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*Jonathan Lian, PT, DPT*
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*Ashley Royer, PTA*

689 Gilford Avenue, Gilford, NH 03249 | Phone: (603) 528-4152 | Fax: (603) 528-1591

# Welcome to Gilford Physical Therapy & Spine Center!

Your appointment is scheduled for: _____ at ___:___.

**PLEASE NOTE:** Our address is above. We are not located on Maple St. and we are not part of LRGH. Visit our website for directions & a photo of our building.

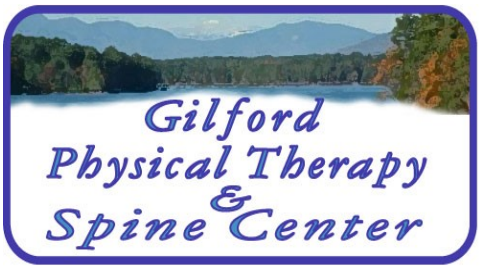
**Your first appointment with the therapist is 1 hour. In order to make the most of your time, please arrive 10 minutes early & fully prepared with the following:**

- The attached Gilford PT paperwork completely filled out (If you do not have our 6-page paperwork completely filled out beforehand, you **must arrive 30 minutes early**)
- Your insurance card(s)
- Your referral/prescription for physical therapy from your doctor
- An updated, accurate medication list
- A form of payment for your deductible, co-insurance, or copay. We accept checks, credit cards & cash. Payment is due at each visit.
- Your operative report and/or any imaging reports, if applicable
- An extra pair of shoes to change into upon arrival - patients may be exercising on the floors, and we like to keep them clean!
- Your claim and adjustor information if this is a worker's compensation case or auto accident

**Have more questions? Please visit our website, www.GilfordPhysicalTherapy.com, & click on the "Patient" tab for a physical therapy FAQ.**

**Parking:** Please help us reserve our front parking spaces for those who have difficulty walking or poor balance by **parking in the back of the building and walking around to the front door**, even if the front parking lot has vacant spots.

**Late Policy:** If you are going to be late for an appointment, please give us a call to see if your therapist will still be able to see you. "Squeezing" people in who have arrived late can lead to increased wait-times for those who arrived on time for their appointments, so if you are going to be 15 or more minutes late we will generally reschedule you for a different time or day. There is no charge for cancelling an appointment.

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## Patient Information

Date: _____

Patient Name (please print): _____ Birthdate: _____ Age: ____

Sex: _____ Marital Status: _____ Social Security Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Email Address: _____

**24-hour courtesy reminders are made before each of your appointments. I'd prefer:** EMAIL / VOICEMAIL / NONE

Employer's Name: _____ Phone: _____ Ext: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Name of Insurance Company: _____ Policy ID #: _____

Policyholder (if not patient): _____ Relation: _____ DOB: _____

**COMPLETE THIS SECTION IF WORKER'S COMPENSATION**

Insurance Carrier: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Date of injury: _____ Claim #: _____

Employer When Injury Occurred: _____ Phone: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

**COMPLETE THIS SECTION IF AUTO ACCIDENT**

Auto Insurance Carrier: _____ Phone: _____

Name of Policyholder: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Date of Injury: _____ Claim #: _____

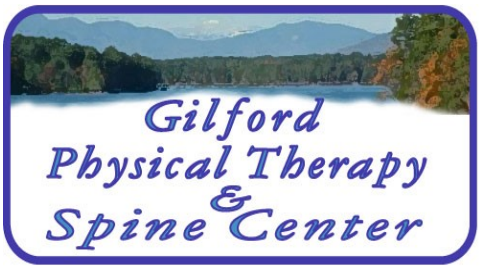
**COMPLETE THIS SECTION IF ATTORNEY INVOLVEMENT**

Law Firm: _____ Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____

**I certify that all of the above information provided herein is true and correct:**

Patient/Guardian Signature: _____ Date: _____

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## **Office Policies** (1 of 2)

*The following are Gilford Physical Therapy & Spine Center's policies governing appointment scheduling, payment terms, insurance acceptance, financial responsibility and information releases.* ***Please read carefully*** *before signing, and be sure to ask questions you might have before signing the document.*

**Appointment Attendance/Cancellation:** I understand that in order to help ensure that my insurance company pays for the care I receive at Gilford Physical Therapy & Spine Center, it is important that I adhere to the recommended care program. If I am unable to attend one of my scheduled appointments, I agree to notify the office as soon as possible via phone or email. I understand that Gilford Physical Therapy & Spine Center will never charge me for canceling or rescheduling an appointment. I understand that should I fail to attend several consecutive appointments, the office reserves the right to cancel the remainder of my appointments until I make contact.

**Consent for Treatment:** I, the undersigned, consent to rehabilitation and related services at Gilford Physical Therapy & Spine Center. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching and/or contact of a sensitive nature.

**Treatment of Minors:** I as parent/guardian of a minor receiving treatment at Gilford Physical Therapy & Spine Center do hereby give my consent to treatment for the injury that my son/daughter/other has been referred for.

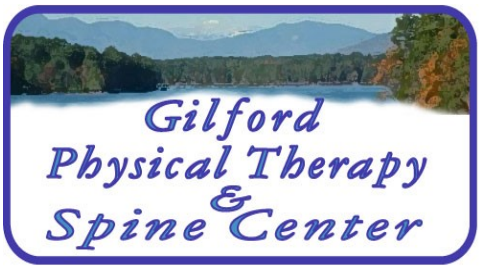
**Assignment of Payment:** I hereby assign all medical benefits to which I am entitled, including Medicare and other health plans to Gilford Physical Therapy & Spine Center.

**Authorization of Release of Information:** I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office. I also authorize this office to release a copy of my evaluation or re-evaluation to the Physicians involved with this injury.

**Waiver, Release, and Liability:** I understand that Gilford Physical Therapy & Spine Center is not responsible for loss or damage to personal valuables. I also release, discharge and acquit Gilford Physical Therapy & Spine Center, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

**Insurance Acceptance:** Gilford Physical Therapy & Spine Center is a participating provider with most major health insurance plans. Although physical therapy is by most insurances considered a "covered service", this does not necessarily mean your insurance will pay 100% of each visit. It is important for you to know how much your plan may charge you for outpatient physical therapy services. Your insurance plan may also limit the amount of visits you are allowed per calendar or policy year or per injury. We urge every patient to contact their insurance company to see if they will owe a deductible, co-insurance, or copay for receiving outpatient physical therapy services. We do our best to verify this information before your initial visit.

**Notice of Privacy:** I acknowledge receipt of Notice of Privacy Practices.

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## **Office Policies** (2 of 2)

**Insurance Acceptance:** Gilford Physical Therapy & Spine Center is a participating provider with most major health insurance plans. We also accept worker's compensation and auto accident policies. Although physical therapy is often considered a "covered service" by most insurance plans, that does not mean the insurance will pay 100% of each physical therapy service. The insurance plan dictates if a co-insurance, copay, or deductible will be owed (see FAQ below). Insurance plans may also limit the amount of visits of outpatient physical therapy that are allowed per calendar or policy year or per injury. If you are to meet this limit or become uninsured during treatment, the office manager can arrange a self-pay program to help your therapy continue without interruption.

**Financial Responsibility:** I understand that I am responsible for all services rendered by Gilford Physical Therapy & Spine Center. I understand that all co-payments are due at the time of service. If I am working on paying down my deductible, a minimum $50 payment is due at each visit. Co-insurances will be charged as a dollar amount equal to the percentage (for instance, a 20% co-insurance means $20 is due at each visit). All co-insurance and deductible balances (if applicable) are due upon receipt of the Explanation of Benefits from the insurance company. Gilford Physical Therapy & Spine Center accepts payment in the form of cash, check, or credit card (excluding American Express). If a receipt is needed to turn in for a Health Savings Account or a Flexible Spending Account, one may be requested from the front desk staff. I understand that Gilford Physical Therapy & Spine Center reserves the right to forward my account to a collections agency if my account becomes 3 or more months overdue.

**After reading the Office Policies (pages 1 & 2) and Notice of Privacy Practices, I agree to adhere by all of these conditions. I understand that if I would like a copy of any of these policies to take home, the staff at Gilford Physical Therapy & Spine Center will provide me such upon request.**

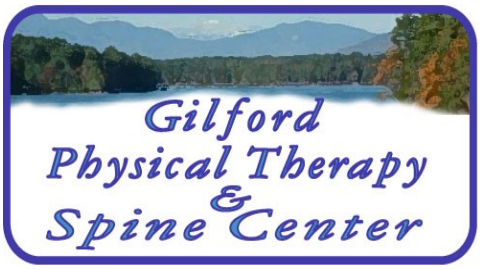
Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# Health History

**NAME:** _____ **DOB:** _____ **DATE**: _____

Are you currently working? YES NO Occupation: _____

Leisure activities: _____

**ALLERGIES:**
Are you latex sensitive? YES NO
List any other allergies we should know about, including medications: _____
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? YES NO

Please check any of the following whose care you're under and the provider's name.

___ Medical doctor _____
___ Osteopath _____
___ Dentist _____
___ Other_____

___ Psychiatrist/Psychologist _____
___ Physical Therapist _____
___ Chiropractor_____
___ Other_____

Date of last physical examination: _____ Date of next M.D. Appointment: _____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

What is your reason for attending physical therapy? _____

Because of your problem, what specific activities are you having difficulty with? _____

What are you personal goals/outcomes you hope to achieve from therapy?_____

**INJURIES/SURGERIES/HOSPITALIZATIONS (Include date & cause)**
Please list any injuries or surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

Have you had prior physical therapy for this condition? YES NO This calendar year? YES NO How long? _____
Received at: Hospital __ Outpatient Center __ Home Health __
If yes, what was done/what were the results?_____

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| Have you ever been diagnosed with… | Yes | No | Type |
|---|---|---|---|
| Respiratory problems | | | |
| Cancer | | | |
| Heart problems | | | |
| Thyroid problems | | | |
| Kidney disease | | | |
| Chemical dependency (i.e. alcoholism) | | | |
| Circulation problems | | | |
| Multiple sclerosis | | | |
| Rheumatoid arthritis | | | |
| Other arthritic conditions | | | |
| Osteoporosis | | | |
| Anemia | | | |

| Have you ever been diagnosed with… | Yes | No | Type |
|---|---|---|---|
| Diabetes | | | |
| Stroke | | | |
| Hepatitis | | | |
| Blood clots | | | |
| HIV | | | |
| Low blood pressure | | | |
| High blood pressure | | | |
| Metal implants | | | |
| Depression | | | |
| Stomach ulcers | | | |
| Tuberculosis | | | |
| Pacemaker | | | |

Please list any other diagnoses not above: _____

_____

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

**Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?**

YES NO Chemical dependency (i.e. alcoholism)
YES NO Inflammatory Arthritis (Rheumatoid, Ankylosing)
YES NO High blood pressure
YES NO Heart disease
YES NO Stroke
YES NO Diabetes
YES NO Cancer
YES NO Depression
YES NO Kidney disease

**Have you taken any of these medications within the last week?**

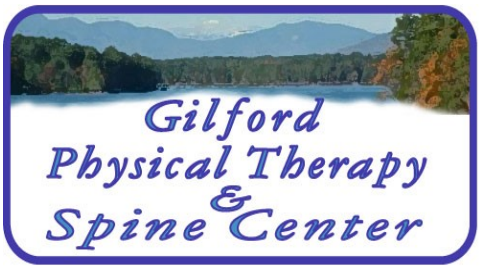
| | | **Physician Prescribed?** |
|---|---|---|
| Aspirin | YES NO | YES NO |
| Tylenol | YES NO | YES NO |
| Anti-inflammatories (Advil/Motrin/Ibuprofen etc) | YES NO | YES NO |
| Stomach ulcer medications | YES NO | YES NO |
| Vitamins/mineral supplements | YES NO | YES NO |
| Herbals/Remedies | YES NO | YES NO |

Others NOT prescribed by a physician: _____

Please list any other physician-prescribed medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

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**Describe your general health (circle one):** Excellent Good Fair Poor

**If you have Medicare, they require us to record your height & weight:** Height: ____ feet ____ inches Weight: _____ pounds

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

**Tobacco use:** How many packs do you smoke per day? ____. For how many years? _____. If you quit, when? _____

How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

| **Have you recently noted…** | **Yes** | **No** |
|---|---|---|
| Weight loss or gain | | |
| Nausea/vomiting | | |
| Dizziness/lightheadedness | | |
| Fatigue | | |
| Weakness | | |
| Fever/chills/sweats | | |
| Numbness or tingling | | |
| Tremors | | |
| Seizures | | |
| Double vision | | |
| Loss of vision | | |
| Eye redness | | |
| Problems urinating (difficulty starting, painful, etc) | | |
| Skin rash | | |
| Problems sleeping | | |
| Pregnant or think you might be pregnant | | |
| Sexual difficulties | | |
| Hearing problems | | |

| **Have you recently noted…** | **Yes** | **No** |
|---|---|---|
| Joint/muscle swelling | | |
| Easy bruising | | |
| Excessive bleeding | | |
| Difficulty breathing | | |
| Regular cough | | |
| Arm/leg swelling | | |
| Heart racing in your chest | | |
| Difficulty swallowing | | |
| Heartburn/indigestion | | |
| Constipation/diarrhea | | |
| Blood in stools | | |
| Post menopause | | |
| Urinary incontinence | | |
| Blood in the urine | | |
| Night sweats | | |
| Stress at home or work | | |
| Headaches | | |
| **Other:** | | |

_____ _____ _____ _____
Therapist signature Date Patient signature Date

How did you hear about our practice?_____

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Mark these drawings according to where you hurt (i.e., if the back of your neck hurts, mark the drawing on the back of the neck, etc). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below on the corresponding body locations.

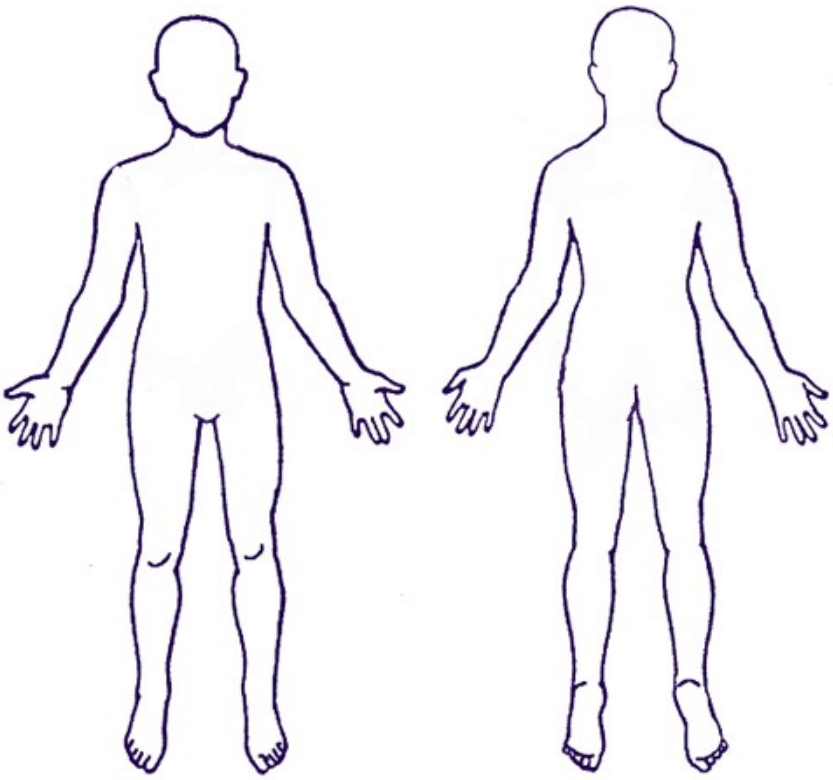
**Numbness**: ==========

**Aching**: ++++++++++++++++++++++++++

**Burning**: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

**Stabbing**: //////////////////////////////////////////////////

**Pins and Needles**: oooooooooooooooooooooooo



**On a scale of 0 (no pain) to 10 (worst pain imaginable), please rate your pain:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| At its worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Current: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At its best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |