EKREN PHYSICAL THERAPY SERVICES

Together we make it happen.

PATIENT QUESTIONNAIRE

Name_____ Date_____ Patient #_____

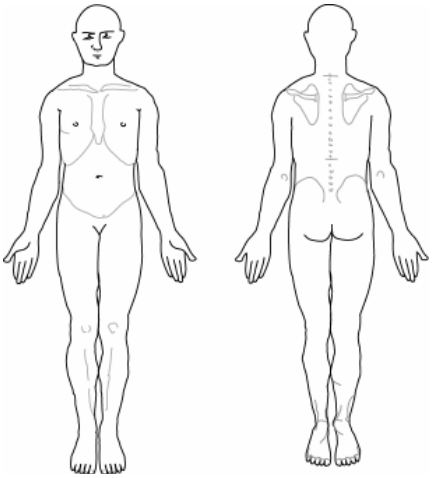
Phone # _____ Who referred you to our clinic? Self ___ Physician ___ Other: ___

Age_____ Height_____ Weight_____ Level of Education _____

Disabled ? Explain_____ When?_____

1. What are your symptoms? _____

_____



Please shade in the location of your pain/problem on the diagram to the left.

2. When did your symptoms begin?_____

3. Describe your pain: Sharp____ Dull____ Aching___

Shooting___ Throbbing___ Other___

4. On a scale of 1 -10, what is your current level of pain?

(low) 1 2 3 4 5 6 7 8 9 10 (high)

5. Does the pain wake you up at night? Yes___ No ___

6. List any recent diagnostic tests that have been done for this condition, ie: MRI, Cat Scans or X Rays:

_____

7. Please list any prescription medications you are currently taking:

_____

_____

Any Medication Allergies:_____

8. How would you rate your general health?

Excellent___ Good___ Average___ Fair ___ Poor___

Name_____ **Patient #** _____

9. Do you exercise outside of normal daily activities?

5+ days/wk___ 3-4 days/wk___ 1-2 days/wk___ Occasionally ___ Not at all___

10. Do you drink caffeinated beverages?

Yes___ No ___ How many cups per day? _____

11. Do you smoke?

Yes___ No___ Packs of cigarettes per day____

12. Do you drink alcohol?

Yes___ No____ How often?_____

PAST MEDICAL HISTORY

13. Have you ever been diagnosed with any of the following conditions: (Check all that apply)

Cancer (type)	_____	**Arthritis**	_____	**Depression**	_____	**Kidney Disease**	_____
Diabetes	_____	**Heart Disease**	_____	**Pacemaker**	_____	**Lung Disease**	_____
Stroke	_____	**Osteoporosis**	_____	**Fibromyalgia**	_____	**Liver Disease**	_____
High Blood Pressure	_____	**Thyroid Problems**	_____	**Back Problems**	_____	**Epilepsy/ Seizure disorder**	_____

14. Please list any recent/relevant surgeries related to your current problem:

Surgery	**Date**

15. Are you seeing any of the following for your current condition? Physician___ Dentist ___

Massage Therapist___ Physiatrist/Psychologist ___ Physical Therapist ___ Accupuncturist ___

Attorney___ Chiropractor ___ Other: _____

Emergency Contact:

Name _____ **Relationship** _____

Phone _____

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____

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Financial Agreement: I hereby authorize my insurance benefits and/or attorney settlement payments to be paid directly to Ekren Physical Therapy Services, Inc. I understand that I am financially responsible for non-covered services, all deductibles, my co-pay, any settlement funds released to me by my attorney (if auto related), and any other amount that is not payable under my insurance policy. I authorize Ekren Physical Therapy Services, Inc. to release all medical information in connection with these services to secure the payment on insurance benefits and/or legal representation to my insurance carrier or attorney upon their request.
*****I understand that when Ekren Physical Therapy Services. Inc. verifies insurance benefits, they are given a quote and not a guarantee of benefits.** *I understand that I am responsible to verify my out-patient physical therapy benefits with my insurance company.*
_____ ***Patient Initials***

Collection of Account: I understand that if this account is assigned to an attorney for collection and/or suit, Ekren Physical Therapy Services, Inc. shall be entitles to reasonable attorney's fees and the cost of collection. I also understand that if any bad check is written, that I am to come to the office with a money order or cash to redeem that check and pay any insufficient fund fees due. I understand that I will be responsible to pay a minimum fee of $25 for each checked deemed insufficient. I understand that I write a bad check to Ekren Physical Therapy Services, Inc., that future check payments may be refused and payments for services rendered would need to be paid by cash, money order, or credit card.

Consent for Treatment: I understand that medical treatment is necessary for the patient names below and that such treatment will be performed by Ekren Physical Therapy Services, Inc and employees. I grant authorization and consent of such treatment as ordered and prescribed by my referring physician. I certify that no guarantee or assurance has been made as to the results that may be obtained. I authorize Ekren Physical Therapy Services, Inc. to release medical information to health care providers, attorneys, and/or my insurance carrier, as necessary to provide continuity of patient care.

Is there anyone you grant permission for Ekren Physical Therapy Services, Inc. to discuss your treatment and/or insurance matters to? _____

If yes, who and their relationship to you: _____

When calling your contact number, can we leave a message? _____

On your answering machine or voicemail? _____

With a person answering the phone? _____

Where is the best way to contact you regarding appointments and/or billing issues?

_____

Patient/Guardian Signature: _____

Relationship to Patient: _____

Date: _____

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Notice of Privacy and Practices Acknowledgement

By signing below, I acknowledge that I have received the Notice of Privacy Practices. I understand that I may ask questions about the Notice of Privacy Practices at any time.

TO ALL PATIENTS:

We regret that it has become necessary to implement A missed appointment fee.

No shows, missed appointments and those cancelled less than *24 business hours* in advance may result in a $25.00 charge. Please notify us as soon as possible if you need to change your appointment.

Thank you for your cooperation

The Staff at
Ekren Physical Therapy
Services, Inc.

Patient Signature_____

Date_____

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Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to the information.

Ekren Physical Therapy's Legal Duty

Ekren Physical Therapy Services, Inc. will use your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, Ekren Physical Therapy Services, Inc. may use your personal health information to contact you and to provide appointments reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Ekren Physical Therapy, Svcs, Inc. may also use or disclose your personal health information without your prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Ekren Physical Therapy Svcs, Inc.'s policy is to obtain written authorization before disclosing your personal health information. Of you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Ekren Physical Therapy Svcs, Inc. may change its policy at any time. When changes are made, a new notice of Information of Privacy Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patients Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information of your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, administrative purposes or for any disclosures when an authorization form from you was not obtained.

You may also request in writing that we will not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in an emergency circumstance. Ekren Physical Therapy Svcs, Inc. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns or Complaints

If you are concerned that Ekren Physical Therapy Svcs, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our privacy officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Ekren Physical Therapy Svcs, Inc's health practices or if you have a complaint, please contact the following person:

Filiz Ekren
2349 Sunset Point Road, Suite 400, Clearwater, Fl. 33765
Telephone: 727-723-8457 Fax: 727-723-8467