CUTTING EDGE PHYSICAL THERAPY PATIENT DATA SHEET

First: MI: Last:

Date of Birth: Age: Gender: Male ☐ Female ☐

Mailing Address: ______________________
____
____

Physical Address: ______________________
____
____
____

May we send you text messages relating to your care with us? ☐ Yes ☐ No

By providing your text number below, you understand that text messages will NOT be sent via secure, encrypted format.

OK To Call	OK To Text	Phone:	Best Time To Call
☐	☐	Home: ____________	____________
☐	☐	Work: ____________	____________
☐	☐	Cell: ____________	____________

SSN:

May we send you emails relating to your care with us? ☐ Yes ☐ No
By providing your email address below, you understand that emails will NOT be sent via secure, encrypted format.
Email: ______________________

Preferred language:
Intepreter required? ☐ Yes

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status: ☐ Full-Time ☐ Part-Time ☐ None

Date of Injury: __________ Referring Physician: ______________________

Injury Area: __________

Auto or Work Accident: __________

EMPLOYMENT STATUS

Employment Status:
☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: Occupation:

Address:

Phone:

Employer: Occupation:

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name: Holder's Birth Date:

Policy or Certificate #: Group #:

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: Holder's Birth Date:

Policy or Certificate #: Group #:

Policy Holder's Employer:

Are you receiving or have you received Home Health Services? ☐ Yes ☐ No

Are you receiving or have you received other therapy services? ☐ Yes ☐ No

How did you hear about us?

☐ Physician	☐ Hospital	☐ Marketing Ad - Print
☐ Employer	☐ Cross Referral	☐ Marketing Ad - TV
☐ Case Manager	☐ Friend - Word of Mouth	☐ Marketing Ad - Billboard
☐ Former Patient	☐ Attorney	☐ Marketing Ad - Direct Mail - Email
☐ Adjustor	☐ Self	☐ Marketing Ad - Facebook
☐ School	☐ Screens - Open Houses	☐ Marketing Ad - Other

Specify if other : ______________________________

Note: Please provide us with the most updated information down below.

CONTACTS

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

____ ____________
Signature of Patient Date

Please Initial Each as Applicable:

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C#	Name	A/C Type	Office

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
CUTTING EDGE PHYSICAL THERAPY
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. ________________

TREATMENT OF MINORS:

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. ________________

LIABILITY

I know and agree that: CUTTING EDGE PHYSICAL THERAPY
is not responsible for loss or damage to personal valuables.

____

WAIVER AND RELEASE

I hereby release, discharge and acquit:
CUTTING EDGE PHYSICAL THERAPY
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. ________________

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to:
CUTTING EDGE PHYSICAL THERAPY
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

____

NOTICE OF PRIVACY

I acknowledge receipt of Notice of Privacy Practices. ________________

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature____________________ Witness Signature ____________________

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of Cutting Edge Physical Therapy This form must be completed in its entirety and must be provided to Cutting Edge Physical Therapy prior to initiation of therapy services.

Cutting Edge
PHYSICAL THERAPY

MEDICAL HISTORY INTAKE FORM

Name:___________________________________ Date:________________________

Occupation:_______________________________

Presently working: □Yes □ No Date of last day worked:____________

Date of Injury:____________

Cause of Injury:___________________

Referring Physician:___________________

Primary Care Physician:____________________

THERAPY HISTORY

What is your reason for attending therapy? _________________________________

Because of your injury, what specific activities are you having difficulty with?

1. ____
2. ____
3. ____

What are your personal goals/outcomes you hope to achieve from therapy?

1. ____
2. ____
3. ____

Have you had prior physical therapy for your current condition? □**Yes** □**No**

If yes, where?____

How long were you in therapy and what where the results:
____

Have you had prior physical therapy this calendar year? □**Yes** □**No**

Was your therapy received at: □Hospital □Outpatient center □Home Health
How long was your physical therapy:_______________

Describe your health: □Excellent □Good □Fair □Poor

Are you allergic to latex? □Yes □No

Do you smoke or use tobacco? □Yes □No If yes, how much?__________

If female, are you pregnant? □Yes □No If yes, number of weeks_____

Allergies: Latex: □Yes □No **Bees: □Yes □No** Others: ___________

Do you wear glasses/contacts: □Yes □No

Have you fallen in the past year? □Yes □No

If yes, how? ____

Did you sustain an injury due to your fall? □Yes □No

Do you have "flu" like symptoms (I.E. fever, coughing)? □**Yes** □**No**

Do you have any cuts, lesions or wounds? □**Yes** □**No**

Medications (List all medications that you are currently taking):
____
____
____
____

List any specialists involved in your care: ____
____

Medical History: (check all that apply)

	Yes	No		Yes	No
Amputation			Hearing impairment		
Anemia			Hemophilia		
Arthritis			High blood pressure		
Asthma			Holter Monitor – Currently Wearing?		
Blood Thinners			Kidney problems		
Cancer			Low blood pressure		
Cardiac/Heart problems			Metal Implants		
Carpal Tunnel			Multiple Sclerosis		
Cerebral Palsy			MRSA (Methicillin resistant Staph Aureus)		
COPD □controlled □uncontrolled			Osteoporosis		
Depression			Pacemaker		
Diabetes			Polio		
Dizziness			Respiratory problems		
Emphysema			Seizures		
Epilepsy			Stroke		
Fractures			Substance abuse		
Headaches			Thyroid		
Hepatitis/HIV			Other:		

Surgical History: (List all surgeries)
Surgery type: **Date:**

________________________________ ________________
________________________________ ________________
________________________________ ________________
________________________________ ________________
________________________________ ________________
________________________________ ________________

During the past month, have you been bothered by feeling down, depressed or hopeless? □**Yes** □**No**

____
Signature of Patient

____
Reviewed By

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CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE

I, ______________________________________, hereby consent to allow Cutting Edge Physical Therapy and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

____   _________________________

Participant Name   Date

____

Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, ___________________________________, hereby consent and authorize Cutting Edge Physical Therapy and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

____   _____________________

Participant Name   Date

____

Parent/Legal Guardian (If Participant is a Minor)