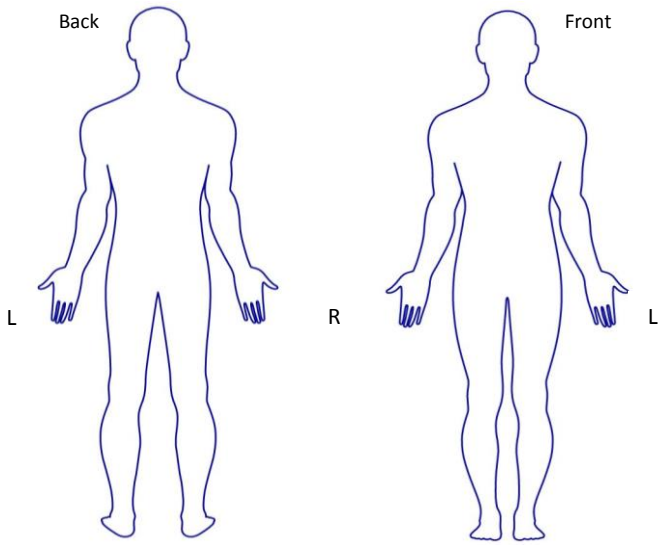
Primary Complaint _____

Secondary Complaint _____

Have you had physical therapy this year? Y N
Have you had X-rays, MRI or other tests for this condition? Y N

Findings? _____

Shade areas of pain:



Describe your pain. Please check all that apply:

□Dull Ache □Burning □Heavy Twinge
□Deep Ache □Throbbing □Stabbing
□Squeezing □Nagging □Sharp
□Numbness □Tingling □Sore
Other _____

Rate your pain: *None* 0 1 2 3 4 5 6 7 8 9 10 *Worst possible*

Date symptoms started _____

What makes your pain better? _____

What makes your pain worse? _____

Do you feel you are getting: better worse staying the same

Rate your functional ability (%):
Completely incapacitated 0 10 20 30 40 50 60 70 80 90 100 *Prior level of function*

What are **your personal** goals for physical therapy? (please check all that apply)

□Decrease pain □Improve motion □Learn proper body mechanics
□Increase strength □Improve posture □Improve sleep
□Return to work □Return to sorts, hobbies, recreation
Other: _____

Please list ALL medications you are taking (prescribed, over-the-counter, supplements, etc.).

Medicine	**Dosage**	**Frequency**	**Route (Pill, Patch, Liquid, etc.)**

How often do you exercise?

□Daily
□1-2 days per week
□3-4 days per week
□Less than 1 day per week

What exercise do you do?

□Walk □Jog/Run
□Gym □Tennis
□Swim □Golf
□Biking □Housework
Other: _____

DATE: _____ **INITIAL: _____**

MEDICAL INFORMATION

Do use tobacco? Y N □ Dip/Snuff □ Cigarettes Cans/Packs per day: _____

Please check all that apply to you (previously or currently) : Comments:

□Anemia _____
□Asthma _____
□Cancer _____
□Chemical dependency (e.g. alcoholism) _____
□Constipation/diarrhea _____
□Depression _____
□Diabetes _____
□Emphysema _____
□Epilepsy _____
□Heart problems _____
□Hepatitis _____
□High Blood Pressure _____
□Insomnia _____
□Kidney disease _____
□Loss of bowel/bladder control _____
□Multiple Sclerosis _____
□Pacemaker _____
□Pregnant/possibility of pregnancy _____
□Rheumatoid Arthritis _____
□Other arthritic problems _____
□Stroke _____
□Surgery (within last 2 years) _____
□Thyroid problems _____
□Tuberculosis _____
□Other _____

Is there anything else you think we should know, but did not ask? Yes No

If yes, please specify: _____
_____
_____
_____

Whom can we thank for this referral? _____ □ Website □ Yellow Pages □ Other _____

DATE: _____ **INITIAL: _____**

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Welcome to **McMaster Physical Therapy Clinic.** We are happy that you have chosen us for your rehabilitation needs. We will do everything in our power to make your physical therapy experience a positive one.

Statement of Rights and Responsibilities

You have the right to:

1. Be treated with dignity, courtesy, and respect, and have your property treated with respect.
2. Receive competent, quality services regardless of age, race, color, national origin, religion, sex, disability, or any other category protected by law.
3. Expect McMaster Physical Therapy to coordinate your care through regular communication with your physician, caregivers and other providers.
4. Have visitors attend therapy sessions at times if approved by therapist and visitation would not interfere with therapy session.
5. Receive an explanation of any responsibilities you or your family/caregiver may have in the care process.
6. Refuse treatment to the extent permitted by law and to be informed of the consequences of this right.
7. Request a review of the information practices utilized by McMaster Physical Therapy Clinic, Inc. regarding the use and disclosure of your Protected Health Information. A complete description of these practices is available on the premises for your review at any time. You may request a review of this description prior to signing this statement. You may request restriction on uses and disclosures of your Protected Health Information in order to carry out treatment, payment, and other related healthcare operations, but McMaster Physical Therapy is not required to agree to any restrictions requested.

You have the responsibility to:

1. Provide complete and accurate information about your health and for reporting effects of physical therapy treatment.
2. Attend scheduled therapy sessions; participate in treatment activities and to be compliant with home exercise programs outlined by the treatment plan given to you.
3. Be considerate of the rights of other McMaster patients while participating in your rehabilitation program.
4. Notify the clinic as soon as possible concerning cancellation of scheduled appointment to allow adequate time to reschedule other patients.
5. Pay any balance not covered by your insurance, including co-pays, co-insurance, or deductibles. You will be billed and expected to pay the balance.

*** I have read and understand the above Patient Rights and Responsibilities.**

Signature: _____ Date: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I understand that my Protected Health Information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This Protected Health Information relates to my past, present, or future physical or mental health or condition. This information identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my Protected Health Information by McMaster Physical Therapy Clinic, Inc. for the purpose of diagnosing or providing treatment to me. I voluntarily consent to receive therapy services provided by River Valley Therapy & Sports Medicine, Inc.

Signature: _____ Date: _____

I consent to the use or disclosure of my Protected Health Information by McMaster Physical Therapy Clinic, Inc. for the purpose of obtaining payment of my health care bills from authorized insurance, prepaid medical plans, Medicare or Medicaid to McMaster Physical Therapy Clinic, Inc.

Signature: _____ Date: _____