EKREN PHYSICAL THERAPY SERVICES, INC.

Together we make it happen.

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____

Current Address: _____

Home Phone #: _____ Cell #: _____

Emergency Contact
Name: _____ Relationship : _____ Phone #: _____

Primary Care Dr: _____ Phone# _____

Diagnosis: _____

Referring Doctor: _____ Phone# _____

PLEASE LIST ANY SURGERIES:

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY – (Please check all that apply)

Cancer _____	Arthritis _____	Depression _____
Diabetes _____	Heart Disease _____	Pacemaker _____
Stroke _____	Osteoporosis _____	Fibromyalgia _____
HBP _____	Thyroid _____	Seizure(s) _____
Kidney Disease _____	Liver Disease _____	Lung Disease _____

Other _____

Height: _____ Weight: _____

Exercise: How many times: A Day? _____ A Week? _____
Caffeine: Yes_____ No_____ How many per day _____
Smoke: Yes_____ No_____ How many per day _____
Drink Alcohol: Yes_____ No_____ How often _____
How would you rate your general health:
Excellent_____ Good_____ Average_____ Fair_____ Poor_____

PATIENT SIGNATURE _____ **DATE** _____

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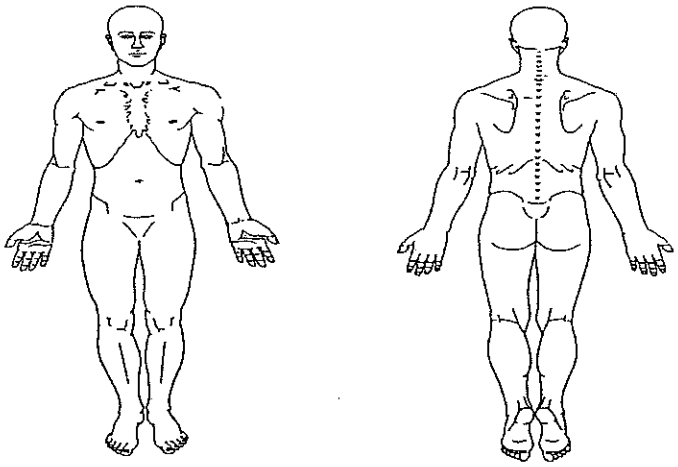
Name:_____ Date:_____

Please shade in the location of your pain / problem on the diagram below:



What symptoms are you having?_____

When did your symptoms begin? _____

Describe your pain:
Sharp____ Dull____ Aching____ Shooting___ Throbbing_____ Other_____

On a scale of 1 to 10, what is your current level of pain:

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

Does the pain wake you up at night? Yes_____ No_____

List recent diagnostic tests you have had for this condition:_____
(i.e. x-ray, MRI, cat scan, etc..)

Are you receiving any other services / treatment? _____
(i.e. chiropractic – pain management – massage therapy, etc.)

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Name:_____ Date:_____

Medication Name	Dose	Frequency	Oral Or Other

Please list any known allergies: _____

_____

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Dear Patients:

Welcome!

It is a pleasure to have you with us. We will make every effort possible to make your treatment and recovery an excellent experience.

In order for us to provide you the best care, we would appreciate your cooperation in observing the following:

1. **Please arrive on time for your appointment. There is a 10 minute maximum tolerance for lateness. More than that and you will need to call to see if your therapist is still able to see you, or if we will need to re-schedule your appointment.**
2. **A 24 hour notice to cancel is required. Patients will be charged a $25.00 No call / No show or Cancellation fee with less than a 24 hour notice.**
3. Companions and children are allowed, but for your safety and the safety of the other patients they will be required to remain in the waiting area.
4. Patients are not allowed to take food or drink into the treatment area. Exception being water.
5. Please refrain from using cell phones, as that will take time away from your therapy.
6. **Patients who no show for 3 appointments or do not follow their plan of care will automatically be discharged from any further therapy.**
7. Patients are responsible for checking their own Out-patient Physical Therapy-Freestanding Facility insurance benefits. When we verify benefits, we are given a quote, not a guarantee of payment, and may not get the exact amount of coverage until the first Explanation of Benefits comes back to us. **Please check your benefit coverage with your insurance company. Amounts left unpaid by insurance company will fall into the patient's responsibility.**

Thank you for choosing Ekren Physical Therapy!

Patient Signature: X_____ 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 entitled 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 if 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? _____

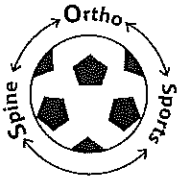
Where is the best way to contact you regarding appointments and/or billing issues?

_____

Patient/Guardian Signature: _____

Relationship to Patient: _____

Date: _____



EKREN PHYSICAL THERAPY SERVICES, INC.
Sports, Ortho, Spine

FALL RISK SCREENING AND ASSESSMENT

Name:_____ **Date:**_____

How old are you?

0. Under 50
1. 50 - 59
2. 60 - 69
3. 70 - 79
4. 80 – 89
5. 90+

Do you utilize a cane or walker?

0. No
1. Yes

How many times have you fallen in the last year?

0. 0 Falls
1. 1-2 Falls
2. 3-5 Falls
3. 6 or more Falls

How confident are you in your balance?

0. Completely Confident
1. Somewhat Confident
2. No Confidence

How many times a week are you doing leg strengthening exercises?

0. 6-7 days per week
1. 3-5 days per week
2. 1-2 days per week
3. Never

How many times a week are you doing balance exercises?

0. 6-7 days per week
1. 3-5 days per week
2. 1-2 days per week
3. Never

Risk Score of Falling *To be completed by Ekren staff*
(sum of the answers above)
High Risk: 12-17
Moderate Risk: 6-11
Low Risk: 1-5
No Risk: 0

Set up your FREE balance consultation with us today

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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
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