



PATIENT INFORMATION FORM

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ First Name _____

Relationship _____ Phone _____

Employer

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Problem

Problem Description _____

When Did Symptoms Begin _____ Date of Surgery _____

Last Physician Visit _____ Referred By _____

Primary Insurance

Insurance _____ Deductible _____

Member ID _____ Max Benefit _____

Group # _____ CoPay _____ Coinsurance _____

Subscriber _____ Subscriber Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

Member ID _____ Max Benefit _____

Group # _____ CoPay _____ Coinsurance _____

Subscriber _____ Subscriber Date of Birth _____

I authorize release of information requested by my insurance plan for payment. I understand that I am financially responsible for any balance due. I agree to comply with the terms and conditions as outlined on the Patient Registration Form. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature _____ Date _____



NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

- 1) I hereby acknowledge that I received a copy of this clinic's **Notice of Privacy Practices**.
- 2) I would like to receive a copy of any amended Notice of Privacy Practices by email: YES or NO

Email Address: _____

Signature _____ Date _____

LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

- 3) I authorize Bratton Physical Therapy to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes (circle one):

Home Answering Machine/Voicemail	Yes	No
Work Answering Machine/Voicemail	Yes	No
Cell Phone/Voicemail	Yes	No
Spouse	Yes	No
Parent	Yes	No
Other Individuals Who May Answer Phone (such as fiancé, sister, brother, etc.)	Yes	No

List Specific Exclusions Here _____

Signature _____ Date _____

Print Name _____

If Not Signed by Patient, Please Indicate Relationship _____

Patient Name _____ Witness _____

For Office Use Only

Signed Form Received by _____

Acknowledgement Refused Efforts to Obtain _____

Reason for Refusal _____



MEDICAL HISTORY

Patient Name _____

List Any Medications You Are Currently Taking (If You Have A List, We Can Copy It)

List Any Medical Conditions (i.e. Hypertension, Diabetes, etc.)

List Any Past Surgical Procedures



NEXT SCHEDULED DOCTOR APPOINTMENT NOTICE

We ask that you give us advance notice of your next scheduled appointment with the physician who prescribed you physical therapy. The therapist needs this notice in order to create an updated report of your progress.

If you are called in by your physician for an unexpected appointment, please give us notice if possible.

DATE OF NEXT SCHEDULED DOCTOR APPOINTMENT _____

Patient Signature _____ Date _____

PHOTO AND PROMOTIONAL RELEASE

I hereby consent to be interviewed, recorded, photographed, videotaped or filmed by representatives of Bratton Physical Therapy for purposes of publication, display or broadcast (print, web, digital display, and all other forms of media). I agree that such interviews, recordings, articles, quotes, photographs, films, audio or video and/or reproductions of same in any form are the property of Bratton Physical Therapy and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

I hereby release Bratton Physical Therapy, its affiliates, employees, representatives, and agents from any and all claims, demands, costs, and liability that may from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed, recorded, photographed, videotaped, or filmed.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Patient Name (Print) _____

Patient/Guardian Signature _____ Date _____

****Parent or Legal Guardian name and signature required for individuals under the age of 18****

Bratton Physical Therapy Patient Attendance Policy

ATTENDANCE POLICY

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. **We require that you cancel any appointment that you cannot make with no less than 24 hours' notice.**
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. While we understand that illness can strike at any time, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will arrive on time and ready to begin at your scheduled treatment time.
6. **Life happens and sometimes we all run late. We get it. If you are running late, we need you to call us immediately so we can be prepared for your late arrival.**
7. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times or may be discharged.
8. **Please note, you will be charged a \$50 fee for any no-shows and ALL cancellations that occur with less than 24 hours' notice. This amount is your responsibility as insurance will not cover this fee.** To avoid the \$50 fee, you simply need to call the office and provide at least 24 hours' notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice so please call during business hours. Calls for Monday's appointments must be made before the end of the business day on Friday. *Advanced notification allows us to help another patient by offering them your appointment slot.*
9. If you are Worker's Comp, we are required to notify your claims adjuster if you cancel or no-show.
10. You may be discharged from services if you do not show up for your appointment or cancel for 2 consecutive appointments or if attendance falls below 75%. We will notify your physician of your non-compliance.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records. We look forward to working with you to meet your therapy goals.

Bratton Physical Therapy Staff

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓝ The pain is moderate and does not vary much.
- Ⓓ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓝ Because of pain my normal sleep is reduced by less than 50%.
- Ⓓ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓝ Pain prevents me from sitting more than 1/2 hour.
- Ⓓ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓝ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓓ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓝ I cannot walk more than 1/2 mile without increasing pain.
- Ⓓ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓝ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓓ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓝ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓓ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓝ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓓ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓝ Pain has restricted my social life and I do not go out very often.
- Ⓓ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓝ My pain is neither getting better or worse.
- Ⓓ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score