Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. What is your age? __________

2. What is your gender? ❒ Male ❒ Female

3. What is your occupation? ____________________
   - Are you working now? ❒ Yes ❒ No

4. Have you had physical therapy before? ❒ Yes ❒ No

5. Where is your pain/problem? ____________________

6. What caused your pain/or problem? ____________________

7. Approximately when did it start? ________/ ________/________

8. Is it getting worse, better, or staying the same? ____________________

9. Have you ever had this pain/problem before? ❒ Yes ❒ No

10. Is your pain constant (never goes away)? ❒ Yes ❒ No

11. On the scale below cicle your worst pain level in the past couple of days:

    Mild Moderate Severe

    0... 1... 2... 3... 4... 5... 6... 7... 8... 9...10

12. Are you taking any medication for this ain/problem? ❒ Yes ❒ No
    -If yes, what and does it help?

13. Are any of your usual everyday activities affected? ❒ Yes ❒ No
    - If yes, describe how.

14. List all past surgeries with dates:

15. List all medical conditions you have (or were told you have)?

Patient Name: ____

Signature: ____ Date: __________

Important Company Policies for a Successful Relationship

Metro SportsMed® is dedicated to providing you with the best in personalized care. To achieve this goal we follow a set of very important guidelines. As you review this information please initial each box and sign the final statement of agreement.

❒ **Clothing**

It is recommended that you wear comfortable loose fitting clothing along with sneakers to your therapy session. This will allow for ease of examination and performance of your therapy routine.

❒ **Therapy Sessions**

Therapy treatments will be performed only after an evaluation by a licensed therapist. This treatment may be performed in consultation with your physician's prescription. Treatments may include: the use of modalities-ultrasound, electrical stimulation, hot and cold packs; therapeutic exercise, functional activities, splinting and manual therapy techniques.

❒ **Appointment Policy**

We ask that you arrive **15 minutes** before your scheduled appointment time. This will allow you time to prepare for your therapy session and deal with any appointment/insurance issues. If you arrive more then **10 minutes** after your scheduled start time you will be asked to wait for the next available opening or to re-schedule. Every attempt will be made to accommodate you but last minute openings are unpredictable.

❒ **24-Hour Advance Notice**

If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Less then a 24-hour notice will result in a $25 cancellation fee. Advanced notice allows someone else the opportunity to make a needed appointment in place of yours.

If you fail to keep two appointments without notice all future appointments will be removed and the cancellation fee will be charged to your account. You may re-schedule your appointments on a "first come, first serve basis."

❒ **Co-Pays**

All co-pays must be paid **before** being seen by your therapist. If you are unable to pay your co-pay at the time of your appointment you will be asked to complete an "Extension Request Form." This is a promise-to-pay form that carries a minimal additional fee and allows you to maintain your appointment.

If you are experiencing financial hardship and are unable to afford the cost of our services we have a "Financial Hardship Application," that will help us determine if you meet established Federal Guidelines.

Metro SportsMed is bound by Federal and State Law to comply with the payment policies as set by your insurance plan. These regulations prevent Metro SportsMed from uniformly waving co-pays and deductibles.

❒ **Cell Phones**

Cell phones should be used for emergencies only. Please set phones to vibrate or silent when in the therapy area.

❒ **Minor Children**

Children under sixteen receiving therapy must be accompanied by an adult guardian.
Children that are not receiving therapy are not allowed in the therapy area. Children may wait in the waiting room if there is not an obvious safety concern. Childcare is not available.

I, the undersigned, do hereby agree and give my consent for therapy treatments which will be performed by METRO SPORTSMED considered necessary and proper in diagnosing or treating his/her physical condition

I have read this notice and have been given the opportunity to have my questions answered. My questions have been answered to my satisfaction and I agree to treatment under the above terms.

Signature: ______________________________ **Date:** ____________

Patient / Guardian

METRO SPORTSMED®

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully. If you have any any questions about this notice, you may contact our Privacy Officer @ 718.369.8000

We are required by law to protect the privacy of health information that may reveal your identity and provide you with a copy of this notice, which describes the health information privacy practices of **METRO SPORTSMED®** "Protected Health Information" is information about you, including demographic information that may identify you, relates to your past, present, and future health condition and related health care services.

My signature ________________________________ indicates having received a copy of the HIPAA Notice of Privacy Practices on _______/________/20________.