MM

M.J. Scott D.O. & Associates, PA

Last Name: _____ First Name: _____ SEX: M F
If patient is a minor, name of parent or guardian accompanying patient: _____
Relationship to patient: _____ Phone # (if different): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ 2nd Phone: _____ Email: _____
Date of Birth: _____ SS#: _____ married single divorced widowed (circle one)
Referred by: _____ Phone: _____ Location: _____
Family Doctor: _____ Phone: _____ Location: _____
Date of accident: (If applicable): _____ **Type of accident:** _____
Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at the time.

_____

Primary Insurance Name: _____ Auto Health WC (circle one)
Phone #: _____ Adj.: _____ Ext.: _____
Claim or ID #: _____ Group #: _____
Subscriber: _____ Relationship: _____
Subscriber Date of Birth: _____ Subscriber Social Security #: _____
Secondary Insurance Name: _____ Auto Health WC (circle one)
Phone #: _____ Adj.: _____ Ext.: _____
Claim or ID #: _____ Group #: _____
Subscriber: _____ Relationship: _____
Subscriber Date of Birth: _____ Subscriber Social Security #: _____
Attorney Name: _____ Firm: _____
Location: _____ Phone: _____
Employer Name : _____ Phone: _____
Emergency Contact: _____ **Phone:** _____
Are we authorized to release your medical information to the listed emergency contact? Yes or No (circle)

ACKNOWLEDGEMENT AND UNDERSTANDING

Medical Release – I hereby request and authorize Martin J Scott D.O., to disclose, make available and furnish to:
Company Name: _____
Or his/her authorized representatives all information, records, xrays, reports or copies related to my examination, consultation or treatment and do permit him/her to inspect and make copies or abstracts thereof. I release the doctors, therapists, agents, employee's and any personnel acting on behalf of this office from any and all liability whatsoever pertaining to any use of these records. A photocopy of this form will be valid as the original form
Patient Signature: _____ Date: _____

Records Release – I hereby authorize the release of my records/x-rays/reports or copies of such and request that they be transferred or made available to Martin J. Scott, D.O.
Patient Signature: _____ Date: _____

Consent to Treatment of Minor – I hereby authorize Martin J. Scott, D.O., to render healthcare to my son/daughter as deemed necessary by the physician.
Patient Signature: _____ Date: _____

M.J. Scott D.O.
& Associates, PA

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Martin J Scott is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
° Voice Mail	° Results of lab tests/x-rays Other: _____ _____
° Spouse (provide name & phone number) _____ _____	° Financial ° Medical as follows: _____ _____
° Parent (provide name & phone number) _____ _____	° Financial ° Medical as follows: _____ _____
° Other (provide name & phone number) _____ _____	° Financial ° Medical as follows: _____ _____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Signature of Witness Date

Personal Information

Please answer each question with your best judgment.
This will ensure the most accurate course of treatment for your injuries.

Start date of symptoms: _____

Possible cause of symptoms: _____

Are you pregnant? Y / N **Do you have a Pacemaker? Y / N**

Have you received any other treatment? ☐ No ☐ Yes

☐ PT: _____ ☐ Chiropractor: _____

☐ Trigger Point Injections by: _____ ☐ Neurologist: _____

☐ Orthopedic Surgeon: _____ ☐ Surgery: _____

☐ Other: _____

When did this treatment occur? : _____

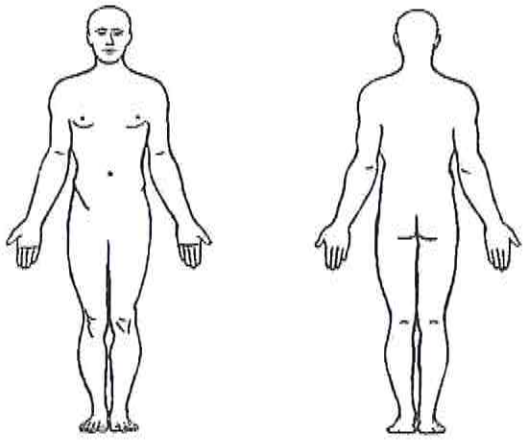
What was treated? (ex: lower back, right shoulder…):

_____

Result from treatment? (ex: worsened, remained same, improved, cured…):

_____

CURRENT PAIN?



- **NECK: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **MIDBACK: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **LOWER BACK: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **HEADACHE: Pain level (0-10) 0 1 2 3 4 5 6 7 8 9 10**
- **Other Location _____: 0 1 2 3 4 5 6 7 8 9 10**

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- **Does the pain radiate anywhere? ("shooting down to the left or right arm" or "shooting up to the head")**

  _____

  _____
- **Please, describe your pain** ▫ Dull ▫ Aching ▫ Sharp ▫ Shooting ▫ Stabbing ▫ Throbbing ▫ Numbness ▫ Burning
- **How often is your pain present?** ▫ Occasional ▫ Frequent ▫ Constant
- **Worst time of day?** ▫ Morning ▫ Afternoon ▫ Evening ▫ Night ▫ All the time
- **Numbness anywhere?** _____
- **"Pins and needles" or tingling sensation anywhere?** _____
- **Weakness? (Right leg, right arm, both legs...)**

  _____
- **Swelling?** _____
- **What makes symptoms worse/exacerbate?**

  ☐ Walking ☐ Standing ☐ Lying down ☐ Sitting ☐ Bending forward ☐ Bending backward ☐ Driving ☐ Coughing ☐ Bowel movement ☐ Cold weather ☐ Hot weather ☐ Rainy day ☐ Lifting objects
- **What makes the symptoms better?**

  ☐ Resting ☐ Massage ☐ Exercise ☐ Sitting ☐ Lying down ☐ TENS unit ☐ Physical therapy ☐ Chiropractic treatment ☐ Sleeping ☐ "Injections" ☐ Medication (Names): _____ ☐ Other: _____
- Sleeping: ☐ Well ☐ "OK" ☐ Terrible ☐ 2 hrs ☐ 4 hrs ☐ 6 hrs ☐ 8 hrs ☐ > 10 hrs
- How often do you wake up at night due to pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >5 times

Do you have any of the following today? (Check all that apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Injection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Pride Physical Therapy

CONSENT TO TREAT

The patient has the right to informed participation is decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending physical therapist. The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. After reading the above, I _____, hereby consent to receive physical therapy treatment at Pride Physical Therapy/ Steve Demkowicz, DPT, commencing on _____(Date) and terminating when determined by myself, my physician, or my physical therapist. I have read this information and understand its content.

*Patient Signature:*_____ *Date:* _____

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

I give my consent to PRIDE PHYSICAL THERAPY, to disclose health information to my insurance carrier for the purpose of billing, to my physician or other healthcare professionals involved in my care, or receive health information from other healthcare professionals as it relates to my treatment, as permitted/required by law. I understand that confidentiality of my health information is protected under state and federal law, and that this release gives consent to PRIDE PHYSICAL THERAPY only, and not to any party to whom such information is released.

Patient Signature: _____ *Date:* _____

PATIENT PAYMENT POLICY

The fee schedule of PRIDE PHYSICAL THERAPY, is based on usual and customary fees for the type of services provided. Generally, your insurance policy will cover some portion, if not all, of the payment for services provided. There is, however, no guarantee of payment. The balance amount that your insurance carrier does not cover will be your responsibility. You are also responsible for any deductible and co-pay. We request that any insurance payments that are sent directly to you be presented promptly to PRIDE PHYSCIAL THERAPY, along with the explanation of benefits and/or any other information you received with the payment. You are directly responsible for payment of medical supplies. Statements will be sent to you if you have an outstanding patient balance. Payment for your portion of services is requested to be paid within fifteen (15) days of receipt of the statement. I attest that my insurance coverage and personal financial responsibilities regarding physical therapy treatments have been fully explained to me. **Any missed appointment or late cancellation will result in a $60.00 charge. To avoid these fees please cancel appointments the day before, no later than 4pm (late night phone messages WILL NOT be acceptable for appointments before10:30AM)**

Patient Signature: _____ *Date:* _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made to me or on my behalf to the practitioner named above. I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I have read this information and understand its content.

Patient Signature: _____ *Date:* _____