POWERED BY:

imc internal medicine consultants POWERED BY: ReShape PHYSICAL THERAPY Redefining Access To Quality Care

ReShape MD Redefining Healthcare

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 under care by another provider 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 select 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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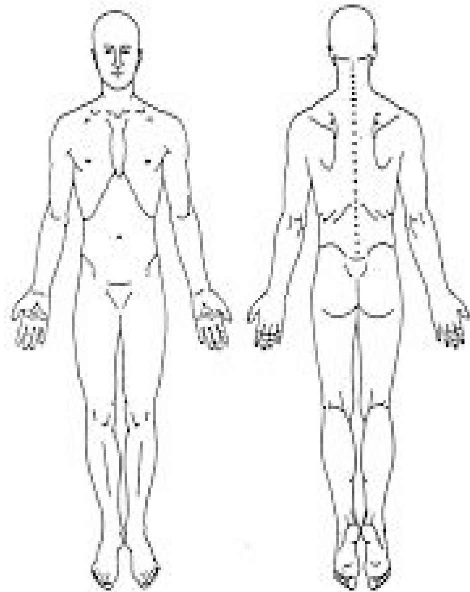
Pain Body Diagram:

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.

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: ____

POWERED BY:

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: ___________________________________