History of Present Condition:

PATIENT NAME:	*THERAPIST:*	*REFERRING DR:*

- ***Date of Injury or start of symptoms:***_____
  Circle One: *Acute / Insidious (gradual) / Chronic*
- ***History of Injury:***_____
  Surgery: *Yes or No* If yes, date:_____ Procedure:_____
- ***What is your chief complaint?***_____
- ***Before injury or pain started were you independent in the following:*** *All or circle each*

  Self Care Hygiene Sleep Activities of Daily Living Changing/Maintaining body position
  Lift/Carry Work Recreation Mobility/Ambulation
- ***List Current Functional Limitations or Circle:***_____

  Self Care Hygiene Sleep Activities of Daily Living Changing/Maintaining body position
  Lift/Carry Work Recreation Mobility/Ambulation
  - ***Pain:***

At its WORST 0 1 2 3 4 5 6 7 8 9 10
No pain ⟷ ***Worst pain***

Current Pain 0 1 2 3 4 5 6 7 8 9 10
No pain ⟷ ***Worst pain***

At its BEST 0 1 2 3 4 5 6 7 8 9 10
No pain ⟷ ***Worst pain***

- ***Pain Location:***_____
- ***Nature of pain: Please circle all that apply***
  Burning Sharp Dull Aching Throbbing Shooting Numbness
  *Other*_____
- ***What Aggravates Pain****:* _____

- ***Work Status:*** *Yes or No*
- ***Work Occupation:***_____ ***Last Day Worked:***_____

- ***Medical History(self only): Please circle all that apply***
  *Osteoarthritis Heart Disease Diabetes Allergies*_____ *Complicating Factors*_____
  *Surgical History*_____ *Previous Therapy*_____

- ***Have you had any of the following test for your current condition: please circle all that apply***
  X-rays MRI CT Scan Bone Scan Ultrasound-Imaging
  Nerve Conduction Study EMG Arthrogram ***Results****:*_____

- ***Medication: Are you currently taking any medication? Yes or No /*Please list below or attach list**
  Prescription: _____ *Non-Prescription:*_____
  *Other:*_____

- ***What are your goals for physical therapy?***_____

- ***What is your height:***_____ ***What is your weight:***_____

PROGRESS NOTES

DATES	

RIVER CITY PHYSICAL THERAPY POLICIES

I, the undersigned patient and/or the responsible party have read and received a copy of River City Physical Therapy's Privacy Statement.

FINANCIAL

River City Physical Therapy is happy to bill our patients' insurance carriers *as a courtesy* when they present with a *current* insurance card. However, we are not contracted with all insurances, nor do we know your individual policy. As a courtesy, we will call your insurance to check your physical therapy benefits although we are only *given a description of benefits and not a guarantee of payment*. It is **ULTIMATELY** the ***patient's*** responsibility to know their insurance carrier's benefits and policies.

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. In the case of non-payment by contracted/non-contracted carriers, patient is ultimately responsible for payment and follow-up with carrier for services rendered. I realize that failure to keep this account current may result in my being unable to receive additional services. In the case of default on payment, I understand that my account balance may be forwarded to a collection agency.

MEDICAL SUPPLIES AND ORTHOTICS

Many insurance companies do not consider medical supplies a covered benefit. Therefore, we ask for payment in full at the time of pick-up if you are purchasing a non-covered item.

LATE CANCELLATIONS AND NO SHOWS

Cancellations or changes must be made at least 24 hours prior to the scheduled appointment. If a patient fails to show for two scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and their physician will be notified.

I acknowledge that I have read and understand the policies as stated above.

_____ _____

Signature **Date**

RELEASE OF MEDICAL INFORMATION

I, (we) orally or in writing, as may be requested, authorize the release and disclosure of any and all information regarding my condition when under your observation, treatment of care, including history, findings, treatment, x-ray readings and diagnosis and your prognosis. You are also authorized to follow my physical therapists to inspect and take copy of your clinical or hospital records pertaining to me, and to inspect and borrow x-rays or photographs in your possession for examination.

I (we), the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patient's medical records to any entity which is, or may be liable for all or part of the provider charges.

I (we), authorize the release and disclosure of any and all my medical records to any other entity, including, but not limited to referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I (we), authorize the release of records necessary to assist in the reimbursement of benefits to which I (we), may be entitled. I (we), authorize this office and/or its employees to release via fax machine, medical records which are needed in order to provide patient with the most appropriate medical care/payment for treatment rendered.

_____ _____

Signature **Date**

Appointment Cancellation and No Show Policy

We schedule our appointments so each patient receives the best possible care from our physical therapists and staff. It is very important you keep your scheduled appointments with us and arrive on time.

If your schedule changes and you cannot keep your appointment, please contact us at least 24 hours in advance. This allows us to reschedule you and accommodate patients who are waiting for an appointment. A No Show or less than 24 hour cancellation notice adversely affects you and your River City Physical Therapy team. **If this occurs we will apply a $50 charge to your account.**

We at RCPT think of all of our patients as family and we thank you in advance for your understanding and effort to make all scheduled appointments.

My signature below acknowledges that I have read and understand this Cancellation / No Show Policy.

Name: _____Date:_____

Signature: _____

Trish Ortega
Office Manager
208-777-7800