Patient Information Sheet

Name _____ Date _____ Gender: M or F

Nickname_____ DOB ___/___/___ Married: Y ☐ N ☐ Pace Maker Y ☐ N ☐

Ph. (H)( ) _____-_____ (C)( ) _____-_____ (W)( ) _____-_____ Email _____

Communication Pref: Phone ☐ Text ☐ Email ☐ Student: Y ☐ N ☐ Full-time: Y ☐ N ☐

Current Address _____ City _____ State ____ Zip _____

Employer_____

Spouse_____ Phone ( ) _____-_____

Employer_____

Referring Physician_____ Part of body injured/hurt_____

Date of 1st symptoms ___/___/___ Date of accident (if applicable) ___/___/___

Is your condition/injury due to a work related accident? Y ☐ N ☐ Date ___/___/___

Is your condition/injury due to an automobile accident? Y ☐ N ☐ Date ___/___/___

Did your accident occur in NC? Y ☐ N ☐ If not, what state? _____

Is your condition/injury due to a school accident/sports injury? Y ☐ N ☐ Date ___/___/___

If you are under 18…

Father_____ DOB ___/___/___ Ph. ( ) _____-_____

Mother_____ DOB ___/___/___ Ph. ( ) _____-_____

Legal Guardian_____ DOB ___/___/___ Ph. ( ) _____-_____

Insurance: We will make copy of your card(s) for our records.

Primary Insurance_____ Policy Holder_____ DOB ___/___/___

Secondary Insurance_____ Policy Holder_____ DOB ___/___/___

Who will be financially responsible? _____

I understand that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and Goldsboro PT. I agree to pay my estimated copay/coinsurance at the time services are rendered. In the event my insurance company does not pay the estimated charges, or within a reasonable period of time, upon request of this office, I will immediately pay the balance owed on my account.

I authorize GPT to release any medication information relating to my treatment to any insurance companies that may be responsible for paying benefits to me and to any attorneys who may be representing me due to my condition and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understand, and agree to all of the above. The information I have provided is true and complete to the best of my knowledge.

Patient's Signature_____ Date___/___/___

Guardian's Signature (if patient is a minor)_____ Date ___/___/___

Goldsboro Physical Therapy & Wellness
2503 Wayne Memorial Drive
Goldsboro, NC 27534
Phone: (919) 734-1311
Fax: (919) 734-8816

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Under federal law, **Goldsboro Physical Therapy & Wellness** has a legal duty to protect and maintain your privacy, including your personal health information (PHI) in accordance with the HIPAA Privacy Rule. Our primary goal is to provide you with the highest quality care and, at the same time, preserve your privacy. We promise to limit the use of your personal health information.

Uses and Disclosures of Health Information

Goldsboro PT & Wellness uses your personal health information primarily for providing quality treatment and to obtain payment for treatment. Our support staff may use your personal information to conduct administrative duties to provide you with the best care. For example, we may be required to fax an evaluative report to your referring physician to notify your doctor of the therapist's findings or of your progress. We may also use your personal health information for evaluating the quality of care that we provide. For example, our therapist may ask another therapist a clinical question about your condition or review your chart to ensure that the therapist is documenting your functional progress clearly. We also provide information when required by law.

In any other situation such as using your information for marketing purposes, our policy is to obtain your written authorization. At any time, you have the right to revoke your consent in writing, which would stop future disclosures.

Goldsboro PT & Wellness has the right to make changes to this policy at any time. If changes are made to our policy, we will provide you with a new Notice and replace our current posted Notice in the lobby. You may also request an updated copy of our Notice of Patient Information Practices at any time.

What are my Individual Rights?

You have the right to review and edit any incomplete or inaccurate information of your records, and request a copy of your personal health information at any time. You have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You can request in writing that we not use or disclose your personal health information for treatment, payment or administrative purposes except when specifically authorized by you. Goldsboro PT & Wellness will consider each reasonable request on a case by case basis, and respond to your request(s) in writing.

Who do I call with questions or concerns?

If you are concerned that Goldsboro PT & Wellness may have violated your rights to protect your personal health information or if you have questions about our policies, please contact our Office Manager listed below:

Goldsboro Physical Therapy & Wellness
Lori Grady, Office Manager
2503 Wayne Memorial Drive, Goldsboro, NC 27534
Telephone: (919) 734-1311 Fax: (919) 734-8816

You may also contact the U.S. Department of Health and Human Services in writing with concerns or complaints.

Goldsboro Physical Therapy
Patient Information Consent Form

I have read and fully understand GPT's Notice of Information Practices. I understand that GPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that GPT will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in GPT's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I also consent to the release and disclosure of my personal health information to Goldsboro Physical Therapy from any medical providers as deemed necessary by my physical therapist for my care and treatment consisting of doctor's notes, lab reports, x-ray and MRI reports.

_____ _____

Signature Date

_____

Patient Name

Designated Individuals Authorization Form

I hereby authorize one or all of the parties below to request and receive any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Persons

Name: _____ Relationship: _____

Medical Information ☐ Billing Information ☐ Scheduling Information ☐

Name: _____ Relationship: _____

Medical Information ☐ Billing Information ☐ Scheduling Information ☐

Name: _____ Relationship: _____

Medical Information ☐ Billing Information ☐ Scheduling Information ☐

Goldsboro PT No-Show/ Late-Cancellation Policy

There is a $20 no-show/late cancellation fee. All appointments must be canceled by 3 p.m. of the previous day (or Friday for a Monday appointment), to avoid charges for a no-show or late – cancellation. After hour messages regarding cancellations may be left at 919-734-1311. Insurance WILL NOT cover charges for no-show/late cancellation fees.

I have read and understand the above policy.

Signature _____ Date _____

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2503 Wayne Memorial Drive
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Name: _____ Date: _____

Instructions

Rate your major area of pain on the 0-10 Pain Rating Scale. Write the **NUMBER** of your pain at the present time, your best day, and your worst day over the past 30 days in the space **at the bottom of the page**. Remember, the numbers refer to your pain, not how strong or weak you feel. For example: No. 1 is VERY WEAK **PAIN** and No. 7 is VERY STRONG **PAIN**.

0-10+ Pain Rating Scale	
10+	Maximum Pain
10	Very, very strong pain
9	
8	
7	
6	
5	
4	Somewhat strong pain
3	Moderate pain
2	Weak pain
1	Very weak pain
0.5	Very, very weak pain
0	No pain at all

YOUR PAIN RATING using numbers above:

PAIN NOW: _____

PAIN RATING ON YOUR BEST DAY: _____

PAIN RATING ON YOUR WORST DAY: _____

What activities or actions increase your pain?_____

What activities or actions decrease your pain?_____

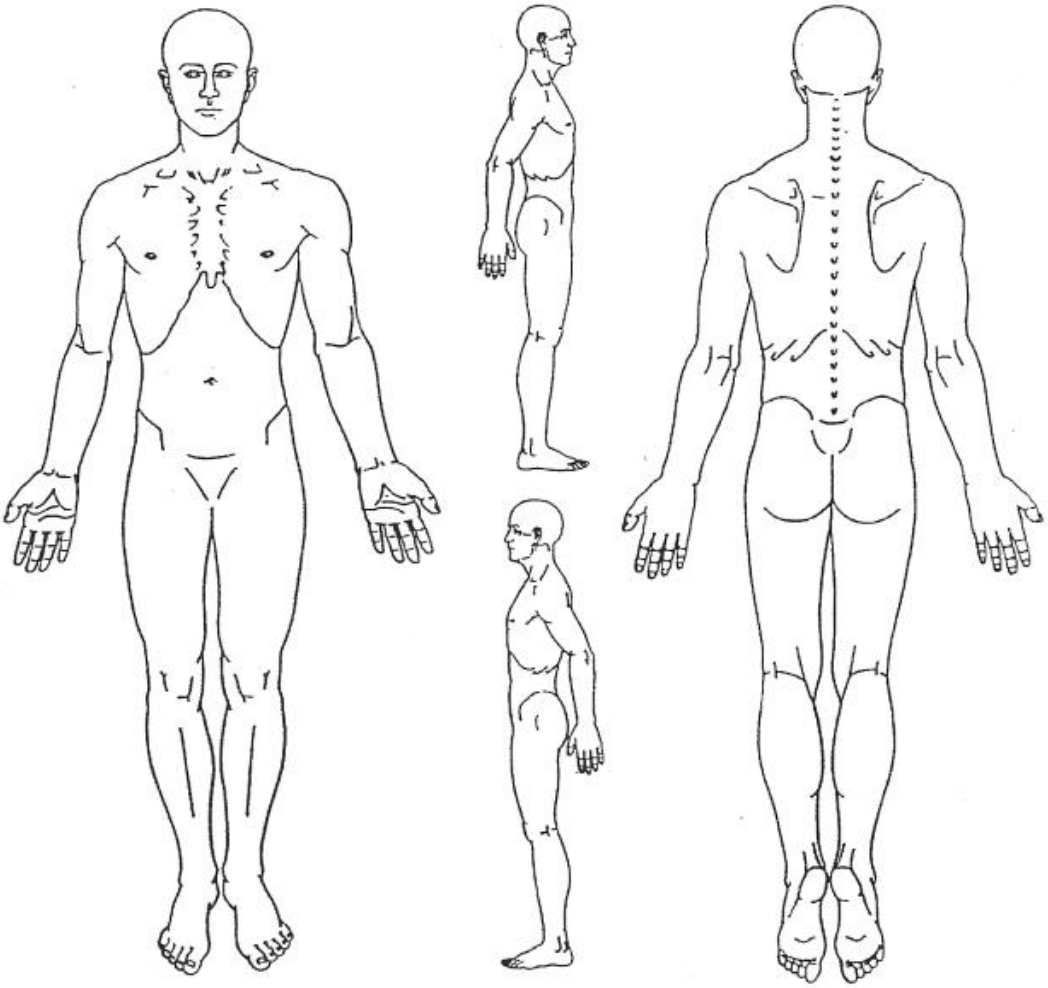
Location of pain: _____

Description of pain: _____

The Revised Oswestry Pain Questionnaire

How long have you had pain? _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain right now.



A = Aching B = Burning N = Numbness P = Pins & Needles S = Stabbing O = Other

Mark Below Where Best Describes Your Pain Intensity