ACUCARE PHYSICAL THERAPY, LTD

WELCOME TO ACUCARE PHYSICAL THERAPY, LTD

Office Hours: Monday-Friday 7:00AM-5:00PM

Thank you for choosing ACUCARE PHYSICAL THERAPY, LTD for your physical therapy needs. We are a small therapist-owned clinic that has been in practice since 1990. We pride ourselves on listening to our patient's needs and goals to get you on the road to recovery.

Please bring in your driver's license, insurance card and doctor's prescription to your initial visit.

If this is a Workers Compensation injury, please provide claim number, contact person and workman's compensation insurance provider at your initial visit.

If this is a Motor Vehicle Accident, please provide the insurance billing, claim number and date of accident at your initial visit.

Please visit us online at Acucarept.com.
We look forward to seeing you.

The staff at ACUCARE PHYSICAL THERAPY, LTD

1700 S. MINNESOTA AVE., SIOUX FALLS, SD 57105 | PHONE: 605-335-7723 | FAX: 605-339-3778 | ACUCAREPT@YAHOO.COM

Patient Information

Name: _____ DOB: _____

Address: _____

City State Zip Code

Home Phone: _____ Ok to contact/leave voicemail: Y ( ) N ( )

Cell Phone: _____ Ok to contact/leave voicemail: Y ( ) N ( )

Would you like a text or call for an appointment reminder: Text ( ) Call Home ( ) Call Cell ( )

E-mail: _____ SSN: _____ Gender: M ( ) F ( )

Occupation/Job Title: _____

Employer Name: _____ Work Phone: _____

Employer Address: _____

Emergency Contact Name: _____

Emergency Phone Number: _____ Relationship: _____

Referring Doctor: _____ Phone: _____

Family Doctor: _____ Phone: _____

Surgery Date: _____ Accident Date: _____

If Patient is under 18:

Fathers Name: _____ Mothers Name: _____

Fathers SSN: _____ Mothers SSN: _____

Fathers DOB: _____ Mothers DOB: _____

Fathers Phone: _____ Mothers Phone: _____

Evaluation

Patient Name: _____

Approximate date of injury/onset of symptoms: _____

When was your last doctor's visit: _____ When is your next doctor's visit: _____

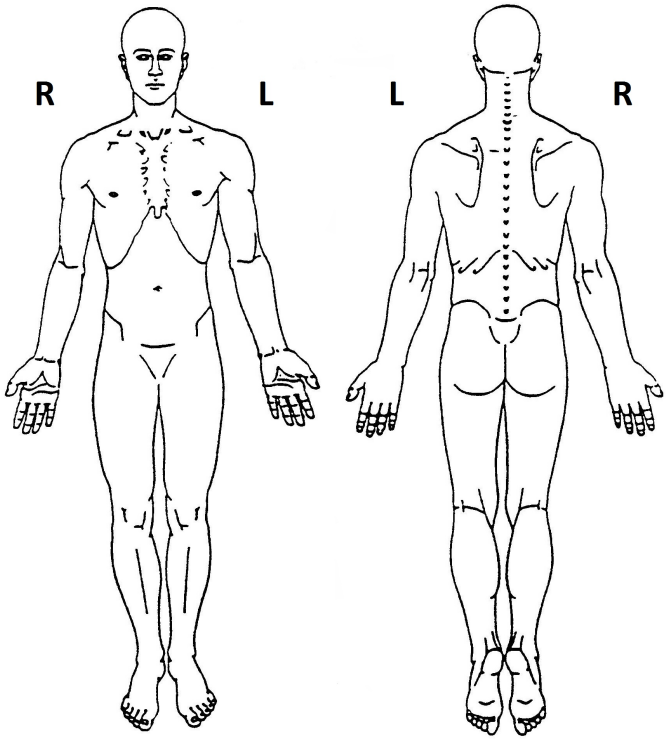
Have you had physical therapy in the last year: Y ( ) N ( ) If so, Where: _____

Are you currently under the care of a healthcare professional for this condition: (please check)

_____ Medical Doctor (MD) _____ Psychiatrist/Psychologist _____ Dentist

_____ Chiropractor _____ Massage Therapist Other _____

Please indicate location of symptoms on chart below



Please check if you have **recently** noted

___ Blood in urine, stool, vomit, mucus
___ Changes in bowel or bladder
___ Dribbling or leaking urine
___ Numbness or tingling
___ Dizziness, fainting, blackouts
___Headaches
___ Nausea, vomiting, loss of appetite
___ Fever, chills, sweats (day or night)
___ Sudden weakness
___ Unusual fatigue, drowsiness
___ Swelling or lumps anywhere
___ Unexplained weight loss/gain
___ Throbbing sensation
Where: _____
___ Confusion/memory loss
___ Problems seeing or hearing

Please circle the number that corresponds most accurately with your current level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Pain at Worst: _____ Pain at Best: _____

Have you fallen in the last year: Y ( ) N ( ) If so, when: _____

Past Medical History

Patient Name: _____

Check all that apply, additional comments can be made down below:

Blood
- ___ Anemia
- ___ Hemophilia

Musculoskeletal
- ___ Arthritis (type and location)
- ___ Back injury
- ___ Carpal Tunnel Syndrome
- ___ Degenerative Disc Disease
- ___ Fibromyalgia
- ___ Fracture (location)
- ___ Osteoporosis/Osteopenia

Liver/Kidneys
- ___ Cirrhosis/ Liver Disease
- ___ Kidney Disease/ Stones

Psych
- ___ Anxiety/ Panic Attacks
- ___ Depression
- ___ Disorder (list what type)

Lungs
- ___ Asthma
- ___ Emphysema
- ___ Sleep Apnea
- ___ Tuberculosis

Cardio-Vascular
- ___ Angina/ Chest Pain
- ___ Blood Clot
- ___ Heart Attack
- ___ High Blood Pressure
- ___ Peripheral Vascular Disease

Brain/Nerves
- ___ Alzheimer's Disease
- ___ Epilepsy
- ___ Herniated Disk
- ___ Multiple Sclerosis
- ___ Parkinson's Disease
- ___ Peripheral Neuropathy

Endocrine/Immune System
- ___ Diabetes
- ___ Hepatitis
- ___ Lupus
- ___ Hyperthyroidism (high)
- ___ Hypothyroidism (low)

Cancer
- ___ Remission

Type and Location:

_____

_____

Allergies:_____

_____

_____

Additional Comments:_____

_____

_____

Surgical History:_____

_____

_____

_____

_____

FOR STAFF TO FILL OUT AT INITIAL VISIT:

Height: _____

Weight: _____

Temperature: _____

Blood Pressure: _____

Heart Rate: _____

Medication List

Patient Name: _____

Please list all prescriptions, over the counter, herbal, nutritional supplements, vitamins, minerals, etc.

Medication	Dosage	Frequency	Method of Delivery

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Reviewed with patient by: _____ Date: _____

Insurance Information

Please complete this page, even though we have received a copy of your insurance cards.

Patient Name: _____

Primary Insurance: _____ Policy Holder (Insured): _____

Subscriber DOB: _____ ID#: _____ Group #: _____

Patient relationship to insured: _____ Insured's Employer: _____

Insurance Address: _____
City State Zip Code

Secondary Insurance: _____ Policy Holder (Insured): _____

Subscriber DOB: _____ ID#: _____ Group #: _____

Patient relationship to insured: _____ Insured's Employer: _____

Insurance Address: _____
City State Zip Code

What type of injury are you being seen for: _____ R ( ) L ( ) Both ( )

Workers Compensation: _____ Auto Accident: _____ Other: _____

Contact Person, Attorney or Case Worker: _____ Phone Number: _____

I, the undersigned or designated representative for the patient, hereby assign all medical benefits to which I am entitled to ACUCARE PT, LTD in the event they file insurance on my behalf. I hereby authorize ACUCARE PT, LTD to release all information necessary to secure the payment of said benefits. I understand I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the standard rates and payments terms of this office.

Our insurance department will file your bill with your insurance company as long as you provide all the necessary information, ie: insurance card, physician referral, and prior authorization, if required by your insurance.

The individual who is receiving treatment is responsible for payment of physical therapy services. Unless prior arrangements are made with our billing department, a 1.8% or $10.00 minimum interest fee will be assessed on accounts that are 60 days or over. Any copay is due on the date of your visit.

CANCELATION POLICY: *Appointments not canceled 24 hours prior to their scheduled time will be assessed a $40.00 cancelation fee.*

Kindly sign and date this form to indicate that you understand and agree to these conditions above.

Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices-HIPPA

Do you wish to receive a copy of ACUCARE PT, LTD privacy practices: Yes _____ No _____

I, _____ have received or denied a copy of Acucare Physical Therapy LTD's notice of privacy practices with an effective date of April 14, 2003.

Please fill out the following:

Name of Patient: _____

Signature of Patient/Guardian: _____

Date: _____

Name of Witness (STAFF) Print: _____

Signature of Witness (STAFF): _____

Date: _____

Clinic Rules

1) Our office hours are Monday-Friday 7:00am to 5:00pm.
2) If you are unable to keep your scheduled appointment time, please give us at least a 24 hour notice. If an emergency arises, let us know as soon as possible, otherwise you may be assessed a charge of $40.00.
3) Worker's Compensation patients who do not show for appointments or call to cancel at least 24 hours will be assessed at $40.00 charge. If this is not covered by your Worker's Compensation carrier, you will be held responsible for payment of this fee.
4) Our insurance department will file your bill with your insurance company, as long as you provide all of the necessary information, ie: insurance card, physician referral (if applicable), and prior authorization, if this is required by your insurance.
5) Payment for physical therapy services is the responsibility of the individual who is receiving treatment. Unless prior arrangements are made with our billing department, a 1.8% or $10.00 minimum late fee will be assessed on accounts 60 days or over. Any copay is due on the date of your visit.
6) I hereby authorize Acucare Physical Therapy, LTD to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Acucare Physical Therapy, LTD, all payments for medical services rendered to myself and my dependents. I understand that it is my responsibility to pay for all charges for the services incurred.

Signature:_____ Date:_____