BRATTON PHYSICAL THERAPY

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_____

BRATTON
PHYSICAL THERAPY

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_____

BRATTON
PHYSICAL THERAPY

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

_____

_____

_____

_____

BRATTON
PHYSICAL THERAPY

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

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80**

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.