Triumph Physical Therapy
8350 Richardson Rd
Commerce Township, MI 48382
947-800-7117 phone
947-800-7109 fax

Medication Log:

Patient Name: _____ DOB: _____

Physician: _____ Date: _____

Please include all medications (including over the counter/ herbal supplements) that you are taking at this time. Please include the exact dosage taken.

Medication	Frequency	Dosage	Route / Circle one	
			Oral	IV
			injection	Patch
			Oral	IV
			injection	Patch
			Oral	IV
			injection	Patch
			Oral	IV
			injection	Patch
			Oral	IV
			injection	Patch
			Oral	IV
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			Oral	IV
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			Oral	IV
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			injection	Patch
			Oral	IV
			injection	Patch
			Oral	IV
			injection	Patch
			Oral	IV
			injection	Patch

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PATIENT MEDICAL HISTORY & INTAKE QUESTIONNAIRE

Name: _____ DOB: _____

What problem(s) are you being treated for today? (Describe type and location of symptoms)

_____

_____

What date did your present symptoms begin? _____

How did your problem(s) begin: _____

My symptoms are currently: GETTING BETTER GETTING WORSE STAYING THE SAME

My symptoms currently: COME AND GO ARE CONSTANT CONSTANT, BUT CHANGE WITH ACTIVITY

What makes your symptoms better? _____

What makes your symptoms worse? _____

What time of day are your symptoms worse? Morning Afternoon Evening Overnight

Treatment received so far for this problem: Physical Therapy Injections Massage
Chiropractic Acupuncture Other: _____

Have you received Physical/Occupational Therapy with the last calendar year? YES ___ NO ___

Approximately how many treatment sessions have you received this calendar year? _____

Indicate special tests performed for this problem and results if known (circle all that apply):

X-ray _____ Bone Scan _____ CT scan _____ MRI _____

Other: _____

What is your goal for therapy? _____

Date of next physician appointment: _____

Occupation:_____

Are you currently working? Please circle the choice that applies:

Full Duty Light Duty Not Working If not working, date last worked_____

MEDICAL HISTORY

Please check all that apply:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune
- ☐ Blood Pressure-High
- ☐ Blood Pressure-Low
- ☐ Cancer
- ☐ Cardiac Condition
- ☐ Chemical Dependency
- ☐ Circulation Problem
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder Condition
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Incontinence
- ☐ Kidney Problem
- ☐ Metal Implants
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Condition
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Vision Problems

If yes to any of the above, please explain:_____

_____

Please list any other medical conditions:_____

SOCIAL HISTORY

Home: Please circle choice that applies: House Condo/Apartment Group Residence Nursing Home

Do you live alone? YES ____ NO ____

Leisure activities/Hobbies/Exercise Routine: _____

What activities comprise your day? (Circle all that apply): Sitting Standing Walking Lifting

Other: _____

Do you use tobacco? YES___ NO___ if yes, indicate type, amount, and frequency: _____

Is there anything else we should know that is pertinent to your treatment? _____

_____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

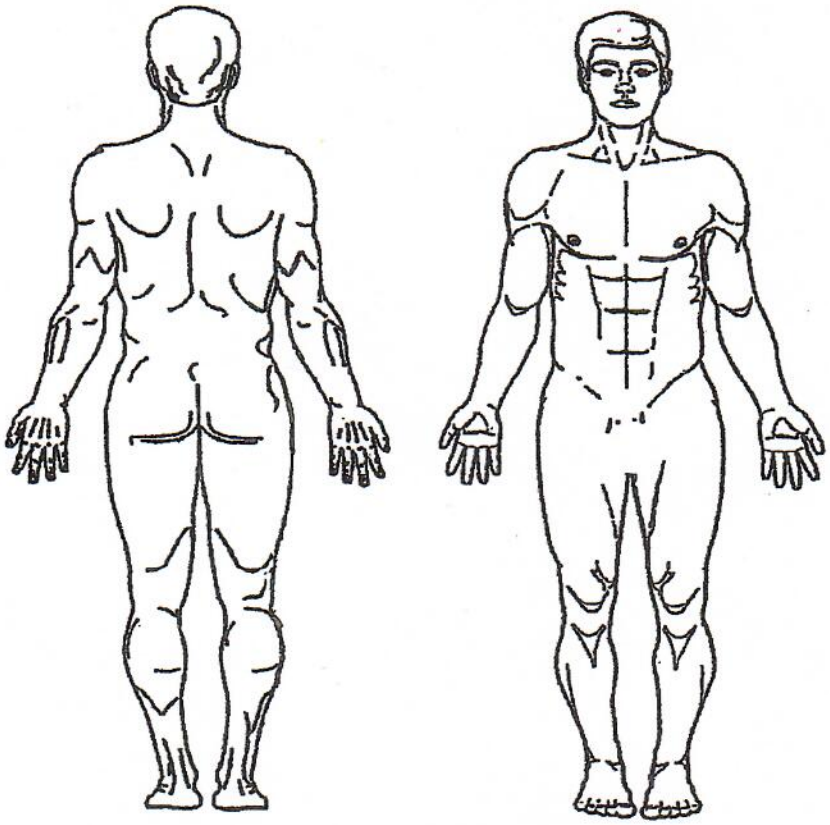
Patient/Guardian Signature _____ Date _____

Triumph Physical Therapy
Patient Pain Chart

Patient Name:_____ Date:_____

Please use the drawings below to indicate where you feel symptoms RIGHT NOW.

Use the following key to indicate different kind of symptoms.
KEY -- Pins & Needles = OOOO Stabbing = /////// Burning = XXXX Deep Ache = ZZZZ



Please use the three scales to rate the intensity of your pain over the PAST 24 HOURS.
Right now = your pain at this moment
Worst in 24 hours = the worst pain you have experienced since yesterday
Least in 24 hours = the least pain you have experienced since yesterday

RATE YOUR PAIN --

	0 = No pain									Extremely Intense = 10
Right Now	0	1	2	3	4	5	6	7	8	9	10
Worst in 24 Hours	0	1	2	3	4	5	6	7	8	9	10
Least in 24 Hours	0	1	2	3	4	5	6	7	8	9	10

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Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s) health care provider(s). I acknowledge that no guarantees have been make to me about the results of treatment.
2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $30 or $60 depending on appointment type.
   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled we are required to inform you Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or cancelled appointments. It is also required that all missed visits be rescheduled.
3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Triumph Physical Therapy. I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Triumph Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balances will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I acknowledge that I am responsible for collection costs and attorney fees if my account is turned over to collections.
   Please note that refusal to sign this form does not change responsibility for payment in any way.
4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Triumph Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.
5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that Triumph Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Triumph Physical Therapy's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Triumph Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.
6. **HIPAA CONSENTS:** In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

_____ _____
Name/Relationship Name/Relationship

I also authorize the release for appointment information left in a voice mail, answering machine, e-mail or text message and understand that there is some level of privacy risk associated with these forms of communication. Initial _____

_____ _____
Signature of Patient or Legally Responsible Person Date

_____
Printed Name of above

Person to contact in case of an emergency:

_____ _____
Name of contact person Phone number

APPENDIX F

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Triumph Physical Therapy** (**Triumph Physical Therapy**) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Triumph Physical Therapy**'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Triumph Physical Therapy** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **Triumph Physical Therapy** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand **Triumph Physical Therapy**, for **Workman's Compensation Cases**, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Triumph Physical Therapy** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

☐ I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

☐ I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Triumph Physical Therapy and agree to the liability limitations explained therein.

_____	_____	_____
Signature of patient or legal representative	Date	Relationship to Patient

_____

Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013