# CONNECT PHYSICAL THERAPY LLC

**PATIENT INFORMATION**

Last Name:_____First Name:_____MI:____M/F: _____
Date of Birth:_____Address:_____
City/State/Zip_____
Cell Phone:_____Home Phone:_____
Emergency Contact:_____Emergency Phone:_____
Occupation:_____Employer:_____
Work Phone:_____Email:_____
How did you hear about us?_____
Referring MD: _____
Primary MD: _____

**BILLING INFORMATION**

Is this a work related or automobile injury? YES/NO (If yes, fill the following information)
Date of Injury:_____Claim #: _____
Contact Person:_____
Auto claims: Do you have Medical Benefits (MedPay) on policy? YES/NO

**Primary Insurance**:_____ID#:_____
Policy Holder Name:_____Relationship to Insured:_____
Insured DOB:_____Insured's Employer:_____
**Secondary Insurance**:_____ID#:_____
Policy Holder Name:_____Relationship to Insured:_____
Insured DOB:_____Insured's Employer:_____

Are you presently receiving Home Health Services (ie. Visiting Nurse, Physical Therapy, Home Companion, etc): YES/NO
Name of Home Health Agency:_____

**PAYMENT POLICY**

I, the undersigned, have insurance coverage with _____and assign directly to Connect Physical Therapy LLC all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. Verification of coverage is not a guarantee of payment. Connect Physical Therapy LLC is not responsible for your insurance misquoting medical benefits. I hereby authorize Connect Physical Therapy LLC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I agree to pay my deductible and/or copayment upon each visit. I understand I am responsible for obtaining any necessary referrals from my physician, if required.

Signature: _____Date: _____

CONNECT PHYSICAL THERAPY LLC

**CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

**OUR PRIVACY PLEDGE**

Protecting your privacy is of upmost importance to us. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (HIPPA). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

**YOUR RIGHT TO LIMIT USES OR DISCLOSURES**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**YOUR RIGHT TO REVOKE YOUR AUTHORIZATION**

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Printed Name:_____

Signature:_____ Date:_____

# CONNECT PHYSICAL THERAPY LLC

**MEDICAL HISTORY**

List your **current** prescription and/or non-prescription medications:_____

_____

Are you currently taking blood thinning or anticoagulant medications? YES/NO

Allergies:_____

Are you Latex sensitive? YES/NO

Height: _____Weight:_____Typical Blood Pressure:_____

Are you pregnant or think you might be pregnant? YES/NO Do you smoke? YES/NO

List any surgeries or other conditions in which you were hospitalized, including dates: _____

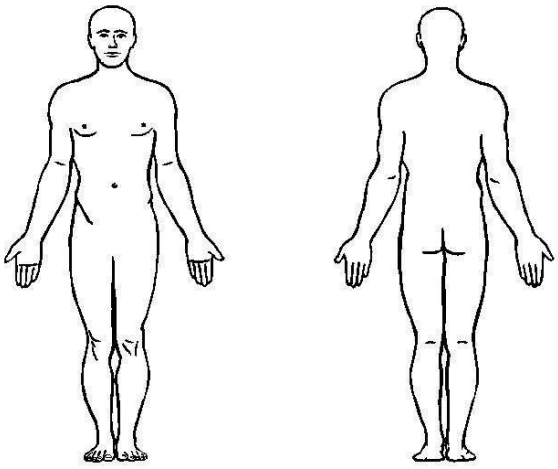
_____

Do you **currently** have any of the following? (Check all that apply)

- ☐ Change in appetite
- ☐ Change in bowel/bladder
- ☐ Visual changes
- ☐ Dizziness
- ☐ Fever/chills/sweat
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ History of falls
- ☐ Weakness/Fatigue
- ☐ Weight loss/gain

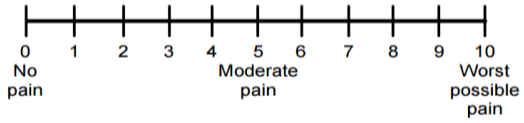
Have you **ever** had any of the following? (Check all that apply)

- ☐ Asthma/Lung Disease
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Stroke/TIA
- ☐ High Blood Pressure
- ☐ Blood Clot/Emboli
- ☐ Infectious Disease
- ☐ Cancer/ Type: _____
- ☐ Thyroid Disease
- ☐ Kidney/Liver Problems
- ☐ Epilepsy/Seizures
- ☐ Diabetes/ Type: _____
- ☐ Depression/Anxiety
- ☐ Osteoporosis
- ☐ Rheumatic Arthritis
- ☐ Other:_____

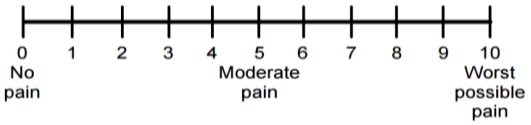


Mark your location of pain on the Body Chart

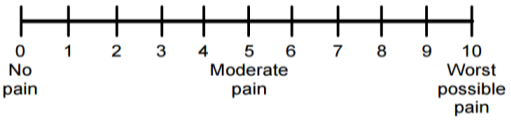
Circle your pain level **AT BEST**




Circle your pain level **RIGHT NOW**




Circle your pain level **AT WORST**




**Circle the word that best describes your pain:**

Sharp Burning Ache Numb Tingling Throbbing

Signature:_____ Date:_____

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# For Motor Vehicle Accidents Only

In the State of Connecticut, in the event of a motor vehicle accident, each injured person must use their **own auto insurance policy** for medical coverage, regardless of who is at fault.

For example, if you were injured in a motor vehicle accident that is not your fault, even if you are injured in someone else's car as a passenger or a driver, your medical bills are still submitted to your own motor vehicle insurance company, **NOT** to the insurance company of the at-fault driver.

You may or may not have medical payment coverage, or "med pay" on your auto insurance policy.

> If you **DO** have medical payment coverage: Payment for your medical bills will be first submitted to your auto insurance company. *A letter of medical payment benefits (med-pay) is required at your first appointment.* Once your med pay is exhausted, the remaining balance will be submitted to your health insurance. Any payment required by your health insurance will be due upon each visit.
>
> If you **DO NOT** have medical payment coverage: *A letter of no medical payment coverage (med pay) needs to be submitted to us at your first appointment.* Any medical bills will be submitted to your health insurance. Any payment required by your health insurance will be due upon each visit.

I have read, understand, and fully accept the handling of my personal injury claim in accordance with the guidelines as stated above regarding my care at Connect Physical Therapy LLC.

Name:_____

Signature:_____

Date:_____