**POWERED BY:**

# Physical Therapy Medical Screening Questionnaire

**Name**: _____ **Date of Birth**: _____ **Age**: _____

**Address**: _____ **Gender**: _____ **Pregnant**:(YES/NO)

_____ **Email**: _____

**Contact Number**: _____ **Height**: _____ **Weight**: _____

**Smoke**: (YES/NO) **Drink**: (YES/NO)

**Referring Physician**: _____ **Diagnosis**: _____

**Images performed (x-ray, mri, or other)**: _____

**Are you other care for this diagnosis**: (YES/NO) **Previous Treatment**: _____

**Occupation**: _____ **Was this injury a result of work**: (YES/NO)

**How would you rate your current health**: Excellent Good Fair Poor

**Regular exercise routine**: _____

**Past Medical History (please circle if you now have or have had any of conditions)**

| | | | |
|---|---|---|---|
| Cancer | High Blood Pressure | Heart Disease | Angina/Chest Pain |
| Heart Attack | Pacemaker | Asthma | Shortness of breath |
| Diabetes | Osteoporosis | Osteoarthritis | Rheumatoid Arthritis |
| Stroke | Dizziness/light headed | Falls | Nausea/Vomiting |
| Swelling in the legs | History of a DVT | Chronic fatigue | Weight loss/gain |
| Numbness/tingling | Changes in bowel | Changes in bladder | Fever |
| Night sweats | Thyroid problems | Headaches | Concussions |
| Fractures | Metal implants | Kidney Disease | Liver Disease |
| Fibromyalgia | Sexually Transmitted Disease | HIV/AIDS | Hepatitis |
| Ulcers | Tuberculosis | Allergies/Asthma | Lung Disease |

**Have you had a recent illness (explain if yes)**? _____

**Do you take blood thinners**? (YES/NO) **Are you allergic to latex**? (YES/NO)

**In the past month, have you often been bothered by feeling down, depressed, or hopeless**? (YES/NO)

**During the past month, have you often been bothered by little interest or pleasure in doing things**? (YES/NO)

**Current Medications**: _____

**Pain Scale**:

(no pain) (worst imaginable)

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Best** | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Current** | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Worst** | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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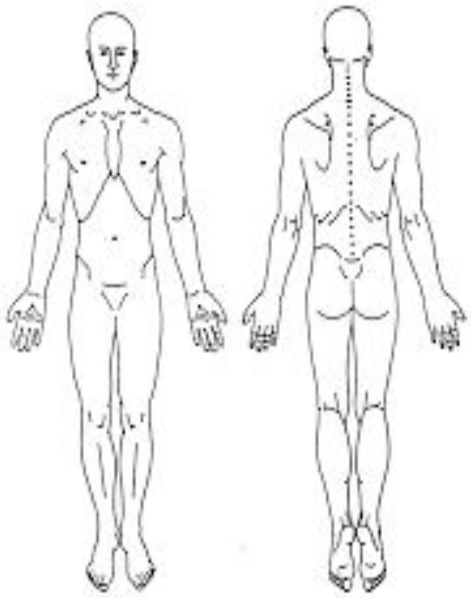
**Pain Body Diagram**:

*Please use these symptoms to mark the pain*

Dull ache- ZZ Pins/needles- 00

Sharp/Stab- // Burning- XX



**What makes your symptoms worse**?

_____

_____

_____

_____

**What makes your symptoms better**?

_____

_____

_____

_____

**How would you rate your overall function**:

(cannot do anything) (able to do everything)

0 1 2 3 4 5 6 7 8 9 10

**Goals you would like to achieve with physical therapy:** **Current Ability**

1. _____ _____/10
2. _____ _____/10
3. _____ _____/10

**Additional comments for the therapist**:

_____

_____

_____

_____

**Medical History was reviewed by:**

**Therapist Signature:** _____ **Date:** _____

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# Informed Consent

I have the right to receive complete and current medical information concerning my diagnosis, treatment, and prognosis. This information will be communicated to me by my provider in terms that I can understand.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol.

IMC & ReShape does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with you treating physical therapist throughout your treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results.

Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

# Privacy Practice (HIPPA Acknowledgement/Consent)

I acknowledge that I have received a copy of the Notice of Privacy Practices for IMC & ReShape. I consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations.

# HIPAA Release Form/Benefits

I authorize payment directly to IMC & ReShape for services and to bill/release payment directly to IMC & ReShape for any services provided. I hereby assign all benefits directly to IMC & ReShape. I understand that in the event my insurance company or financially responsible party does not pay for services, I will be financially responsible for payment.

I give permission to IMC & ReShape to share my medical information and to discuss my medical information with the following people. (i.e. spouse, child, etc).

This can be updated at any time with my signature.

| **Name:** | **Relationship:** |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

**Print Name:** _____

**Signature:** _____ **Date:** _____

**POWERED BY:**

## AUTHORIZATION FOR RELEASE OF INFORMATION

**PRINTED NAME:** _____ _____ _____
LAST FIRST MI

**ADDRESS:** _____

**CITY:** _____ STATE: _____ ZIP: _____

**EMAIL:** _____ PHONE: _____

**DATE OF BIRTH:** _____- _____ - _____
MO DAY YR

## HIPAA Authorization

I hereby authorize Internal Medicine Consultants ("IMC"), to use and release my contact information identified above to:

_____

- I understand the information identified above is being used and released in order to provide health management, and other health-related/health education services to me. Except for the information I provided above, no other protected health information will be disclosed by IMC except as I may otherwise request in writing.
- I understand that this authorization will be valid for **one** year.
- I understand that I may revoke this authorization at any time by notifying IMC in writing to:

Internal Medicine Consultants
172 Linden Drive, Suite 100,
Winchester, Virginia 22601
Attention: Dr. Vaishali Geib

The revocation will be effective on the date notified except to the extent action has already been taken in reliance upon the original authorization.

- I understand that information disclosed to the above organization may be re-disclosed and not protected by the Federal privacy regulations.
- I understand my right to receive services from IMC will not be affected if I refuse to sign this authorization.

**My initials:** _____

**Acknowledgement**
I acknowledge that I have read this authorization in its entirety (or that it has been read to me), and that I understand and agree to the above.

**Agreed and Accepted**

_____ _____
Signature of Patient/Legal Guardian/ Personal Representative Date

_____
If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so.

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## Insurance Information

**Primary Insurance:** _____

**Primary Insurance ID Number:** _____

**Group Number (If applicable):** _____

**Policy Holder Name:** _____

**Relationship to Policy Holder:** _____ **DOB of Policy Holder:** _____

**Secondary Insurance:** _____

**Secondary Insurance ID Number:** _____

**Group Number (If applicable):** _____

**Policy Holder Name:** _____

**Relationship to Policy Holder:** _____ **DOB of Policy Holder:** _____

## Patient and Responsible Party Authorization

I authorize Internal Medicine Consultants on behalf of _____ (your insurance company) to apply for benefits on my behalf for their covered services rendered and request payments from the above-named insurance company be paid directly to IMC AND RESHAPE for the treated person named. I certify that the information reported about my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above-named agent. I permit a copy of this authorization to be used in place of the original. IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN, AND/OR PARENTS RESPONSIBILITY. Patient or responsible party further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest agreed to or that may be adjudicated for the collection of past due debt on accounts for _____ (your name). **A missed appointment not cancelled with 24 hours' notice will be billed $35 for the time allowed and is not covered by insurance**. If Medicare and/or my commercial insurance should deny any or all charges, then I agree to be personally and fully responsible for any and all balances due.

**Print Name:** _____ **Date:** _____

**Signature:** _____

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# Card on File Agreement

**Terms**

**Maximum charge amount:** $400.00
**Effective Date:** _____
**Expiration Date (1 year from effective date):** _____

I agree to allow Internal Medicine Consultants powered by ReShape to charge my credit card for any amount not covered by insurance (up to the maximum charge amount), for all services provided by Internal Medicine Consultants powered by ReShape to the patient(s) on or after the effective date and before the expiration date. I acknowledge that:

- My credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services provided while this agreement is in effect.
- Once a total of $1,500.00 has been charged to my credit card under this agreement, Internal Medicine Consultants powered by ReShape will bill me directly for any amounts not covered by insurance.
- My credit card will be stored by Elavon, Inc., a secure credit card processor affiliated with U.S. Bank that partners with Internal Medicine Consults powered by ReShape to collect payments.
- I will receive receipts detailing the amount charged.
- I may cancel this agreement at any time by contacting Internal Medicine Consultants powered by ReShape; any unpaid amounts relating to services provided while this agreement is in effect that are not covered by insurance will then be billed to me directly.

**Payment Information:**

**Card Type (Mastercard, Visa, American Express):** _____

**Cardholder Name:** _____

**Card Number:** _____

**Security Code:** _____ **Expiration Date:** _____

**Billing Address:** _____

_____

**Billing Zip Code:** _____ **Email:** _____

**Print Name:** _____ **Date:** _____

**Signature:** _____