Cleveland Physical Therapy Associates

Our mission is "To Share the love of Jesus Christ through
Compassionate Care and Excellence in Orthopedic Rehabilitation."

PATIENT INFORMATION/PLEASE COMPLETE ALL SECTIONS

Patient Name: _____ Social Security #_____ Date of Birth: _____

Mailing Address: _____City: _____State: _____ Zip: _____

Home Phone: (____) _____Cell Phone:(____) _____Work Phone:(____) _____

Email Contact: _____ Marital Status: _____ Sex: **F_M_** Nick Name: _____

Emergency Contact Name: _____Tel.#:(_____) ____ _____

Employer: _____ Street Address: _____
City:_____State:_____Zip:_____Phone:(____)_____

Referring Physician: _____ Primary Care Physician: _____

Are you a student? **Y N** Have you received previous Physical Therapy or Home Health? **Y N** if yes, Where/When?_____

Date of current Injury/Onset: _____ Work Related Injury? **Y N** Automobile or Personal Injury? **Y N**

Please explain how injury occurred: _____

_____

Attorney Representation? **Y N** If yes, Attorney info.:_____

INSURANCE INFORMATION

*****CO-PAY/CO-INSURANCE WHEN APPLICABLE ARE EXPECTED UPON ARRIVAL OF YOUR VISIST*****

Primary Carrier:_____Address:_____

Effective Date:_____Group#:_____Policy#:_____

Policy Holder: _____DOB: _____Sex:___Relationship to Patient:_____

Secondary Carrier:_____Address:_____

Effective Date:_____Group#:_____Policy#:_____

Policy Holder: _____DOB: _____Sex: ___ Relationship to Patient: _____

Safety: For the protection of your children and to allow our staff to devote their undivided attention to the care and treatment of our patients, children are prohibited in the treatment area. Please make child care arrangements prior to your scheduled appointment.

I have read and fully understand the above policies.

Patient Signature: _____Date: _____

Cleveland Physical Therapy Associates

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Cleveland Physical Therapy and Associates, Inc. or disclosed for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
The Notice of Privacy Practices is displayed and available at our front desk and you are encouraged to review the privacy practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this form.

Requesting a Restriction on the Use of Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. Cleveland Physical Therapy and Associates, Inc. may or may not agree to restrict the use or disclosure of your protected health information. I Cleveland Physical Therapy and Associates, Inc. agrees to your request, the restriction will be binding on the practices. Use or disclosure of protected information in violation of agreed restriction will be a violation of the privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Cleveland Physical Therapy and Associates, Inc. reserved the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and acknowledge that I have been given the opportunity to review Cleveland Physical Therapy and Associates, Inc. Notice of Privacy Practices. I give my permission to Cleveland Physical Therapy and Associates, Inc. to use and disclose my health information in accordance with it.

_____ _____
Name of Patient (Please Print) Signature of Patient Representative

_____ _____
Patient Signature Relationship of Patient Representative to Patient

Cleveland Physical Therapy Associates

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION
PAYMENT AGREEMENT

I authorize and direct my Insurance Carrier (s) and / or Attorney to submit payment directly to CLEVELAND PHYSICAL THERAPY ASSOCIATES for services rendered. I guarantee to pay any co-pay or coinsurance left unpaid by the applicable carrier as my policy decrees.

I further authorize CLEVELAND PHYSICAL THERAPY ASSOCIATES to release any requested information to my Insurance Carrier (s) and or Attorney at their request necessary for processing my claims.

_____ _____

Patient / Guardian Signature Date

_____ _____

CPTA Representative Signature Date

Cleveland Physical Therapy Associates

Waiver of Liability for Accidents and Injuries

I (and the undersigned parent or legal guardian, if I am a minor) recognize the dangers inherent in sports and fitness activities. I further recognize that Cleveland Physical Therapy and Associates, Inc. cannot be responsible for accidents or injuries resulting from the mishandling or improper use of any equipment or machines. By the execution of this Agreement, I (and my parent or legal guardian, if I am a minor) hereby remise, release and forever discharge Cleveland Physical Therapy and Associates, Inc. its officers, directors, employees, or agents, and their respective successors and assigns, of and from any and all claims, demands, rights and causes of action of whatsoever kind and nature, arising from, and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries and the consequences thereof resulting, and to result from any accident or injury which has happened or may happen to me in the course of my use of the facilities in the complex. Furthermore, the undersigned parent or guardian, if I am a minor, does expressly stipulate and agree to Indemnify and hold harmless Cleveland Physical Therapy and Associates, Inc. its officers, directors, employees, or agents, and their respective successors and assigns against damage or loss from any and all claims, demands or actions in law or in equity that may hereafter be made or brought by the minor member or by anyone on behalf of the minor member for the purpose of enforcing a claim for damages on account of death or any injuries to personal property sustained as a consequence of the above-stated activities, and the parent or guardian hereby waives all rights or exemption both as to real and personal property to which he or she may be entitled under the laws of this or any other state as against such claim for reimbursement or indemnity.

IN NO EVENT SHALL CLEVELAND PHYSICAL THERAPY AND ASSOCIATES, INC. BE LIABLE TO ME OR ANY OTHER PERSON CLAIMING THEREUNDER FOR ANY LOSS PROFITS OR OTHER CONSEQUENTIAL DAMAGES RESULTING FROM AN ACCIDENT OR INJURY OCCURRING FROM OR ARISING OUT OF THE USE OF THE FACILITIES OF THE COMPLEX.

_____
Date

_____
Printed Name

_____
Signature

_____
Parent or Legal Guardian Signature

Name: _____

PATIENT HISTORY

Please circle Yes or No. If yes, please explain.

Have you ever been diagnosed with any of the following?

DISEASES

Cancer	Yes	No	_____
Diabetes Mellitus	Yes	No	_____
High Blood Pressure	Yes	No	_____
Arthritis	Yes	No	_____
Osteoporosis	Yes	No	_____
Kidney Disease	Yes	No	_____
Seizures	Yes	No	_____

MEDICAL CONDITIONS

Heart disease:	(Angina/Chest pain)	Yes	No	_____
	(Stroke)	Yes	No	_____
	(Pacemaker)	Yes	No	_____
Lungs	(Breathing problems)	Yes	No	_____
Headaches	(Migraine)	Yes	No	_____
Skin Ulcers		Yes	No	_____

CURRENT HEALTH HISTORY/CHANGES

Unexplained nausea/vomiting	Yes	No	_____
Unexplained fever/chills, night sweats/pain	Yes	No	_____
Unexplained weight loss	Yes	No	_____
Changes in bowel or bladder function	Yes	No	_____
Dizziness	Yes	No	_____
Numbness or tingling	Yes	No	_____
Changes in appetite	Yes	No	_____
Difficulty swallowing	Yes	No	_____
Frequent Falls	Yes	No	_____
Urinary tract infection	Yes	No	_____
Depression/stress	Yes	No	_____
Are you currently pregnant?	Yes	No	_____
Do you have any allergies?	Yes	No	_____
Are allergic to Latex?	Yes	No	_____

Do you have any problems with the following?

Hearing	Yes	No	Communication	Yes	No
Speech	Yes	No	Reading	Yes	No
Vision	Yes	No	Writing	Yes	No

SURGICALHISTORY__

_____

_____

MEDICATIONS

_____

_____

SOCIAL HISTORY

Alcohol Yes No _____ times per week · Smoking Yes No _____ how many per day?

Tobacco Yes No _____ How much daily?

PHYSICAL THERAPY HISTORY

_____

_____

Name: _____

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

KEY

/// Stabbing	XXX Burning	000 Pins and Needles	= = = Numbness	ZZZ Aching