Initial Self-Evaluation Form - Flaming Physical Therapy

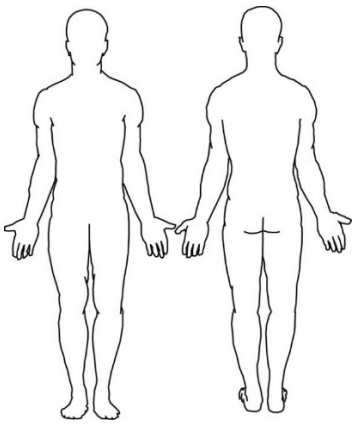
11 Elsinore Avenue, Bath 207-442-9810
68 Chapman Street, Damariscotta 207-563-7990

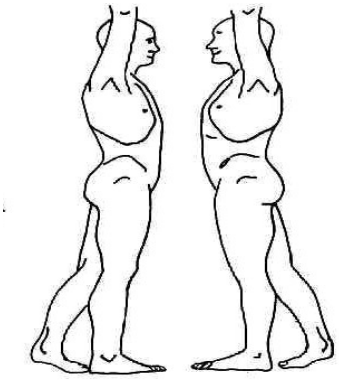
Patient's Name: _____ Date: _____

Date of Original Injury, symptoms or Pain: _____ Date of Birth: _____

PRESENT CONDITION / PAIN / SYMPTOMS:

1. Please Shade or make an "X" in area (or areas) where you are experiencing pain /symptoms.
   a. If the symptoms travel/radiate, use an "arrow" to follow the path of pain
   b. Feel free to use more than one symbol





   c. Current Injury/Symptom Descriptors: Circle any/all words that apply, add others

- Severe
- Moderate
- Numbness
- Tingling
- Weakness

- Dull
- Throbbing
- Aching
- Poor balance
- Stiffness

- Radiating
- Burning
- Stabbing
- Sharp/Searing
- _____

2. When and what initially caused you to seek Physical Therapy? _____
   _____
3. List symptom(s) that you "INITIALLY" experienced _____
   a. Severity Initially: 0 1 2 3 4 5 6 7 8 9 10
4. List Symptom(s) that you "CURRENTLY" experience _____
   a. Severity Currently: 0 1 2 3 4 5 6 7 8 9 10
5. Since Initiation, how has the pain changed? _____

Initial Self-Evaluation Form – Flaming Physical Therapy (Continued)

6. Since onset have your symptoms become:
    a. BETTER B. WORSE C. No CHANGE
7. How often do you experience the Symptoms? _____
8. What makes your symptoms Worse?

Sitting Standing Walking Bending Lifting Other

9. What eases your Symptoms

Sitting Standing Walking Bending Lifting Other

10. How much does your pain interfere with your activities?
    a. None (0%) Rarely (1-19%) Often (20-39%)
    b. Moderate (40-59%) Almost always (60-79%) Always (80-100)
11. Are you taking any Medications related to the reason you're in PT? YES NO
    a. If yes, What and how often? _____

PAST HISTORY OF SYMPTOMS

1. Have you ever had these kinds of symptoms before? YES NO

    If Yes, when was the previous episode? _____
2. How often have they reoccurred? _____

3. Has the frequency of severity of these symptoms increased since that former episode?

    a. FREQUENCY? YES NO B. SEVERITY? YES NO

PAST MEDICAL HISTORY

Accidents or injuries?	YES	NO	_____		
Surgeries?	YES	NO	_____		
Cancer?	YES	NO	COPD	YES	NO
Arthritis	YES	NO	Neurologic Disorders	YES	NO
Pregnancy?	YES	NO	Parkinson's	YES	NO
Immunosuppression?	YES	NO	Pacemaker	YES	NO

Have you had other related P.T. or Body work? _____

By signing, I certify that all information in this form is true and correct to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____

Therapy Treatment Agreement – Flaming Physical Therapy

11 Elsinore Avenue, Bath, Maine 207-442-9810
68 Chapman Street, Damariscotta, Maine 207-563-7990

This document is a treatment agreement in which the patient, or the responsible party for the patient, and Flaming Physical Therapy are identified below. The patient, or responsible party, consents to evaluations and treatments upon the provisions hereof, and patient, responsible party and Flaming Physical Therapy hereby agree with each other as follows:

PATIENT NAME; LAST _____ FIRST _____ MI ___

Date of Birth ____ / ____ / _____

ADDRESS: _____

CITY: _____ State: _____ Zip Code: _____

Billing Address _____ (If Different from above)

PHONE: Home: _____ Cell: _____ Other: _____

E-MAIL: _____

Gender: Male: _____ Female: _____

Marital Status: Married: _____ Single: _____ Other: _____

WORK STATUS: Employed: ____ Unemployed: ____ F/T Student: ____ Retired: ____

Employer: _____

RELATIONSHIP TO SUBSCRIBER: Self: ____ Spouse: ____ Child: ____ Other: ____

IF Someone other than the patient is the subscriber; Please fill out below:

Name of Subscriber _____ Subscriber Birth Date: ___ / ___ /___

Address (if different) _____ Phone: _____

Employer of Insured _____

EMERGENCY CONTACT _____ Phone _____

Is the Patient Condition related to (or results of) any of the Following?

Employment? YES ____ NO ____ If YES, is this Workers Compensation? _____

Auto Accident YES ____ NO ____ IF YES, who's Insurance is Responsible? _____

Other Accident YES ____ NO ____ If YES, Which Insurance is Responsible? _____

Use Space Below to Explain:

DIAGNOSIS of Injury / Illness / Surgery: _____

Date of Current Injury / Surgery / other: ____ / ____ / _____

Date P.T. Ordered: ____ / ____ / _____

Patient's Next Physician Follow up visit ____ / ____ / _____

PRIMARY PHYSICIAN: _____ Phone#: _____

Ordering Physician: _____ Phone#: _____

PRIMARY INSURANCE: _____ Plan Name: _____

ID Number: _____ Group#: _____

Claims Mailing Address: _____

Co-Payment Amount for Physical Therapy: _____ Deductible: _____

SECONDARY INSURANCE: _____ Plan Name: _____

ID Number: _____ Group#: _____

Claims Mailing Address: _____

CO-PAYMENTS ARE COLLECTED AT EACH VISIT. YOU WILL BE BILLED FOR ANY COINSURANCE BALANCE AS INDICATED BY YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO KNOW YOUR COINSURANCE.

AUTHORIZATION for RELEASE OF INFORMATION: The institution rendering services is hereby authorized to furnish and release, in accordance with facility policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party, agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

TREATMENT CONSENT: I, the undersigned, so hereby agree and give my consent and authorization for Glenn Flaming Physical Therapy to provide examination, treatments and services to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments and services.

ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for the charges NOT covered NOR paid by my Insurance, or through Worker's Compensation.

CANCELLATION / NO SHOW POLICY: Your well being is our highest concern. For you to benefit from your Physical Therapy treatment, we encourage you to keep each scheduled appointment. We realize that this is not always possible. Therefore, if you must cancel, we ask that you call the office at least 24 hours prior to the scheduled appointment time. Failure to cancel within the allotted time frame mentioned **will result in a $50.00 charge**, or the amount of your co-pay, **WHICH EVER IS THE GREATER AMOUNT**. This charge will be collected at the next scheduled appointment or will be billed to you upon Discharge. As always, we are glad to answer any questions and work with you if you have special circumstances. **Ongoing failure to keep your appointments may result in decision to terminate your therapy with us.**

PATIENT (or GUARDIAN) Signature: _____ Date:_____

HIPAA Notice of Privacy Practices – Flaming Physical Therapy

11 Elsinore Avenue, Bath, Maine 207-442-9810
68 Chapman Street, Damariscotta, Maine 207-563-7990

Flaming Physical Therapy (FPT) pledges to maintain the privacy and confidentiality of our patients at all times. The full written privacy policy is available upon request. Any complaints regarding privacy issues should be addressed with the management at Flaming Physical Therapy.

All employees at FPT pledge to keep your health information confidential; however, your conversations may, at times, be overheard by other parties. You may meet with your Therapist of other staff members in a private room if this is a concern.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

In accordance with government guidelines, we are herein asking for your consent in sharing necessary information about your care at FPT with other parties including but not limited to your Physician, Health Insurance Carrier, Lawyer, or Case Manager. Necessary information may include but is not limited to the following areas; For Treatment, For Payment of services, For Health Care Operations, Judicial and Administrative Proceedings, to avoid a serious threat to health or safety, Health Oversight Activities, Law Enforcement and Worker's Compensation.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information that we may obtain from you. You have the Right to inspect and copy any protected health information that may be used to make decisions about your care. You have the right to amend or supplement health information, if you feel that it is incorrect or incomplete. You have the right to request an "accounting of disclosures". You have the right to request restrictions or limitations on information we use or disclose about you. You have the right to a paper copy of this notice.

FLAMING PHYSICAL THERAPY IS ASKING FOR YOUR SPECIFIC DIRECTIVES IN THE FOLLOWING AREAS

Please initial <u>ONE</u> of the following options:

____ FPT has my consent to share necessary information regarding my Physical Therapy care as needed in accordance with the HIPAA Privacy Act.

____ FPT has my consent to share health information with ONLY THE FOLLOWING PARTIES:

In order to comply with federal regulations, we ask for your consent regarding TELEPHONE MESSAGES.

____ I authorize a telephone message may be left with any person or machine answering a phone call intended for me.

____ Telephone messages may be left ONLY WITH THE FOLLOWING: _____

I have read and understand the FPT privacy policy and consent to the sharing of necessary information about my care between appropriate parties in accordance with the HIPAA Privacy Act unless directed otherwise

PATIENT (or GUARDIAN) Signature: _____ DATE:_____

PRINTED PATIENT NAME AND BIRTH DATE: _____ DOB: ___/___/_____

PARENT OR GUARDIAN NAME (PRINTED): _____DATE: _____

Neck Disability Index

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR **NECK PAIN** AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU.
ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ **I have no neck pain at the moment.**
- ❑ **The pain is very mild at the moment.**
- ❑ **The pain is moderate at the moment.**
- ❑ **The pain is fairly severe at the moment.**
- ❑ **The pain is very severe at the moment.**
- ❑ **The pain is the worst imaginable at the moment.**

SECTION 2 - PERSONAL CARE

- ❑ **I can look after myself normally without causing extra neck pain.**
- ❑ **I can look after myself normally, but it causes extra neck pain.**
- ❑ **It is painful to look after myself, and I am slow and careful**
- ❑ **I need some help but manage most of my personal care.**
- ❑ **I need help every day in most aspects of self -care.**
- ❑ **I do not get dressed. I wash with difficulty and stay in bed.**

SECTION 3 – LIFTING

- ❑ **I can lift heavy weights without causing extra neck pain.**
- ❑ **I can lift heavy weights, but it gives me extra neck pain.**
- ❑ **Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.**
- ❑ **Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned**
- ❑ **I can lift only very light weights.**
- ❑ **I cannot lift or carry anything at all.**

SECTION 4 – READING

- ❑ **I can read as much as I want with no neck pain.**
- ❑ **I can read as much as I want with slight neck pain.**
- ❑ **I can read as much as I want with moderate neck pain.**
- ❑ **I can't read as much as I want because of moderate neck pain.**
- ❑ **I can't read as much as I want because of severe neck pain.**
- ❑ **I can't read at all.**

SECTION 5 – HEADACHES

- ❑ **I have no headaches at all.**
- ❑ **I have slight headaches that come infrequently.**
- ❑ **I have moderate headaches that come infrequently.**
- ❑ **I have moderate headaches that come frequently.**
- ❑ **I have severe headaches that come frequently.**
- ❑ **I have headaches almost all the time.**

SECTION 6 – CONCENTRATION

- ❑ **I can concentrate fully without difficulty.**
- ❑ **I can concentrate fully with slight difficulty.**
- ❑ **I have a fair degree of difficulty concentrating.**
- ❑ **I have a lot of difficulty concentrating.**
- ❑ **I have a great deal of difficulty concentrating.**
- ❑ **I can't concentrate at all.**

SECTION 7 – WORK

- ❑ **I can do as much work as I want.**
- ❑ **I can only do my usual work, but no more.**
- ❑ **I can do most of my usual work, but no more.**
- ❑ **I can't do my usual work.**
- ❑ **I can hardly do any work at all.**
- ❑ **I can't do any work at all.**

SECTION 8 – DRIVING

- ❑ **I can drive my car without neck pain.**
- ❑ **I can drive my car with only slight neck pain.**
- ❑ **I can drive as long as I want with moderate neck pain.**
- ❑ **I can't drive as long as I want because of moderate neck pain.**
- ❑ **I can hardly drive at all because of severe neck pain.**
- ❑ **I can't drive my care at all because of neck pain.**

SECTION 9 – SLEEPING

- ❑ **I have no trouble sleeping.**
- ❑ **My sleep is slightly disturbed for less than 1 hour.**
- ❑ **My sleep is mildly disturbed for up to 1-2 hours.**
- ❑ **My sleep is moderately disturbed for up to 2-3 hours.**
- ❑ **My sleep is greatly disturbed for up to 3-5 hours.**
- ❑ **My sleep is completely disturbed for up to 5-7 hours.**

SECTION 10 – RECREATION

- ❑ **I am able to engage in all my recreational activities with no neck pain at all.**
- ❑ **I am able to engage in all my recreational activities with some neck pain.**
- ❑ **I am able to engage in most, but not all of my recreational activities because of pain in my neck.**
- ❑ **I am able to engage in a few of my recreational activities because of neck pain.**
- ❑ **I can hardly do recreational activities due to neck pain.**
- ❑ **I can't do any recreational activities due to neck pain.**

PATIENT NAME _____ **DATE** _____

SCORE _____ **[50]**

QUICKDASH

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERELY DIFFICULTY	UNABLE TO DO
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (i.e., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (i.e., golf, hammering, tennis etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE TO DO
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week (circle number).

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH IT PREVENTS SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand (circle one)?	1	2	3	4	5

Since the beginning of therapy my condition has improved:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

During the past 24 hours, my maximum pain rating was:

0 1 2 3 4 5 6 7 8 9 10

This section to be completed by your Physical Therapist/Provider
A Quick DASH score may not be calculated if there is greater than 1 missing item.

QUICK DASH DISABILITY SYMPTOM SCORE

$$\frac{\text{(sum of n response)}}{n} - 1 \times 25$$

Telehealth Consent form – Flaming Physical Therapy

11 Elsinore Avenue, Bath, Maine (207) 442 – 9810

68 Chapman Street, Damariscotta, Maine (207) 563 - 7990

Please complete this initial intake for new patients prior to your visit. We will not be able to start your visit unless this form is completed.

Valid Email address* _____

By signing below, you confirm the email address you entered above is yours and no other individual has access to your email account. This email address should match the email address where you received the link for this intake.

(either Sign, type your name, or insert a digital signature)

Signature: (Patient or Guardian) _____

Type in Your Full Name here: _____

Telemedicine (a.k.a. Telehealth) Patient Consent Form

Glenn J Flaming MPT offers some physical therapy consultations via a telemedicine/telehealth platform. If you elect to receive our telehealth services, you must give informed consent and agree to the following:

1. Our physical therapy telemedicine/telehealth consultations are provided through a HIPAA compliant and secure platform, Zoom.com. By using this service, you agree to the terms of use and privacy policies of this telemedicine/telehealth https://www.zoom.us/

2. The benefits to using our telemedicine/telehealth services including but not limited to not having to take time to drive to and from appointments, minimizing time off work for appointments, being able to access services at more convenient times.

3. We strive to provide telemedicine/telehealth services at the same standard of care of an in-person visit. However, you should know that there may be some limitations to what we can do through a telemedicine/telehealth connection compared to a face-to-face visit. For example, we will not have the use of other senses, such as touch and smell, or the ability to observe your body/condition in a 3-dimensional view. If the limitations of a telemedicine/telehealth consultation will interfere with our ability to properly examine or treat you, we will let you know so you can schedule a face-to-face visit with us or another provider of your choice.

4. Some state laws or health plan policies may require an initial evaluation to be provided in-person before telemedicine/telehealth visits can be provided. We will let you know if any state laws require us to see you in the office on the evaluation, but you are responsible for figuring out if your health plan requires an in-person visit for the initial evaluation as a condition of payment for our services.

5. If it would be beneficial to record our telemedicine/telehealth consultations, we will explain the reason for the need or desire to record the consultation and obtain your verbal consent in advance. If we do record the session, you may request to stop the videotaping at any time. The recording will not be stored as part of your official medical record unless we advise you that we plan to store and maintain it. If we do, it will be stored and maintained with the same privacy and security protections required by applicable state and federal laws that apply to your written medical records.

6. There are potential risks with the use of telemedicine/telehealth technology, including but not limited to: (1) interruption of the audio/video link, (2) disconnection of the audio/video link, (3) video that may not be clear enough to meet the needs of the consultation, and (4) potential of unauthorized access to the live or stored consultation. If any of these occur, the consultation may need to be stopped and/or rescheduled. Also, we are not responsible for these or other technology problems that we are not in control of.

7. Privacy and Confidentiality. The same state and federal laws that protect your privacy and the confidentiality of your medical records apply to our telemedicine/telehealth visits if the visit is for health care services. You acknowledge by signing below that you have been given an opportunity to review our Notice of Privacy Practices and had all your questions answered.

8. Some health plans may cover telemedicine/telehealth services if they are medically necessary. Some state laws require state-governed (fully insured) health plans to cover telemedicine/telehealth visits if the health plan would have covered the same interventions had they been provided in the office. However, there are frequently exceptions to these coverage laws and policies. **That means your health plan is highly likely to deny our claims for telemedicine/telehealth services. Therefore, we require payment at or before the time of service for scheduled telemedicine visits.** If we are out of network with your health plan, we will provide you with a superbill that you can send to your health plan to get reimbursed if your health plan does cover telemedicine/telehealth services. If we are in-network with your health plan, we will bill your health plan and reimburse you if your health plan pays for the telehealth visit.

9. Some of the services we may provide to you through our telemedicine/telehealth platform may be considered fitness or wellness services, *not* physical therapy. Fitness and wellness services may not be subject to the requirements of the physical therapy practice act or other state laws that apply to medical services.

10. If we instruct you on any exercises, balance activities or other physical procedures during the telemedicine/telehealth session, you are responsible for determining whether you can safely perform the activity without risk of falling or otherwise injuring yourself. If you do not feel safe, you must tell us. If the exercise or activity requires the assistance of a family member or caregiver (collectively "Caregivers"), you are accepting the risk of the actions of your Caregivers. We are not responsible if you fall or get injured by the actions, errors or omissions of your Caregiver.

11. Payment and Cancellations. You agree to pay for any scheduled telemedicine/telehealth consultations with a credit card in advance of your scheduled appointment. You must give at least 24 hours-notice in advance if you need to cancel or reschedule an appointment. If you cancel with less notice, you will forfeit the payment made for the scheduled visit.

I, _____ [print name], have read, understand and agree to all the above terms for my telemedicine/telehealth consultation. Understanding the limitations and risks associated with a telemedicine/telehealth consultation as described above, I consent to the examination and/or treatment through Company's telemedicine/telehealth service.

_____ _____

Patient's signature Date

_____ _____

Witness Date