



NORWICH
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121 Broadway

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Ph: 860-376-2564 Fax: 860-376-4812
Ph: 860-779-0150 Fax: 860-774-2371
Ph: 860-537-6798 Fax: 860-537-5926

ECRC PHYSICAL THERAPY INFORMATION PACKET

THANK YOU FOR CHOOSING ECRC PT

THIS PACKET INCLUDES IMPORTANT INFORMATION TO ASSIST IN YOUR RECOVERY AND UNDERSTANDING ABOUT OUR SERVICES.

Therapist: _____

Appointment Date: _____

Appointment Time: _____

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR FIRST APPOINTMENT

- Referral/Prescription Form from your Physician
- A Completed and Signed:
 1. Personal Medical History (PMH)
 2. Consent for Care and Treatment
 3. Authorization to Release Medical Information
 4. Type of Injury / Previous Care
 5. Symptom Questionnaires (SQ) – *please complete on day of evaluation*

(If there are questions about certain parts of these forms, we can help you at the appointment time)

- **Wear or bring comfortable clothing that allows you to move easily:
loose shorts or stretchy cut-offs, or sweat pants, T-shirt**



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ECRC Physical Therapy NEW PATIENT INFORMATION

Welcome to ECRC Physical Therapy! We appreciate the opportunity to treat you. There are a few things that you need to know to make your appointment run smoothly.

- In addition to your referral/prescription for PT, please bring any other information your physician gave you for this referral (reports, office notes).
- Fill out the paperwork provided in this packet prior to your appointment time. If your paperwork is not completed, please arrive at least 10 minutes earlier than your appointment time so we can assist you in completing the forms.
- Your initial appointment will take about 1 hour and follow up appointments will last approximately 45 minutes.
- The times we have given you for your evaluation and treatment are valuable to you and are part of a full schedule for our therapists. If you know you will be late by more than 10 minutes behind the scheduled time please call our office as soon as possible. If you arrive more than 15 minutes after your scheduled appointment time, we may need to reschedule your appointment.
- If there are two or more consecutive missed appointments without your notification (no call or no excuse), we may have to cancel your remaining visits and refer you back to your doctor to continue with your care. **Therefore, if you need to cancel/reschedule your appointment, please call at least 24 hours in advance to allow us to offer your appointment time to other patients.**
- We are providers for a wide range of insurance carriers. Almost all require patient co-pay for physical therapy services. We make every attempt to assist you in determining your payment responsibility and your carriers PT benefit as a service to our patients. However, **it is your responsibility to know your policy benefits. Please come prepared to pay your portion of the PT benefit at the time of service.** Under certain circumstances we do offer payment plans. You can contact your insurance company via the 1-800 number on your insurance card if you have any questions about your physical therapy benefits.

Again, **thank you for choosing ECRC Physical Therapy.**



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ECRC Physical Therapy

CONSENT FOR CARE AND TREATMENT

I, undersigned, agree and give my consent for ECRC to furnish physical therapy care and treatment as considered necessary and proper in the diagnosis and treatment of my illness or injury.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I request that payment of authorized benefits be made on my behalf to ECRC for PT services furnished to me. I authorize any holder of medical information about me to release to my insurance(s) (the "Centers of Medicare and Medicaid Services", formerly the "Health Care Financing Administration" and its agents for Medicare patients) any information needed to determine these benefits or benefits for related services.

We ask that you provide your insurance information to us on your initial visit. This includes Primary and Secondary (if applicable) insurance information.

CANCELLATION / NO SHOW POLICY

If you need to cancel/reschedule your appointment, please call at least 24 hours in advance to allow us to offer your appointment time to other patients. **A fee of \$25 will be charged to your account for any no-shows (not calling to cancel appointment).**

AGREEMENT TO PAY

ECRC will bill your insurance company solely as a courtesy to you. All fees for services provided are your responsibility. We recommend you pay your estimated share or co-pay, as specified by your insurance carrier on each visit. We will bill your insurance and the remaining amount will be billed to you. Co-pays for services provided at each date of service will be collected at each visit unless payment arrangements have been made and are adhered to the terms of the agreement between ECRC and you. We do offer payment plans.

If you are in need of a payment plan, please speak with the front desk.

You are encouraged to contact your insurance company via the telephone number on your insurance card.

I understand and agree that if I fail to make regular payments as described above, I will be responsible for all costs of collection monies owed, including court costs, collection agency fees and attorney fees.

For Medicare patients: Medicare will NOT reimburse ECRC for outpatient physical therapy services if you are actively enrolled with a HOME HEALTH CARE AGENCY. If Medicare denies payment for services based on the above, member will be responsible for payment. Medicare has a yearly Physical Therapy cap (maximal amount of payment for PT services per year). If you need services that are more than that cap and do not fall under the automatic or manual exception criteria, you may be responsible for 100% of the cost of therapy services above this limit. We will inform you of your remaining benefits under this plan limitation and your options if further PT care is needed.

**I have read, understand and agree to the above conditions.
I understand my full responsibility for the payment of my account**

E-MAIL ADDRESS

If you would like ECRC Physical Therapy to email you [**no more than** once monthly] regarding issues that pertain to your health and to inform you about our staff and services, please enter your e-mail below:

E-MAIL: _____

X

Patient / Guardian

Date



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ECRC Physical Therapy

Patient Name: _____

DOB: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize ECRC to disclose my individually identifiable health information to the following:

I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulation, the information described above could be re-disclosed by such a person or entity and will likely no longer be protected by the federal privacy regulation. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the ECRC staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

X

Signature of Patient or Legal Representative

Date

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have reviewed a copy of ECRC's Notice of Privacy Practices (posted in the waiting room and on our web site). I understand that if I have further questions or concerns I may contact ECRC, Linda Gedeon, 150 Otrobando Avenue, Norwich, CT 06360, (860)889-1948. I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy is amended or changed in a material way.

Signature of Patient or Legal Representative

Date



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TYPE OF INJURY / PREVIOUS CARE

Date: _____

You may be treated at our facility for an injury you sustained or for symptoms related to a disease. Please complete the following information. Check all that apply:

The PT is requested due to:

Work-related injury

If so, have you filed a Worker's Compensation claim?

Yes No

Date of Injury: _____

Not Worker's Compensation or Motor Vehicle Accident related

Auto Accident Date: _____

School injury

Home accident

Disease

Other _____

I have been treated for **Physical Therapy / Occupational Therapy / Speech Therapy** and / or **Chiropractic** this year. **Note: A majority of insurance plans with a combined benefit of physical, occupational, speech and chiropractic therapies, will not cover more than one therapy on the same day.**

Yes # of visits _____

Dates treated: _____

No

I request payment of authorized benefits be made on my behalf of **ECRC** for any services furnished me by **ECRC** staff. I understand my signature requests that payment be made and I authorize release of my medical information necessary to process this claim.

Patient signature (or Legal Guardian)

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PERSONAL MEDICAL HISTORY

To help us treat you as a whole person instead of just a body part, kindly fill out the information on **both pages**. Thank you.

Please check if you have been diagnosed with any of these by a doctor in the past:

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes / high blood sugar | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Hypoglycemia / low blood sugar | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Ulcer / GERD / stomach problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Broken bone / fracture |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Circulation / vascular problems | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Stroke | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Parkinson disease | <input type="checkbox"/> Seizures / epilepsy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Repeated infections | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Number of falls in the last year: _____

In the last year, have you had any of the following? [Please check ALL that apply]

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> cough | <input type="checkbox"/> hoarseness |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> dizziness | <input type="checkbox"/> coordination problems | |
| <input type="checkbox"/> weakness in arms or legs | <input type="checkbox"/> loss of balance | <input type="checkbox"/> difficulty walking | <input type="checkbox"/> pain at night |
| <input type="checkbox"/> joint pain or swelling | <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> numbness |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> nausea / vomiting (not flu) | <input type="checkbox"/> tingling | <input type="checkbox"/> bowel problem |
| <input type="checkbox"/> urinary problems | <input type="checkbox"/> weight loss / gain | <input type="checkbox"/> fever / chills / sweats | |
| <input type="checkbox"/> headaches | <input type="checkbox"/> hearing problems | <input type="checkbox"/> vision problems | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

For MEN only:

Have you ever been diagnosed with prostate disease? no yes

- Do you have:
- difficulty beginning to urinate?
 - difficulty continuing to urinate?
 - pain with urination?

For WOMEN only:

Have you seen a doctor for any pelvic problems? no yes

Are you pregnant or trying to get pregnant? no yes

When was your last PAP smear? _____ breast exam? _____

Do you ever have urinary leakage? no yes (ECRC-PT might be able to help you.)

SURGERY

Have you **ever** had surgery? no yes (continue below)

If you've had surgery, please list surgery & approximate dates: _____

MEDICATIONS

[IF YOU HAVE A FULL LIST OF MEDICATIONS, WE CAN COPY THIS FOR YOU IF THIS IS EASIER FOR YOU.]

Current medications (prescription and over-the-counter) with dosages: _____

Please continue...



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Are you currently seeing anyone else for the problem that brought you here?

- acupuncturist, neurologist, obstetrician / gynecologist, occupational therapist, massage therapist, podiatrist, primary care physician, rheumatologist, pediatrician, chiropractor, dentist, cardiologist, orthopedist, osteopath

Are you allergic to latex? oils, lotions, creams?

Do you smoke or chew tobacco? _____ packs/day; how many years? _____

How many days each week do you drink alcohol? _____ If 1 drink equals 1 beer or 1 glass of wine, how much do you drink in an average sitting? _____

How much caffeinated coffee [or caffeine-containing beverages] do you drink each day? _____ Do you ever feel unsafe at home or has anyone hit you or tried to hit you in any way? _____

Anything else we should know about? _____

SOCIAL

With whom do you live?

- alone, child, spouse / significant other only, spouse / and other(s)

Does your home have: (check ALL that apply)

- stairs, no railing, uneven terrain, assistive devices in bathroom, obstacles, stairs, railing, scatter rugs, ramps, elevator

Do you use:

- any assistive devices?, glasses / contact lenses, hearing aids

Do you have difficulty with: (check ALL that apply)

- moving in bed, walking on stairs, getting dressed, toileting, preparing meals, moving from bed to chair, walking on ramps/hills, bathing, household chores, driving, walking on level ground, walking on uneven terrain, eating, shopping, participation in sports

FAMILY HISTORY:

Table with 5 columns: Condition, mother, father, any brother / sister, any grandparent. Rows include heart disease, high blood pressure, stroke, diabetes, cancer, psychological, osteoporosis, other.

The above is true to the best of my knowledge.

Signature of patient (or legal guardian)

Date



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SYMPTOM QUESTIONNAIRE
please complete on day of evaluation

PATIENT NAME: _____ **DATE:** _____

Part 1. INSTRUCTIONS: Please place a check by the words that fit your symptoms. Choose only the words that describe your symptoms and check the intensity of the symptoms felt [mild, moderate, severe].

For words that do not describe your symptoms, check 'none'.

	None	Mild	Moderate	Severe
Throbbing	___	___	___	___
Shooting	___	___	___	___
Stabbing	___	___	___	___
Sharp	___	___	___	___
Cramping	___	___	___	___
Gnawing	___	___	___	___
Hot	___	___	___	___
Burning	___	___	___	___
Aching	___	___	___	___
Heavy	___	___	___	___
Tender	___	___	___	___
Splitting	___	___	___	___
Tiring	___	___	___	___
Exhausting	___	___	___	___
Sickening	___	___	___	___
Fearful	___	___	___	___
Punishing	___	___	___	___
Cruel	___	___	___	___



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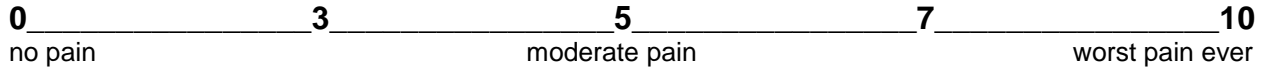
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SYMPTOM QUESTIONNAIRE
please complete on day of evaluation

Part 2. INSTRUCTIONS: Please mark a point on the horizontal line that indicates your pain intensity (how bad does it hurt). Use the words under the numbers to help indicate the intensity of your symptoms.



Part 3. INSTRUCTIONS: Please place an X where your symptoms are / pain is today and / or has been over the last 48 hours. Use an arrow ← → to indicate if it travels to another area of the body.

