Complete Rehab and Sport Physical Therapy
Michele Rauer Physical Therapy Assistant, PC
672 South Country Road East Patchogue, NY 11772
office 631.654.5282 fax 631.654.5253

Medical History Questionnaire

Please fill out this form to the best of your knowledge. Your therapist will review it with you during your initial evaluation.

Name _____ Date:_____
Age _____ Sex _____ Height _____ Weight _____ Occupation _____

Address_____
Home Phone_____ Work Phone _____ Cell Phone _____

Primary Physician _____ Phone: _____
Emergency Contact: _____ Phone : _____

Have you ever/ do you presently have any of the following (PLEASE CHECK):

□ abnormal EKG	□ arthritis	□ asthma	□ hernia	□ chest pain
□ diabetes	□ dietary restrictions		□ epilepsy	□ fainting
□ headaches	□ heart attack		□ heart murmur	
□ cardiovascular problems		□ hypertension		□ back injury
□ orthopedic problems		□ recent surgery		□ short of breath
□ any known allergies		□ other		

If you checked any of the above, or if you have any other medical conditions, please list and explain:

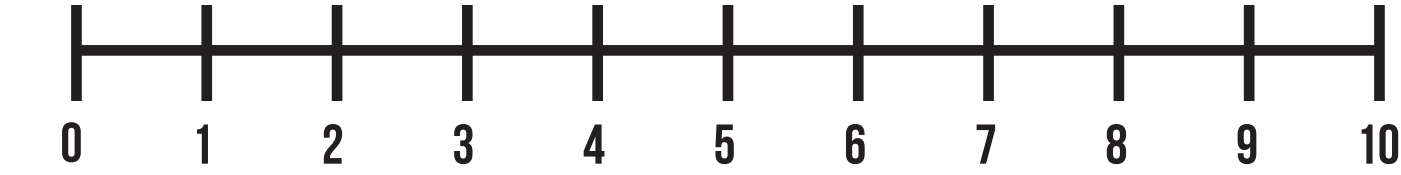
_____
_____
_____
_____

Are you currently taking any medications? If yes, please list here:

_____
_____
_____
_____

In the past 12 months have you had any of the following?

Physical Exam	YES	NO
EKG	YES	NO
Blood Pressure checked	YES	NO
Blood work	YES	NO
Stress Test	YES	NO

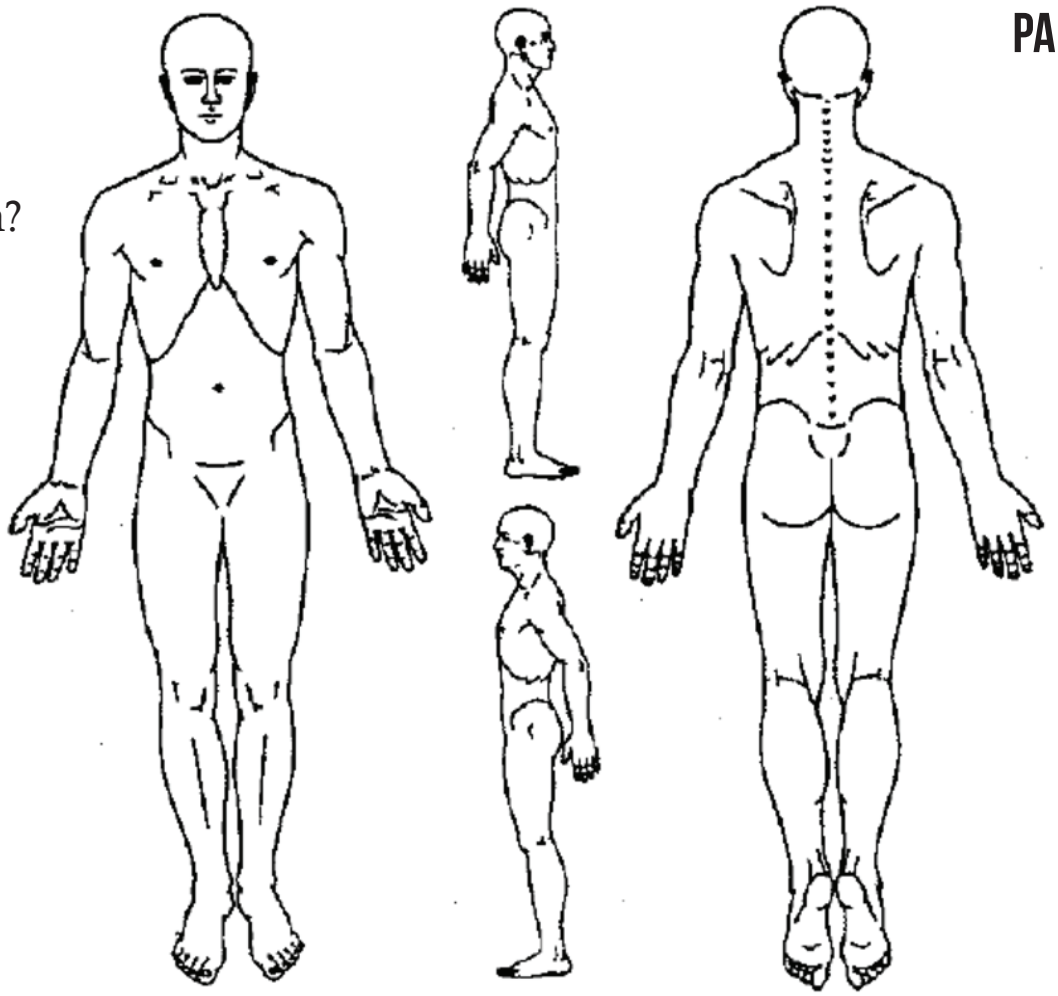


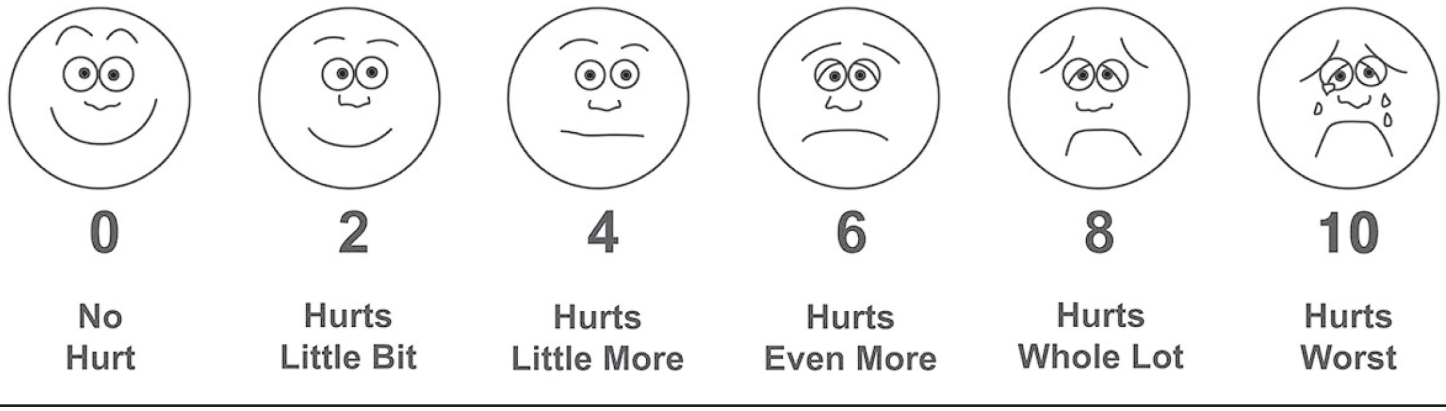
NO PAIN

MODERATE PAIN

WORST POSSIBLE PAIN

Where is your pain?





Indicate the intensity of your pain complaints on the scales above

Height _____ Weight _____

Complete **Rehab and Sport Physical Therapy**
Michele Rauer Physical Therapy Assistant, P.C.
672 South Country Road East Patchogue, NY 11772
office 631.654.5282
fax 631.654.5253

AUTHORIZATION FOR USAGE OF *"SIGNATURE ON FILE"* DESIGNATION FOR CLAIM AUTHORIZATION

I, _____, authorize Michele Rauer Physical Therapy Assistant,
(ENROLEE NAME)

PC. to execute any claim forms with which my signature is required with the designation *"SIGNATURE ON FILE."*

By doing so I authorize:

1.) The release of any medical information necessary to process my claim
2.) Payment of medical benefits to the Michele Rauer Physical Therapy Assistant, P.C.

This authorization will remain in force until terminated in writing by the enrollee.

Date: _____, 20_____ _____
SIGNATURE OF PATIENT OR GUARDIAN

Complete **Rehab and Sport Physical Therapy**
Michele Rauer Physical Therapy Assistant, PC
672 South Country Road East Patchogue, NY 11772
631.654.5282 fax 631.654.5253

CO PAYMENT AGREEMENT

Dear Patient:

Welcome to Complete Rehab and Sport Physical Therapy.

We have been in contact with your insurance company regarding your physical therapy treatment coverage.

According to your policy, your responsibility each visit is $_____. This payment should be paid daily or on a weekly basis.

If you have any questions concerning your payment arrangement, please do not hesitate to speak with us.

Please sign and date below, indicating that you agree to the terms stated above.

Date:_____ Signature:_____

Complete **Rehab and Sport Physical Therapy**
Michele Rauer Physical Therapy Assistant, PC
672 South Country Road East Patchogue, NY 11772
office 631.654.5282 fax 631.654.5253

PRIVACY NOTICE ACKNOWLEDGEMENT OF RECEIPT

HIPPA JOINT PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. A complete copy of Michele Rauer Physical Therapy Assistant, P.C.'s policies and procedures as they pertain to protect health information is available for onsite examination upon your request.

I, _____, acknowledge that I have been provided with Michele Rauer Physical Therapy Assistant, P.C.'s privacy notice information.

Date:_____, 20___

Signature of Patient or Guardian:_____

Complete **Rehab and Sport Physical Therapy**
Michele Rauer Physical Therapy Assistant, PC
672 South Country Road East Patchogue, NY 11772
office 631.654.5282 fax 631.654.5253

INFORMED CONSENT

By signing below you attest that you have been informed through verbal conversation and written instruction, as it relates to your diagnosis, of the nature and purpose of all possible treatments and modalities to be preformed, the risks and benefits of all proposed treatments and procedures, alternatives to and the risks and benefits of all alternate treatments not receiving or undergoing all possible treatments, modalities or procedures ordered by your physician and recommended by your health provider.

By signing below I agree that I have given consent and permission to the health care providers of Michele Rauer Physical Therapy Assistant, PC to provide physical therapy treatment as prescribed and explained in detail as above.

Signature: _____ Date:_____

Print Name:_____