Snyder Physical Therapy and Sports Rehab

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Appointment reminder: Yes / No ☐Call ☐Text ☐E-mail

E-mail: _____ D.O.B: ____/____/____

Sex: M / F Social Security #: _____-_____-_____ DL #:_____ ST: _____

Marital Status: S M D W Employment Status: ☐ Full Time ☐ Part Time ☐ Self Emp ☐ Retired ☐ Student ☐ None

Employer Name: _____ Address: _____ Telephone #: _____

Parent / Legal Guardian Name:_____ (Only required if under the age of 18)

Date of Injury: _____ Date of Surgery: _____

☐ **Commercial Insurance** ☐ **Medicare** ☐ **Workers Comp** ☐ **Self Pay** ☐ **Other**

1st Insurance Company: _____ Employer (if different than above): _____

Insured Name: _____ Address: _____

D.O.B: ____/____/____ Rel: _____ Telephone #: _____

2nd Insurance Company: _____ Employer (if different than above): _____

Insured Name: _____ Address: _____

D.O.B: ____/____/____ Rel: _____ Telephone #: _____

Emergency Contact Name: _____ Telephone #:_____Rel: _____

Referring Doctor: _____ **Date of Order:** _____

Have you had Physical Therapy this calendar year: ☐Yes ☐No Where: _____

Have you had Home Health this calendar year: ☐Yes ☐No Discharge Date: _____

How were you referred to our clinic: Doctor Self Family Friend Facebook Internet Other _____

I understand and acknowledge all information above to be true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

----------For Office Use Only----------

Appt	Date	Time	Therapist	ACCT#	Intake Initials

Initial Self-Evaluation

Name _____ **Height** _____ **Weight** _____ **DOB** _____

Date of injury/onset _____ Body Part _____ Right / Left

Primary symptoms _____

Cause of symptoms _____ Work Related? Yes/No

Activities you are unable to do because of your symptoms _____

_____

Currently working? Yes/No Employer _____ Occupation _____

Job requirements (ie sitting, walking, operating equipment, etc.) _____

Participation in sport or exercise _____

Have you had similar symptoms before? Yes/No Did you receive treatment? Yes/No

If yes, please explain _____

What makes symptoms better? _____

What makes symptoms worse? _____

Does the time of day effect symptoms? Yes/No Explain _____

Current symptom description (check all that apply)

☐ improving ☐ worsening ☐ staying the same ☐ constant ☐ intermittent ☐ weakness ☐ unstable

☐ dull/ache ☐ shooting ☐ sharp/stabbing ☐ burning ☐ numbness ☐ tingling ☐ stiffness

Additional _____

Previous treatment for this condition (please check all that apply and give dates/results)

☐ Physical Therapy _____ ☐ Massage _____ ☐ Chiropractic _____ ☐ Other _____

☐ Surgery (for this problem) _____ ☐ Medication/Injections (for this problem) _____

☐ X-ray _____ ☐ MRI _____ ☐ CT/CAT _____ ☐ Other _____

Fall History (please check all that apply)

☐ Injury as a result of a fall in the last year ☐ Two or more falls in the last year ☐ No falls in the last year

Personal Medical History (please give details including related medications, if applicable)

☐ Allergies (If yes) please list _____

☐ Diabetes
☐ Heart disease
☐ Pacemaker/defibrillator
☐ Lung disease
☐ Muscular disease
☐ High blood pressure
☐ Cancer
☐ Currently pregnant
☐ Head trauma/seizures
☐ Dizzy spells or fainting
☐ Head, neck, spine injury or surgery
☐ Stroke
☐ Smoking
☐ Shoulder, hip, knee, ankle injury/surgery
☐ Any fractures
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Vision or hearing problems
☐ Autoimmune disorder
☐ HIV/AIDs
☐ Parkinson's Disease
☐ Dementia
☐ Fibromyalgia

Medication List

1. _____
2. _____
3. _____
4. _____
5. _____

☐ Other _____

Patient Signature: _____ Date: _____

Consent for Treatment/Authorization

I _____ authorize Snyder Physical Therapy and its staff to perform the physical therapy treatment ordered by my referring physician. I have been informed of the reasons for the treatment/procedures along with the expected benefits, risks, possible alternative methods of treatment and possible consequences involved. I also certify that no guarantee or assurance has been made as of the result of outcomes that may be obtained. ____INITIALS

Release of Information

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician and/or the provider who referred to here. For WORKERS COMPENSATION rehab nurse, case manager, attorney, employer, and/or other assignees as it relates to my treatment. _____INITIALS

Direct Payment to Snyder Physical Therapy and Sports Rehab

I request that payment of any insurance or other benefits be made directly to Snyder Physical Therapy on my behalf for and services provided to me. I authorize the holder of medical and other information about me to release to Medicare and its agents, and insurance company, and third party payer, state medical assistance agency or and other governments private payer responsible for paying such benefits, and information needed to determine these benefits or benefits for related services. _____INITIALS

Missed Appointments

Attending your scheduled appointment is critical to successful treatment and recovery from you injury. Cancelling your appointment with less than 24 hours' notice or especially NO SHOWING for your appointment(s) is not only detrimental to your treatment and recovery, it also prevents us from scheduling more appropriately for other patients. For WORKERS COMPENATIONS, all absences and excessive tardiness will be reported to your physician, employer, case manager and adjustor. Chronic non-compliance will result in discharges from your therapy, and a report reflecting non-compliance forwarded to your physician, employer, case manager and adjustor. _____ INITIALS

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. _____ INITIALS

Release of Personal Health Information

Persons who are involved in your care (spouse, children, friends, etc.) may inquire about your treatment, appointments, billing, medical records, etc. Please list with whom we may share your information.

Name: _____ Phone #: _____ Rel: _____

Name: _____ Phone #: _____ Rel: _____

Name: _____ Phone #: _____ Rel: _____

I have read, understand and agree to the above Consent of Treatment/Authorization, Release of Information, Direct Payment, Missed Appointments, Notice of Privacy Practices and Release of PHI.

Signature: _____ Date: _____

Relationship to Patient: _____ Patient's DOB: _____

Witness: _____ Date: _____

Snyder Physical Therapy and Sports Rehab

Cancellation Policy

Our goal at Snyder PT and SR is to provide high quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call us as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment
If you need to cancel your appointment, please call us at 325-436-0500 between the hours of 8:00 am and 5:00 pm. If necessary, you may leave a detailed voicemail message outside of normal business hours. We will return your call as soon as possible.

Late Cancellations / No-Shows
A cancelation is considered late when the appointment is canceled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without canceling.

Cancellations / No-Shows Follow Up
We know your time is valuable, and ours is too. Out of respect for our staff and our other clients, we ask that you give us at least 24 hours notice if you need to cancel an appointment.

- The first time a client misses an appointment, we will make a note in your file.
- The second missed appointment may result in you being removed from our schedule to allow other patients to have that appointment time.

Patient Signature: _____ Date: _____

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

Your confidential healthcare information may be released to:

- Other healthcare professionals or other treating physicians for the purpose of providing you with quality healthcare.
- Your insurance carrier and/or treating vendor for the purpose of the practice receiving payment for the providing you with needed healthcare services.
- Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Other healthcare providers in the event you need emergency care.
- A public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Certain parties only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

YOU MAY BE CONTACTED BY Snyder Physical Therapy TO REMIND YOU OF ANY APPOINTMENTS, HEALTHCARE TREATMENT OPTIONS OR OTHER HEALTH SERVICES THAT MAY BE OF INTEREST TO YOU. IF YOU ARE NOT HOME AND/OR UNAVAILABLE, WE MAY LEAVE APPOINTMENT INFORMATION ON YOUR ANSWERING MACHINE OR IN A MESSAGE LEFT WITH THE PERSON ANSWERING THE PHONE.

We may use and disclose limited protected health information about you by having you sign in when you arrive at our office. We may also call out you name when we are ready to see you.

You have the right to restrict the use of your confidential healthcare information. However, Snyder Physical Therapy may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

You have the right to receive confidential communication about your health status.

You have the right to review any/all portions of your healthcare information upon written request within the timeframes set by law.

You have the right to request changes be made to your healthcare information

You have the right to know if certain parties have accessed your confidential healthcare information and for what purpose.

You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

Your confidential healthcare information may not be released for any other purpose that which is identified in this notice.

Snyder Physical Therapy is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients, upon request with a list of duties or practices that protect confidential healthcare information.

Snyder Physical Therapy will abide by the terms of this notice. The practice reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Any changes to this notice will be posted in our practice within 30 days of making any changes.

You have the right to file a complaint to Snyder Physical Therapy if you believe your rights to privacy have been violated: please mail your complaint to the facility, in care of Daniel Burk, owner.

All complaints will be investigated. No personal issue will be raised for filing a complaint. For further information about the Privacy Notice, please contact: Daniel Burk, owner at 325-436-0500

Notice effective 08/22/2024