Trumble Physical Therapy
Medical History

Name:_____ **Date:**_____

What is your Major Complaint?_____
Symptoms you are Experiencing:_____
Is your pain getting better or worse?_____ Have you had this pain before? [] Yes [] No
Current Duration of Pain: [] Intermittent []Constant []With Certain Activities:_____
Current Level of Pain: [] Mild [] Moderate []Severe [] Excruciating
Please, list any additional information that would assist us in providing care to you:_____

History:

Current Exercise Frequency:_____ Types of Exercise:_____
Are you currently pregnant? []Yes []No If pregnant, how many weeks?_____
Current Medications:_____
[] Pain Medication:_____ [] Birth Control:_____
[] Muscle Relaxers:_____ [] Anti-Inflammatories:_____
Any Surgical History with Relation to current Pain?_____
Any Allergies? []Yes [] No If yes, explain:_____

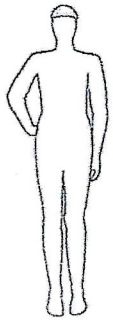
Do You Have Any of the Following Today? (Check All that Apply)

[]Asthma, Emphysema	[]AIDS,HIV,STD	[]Anemia, Blood Clots, Circulation Issues
[]Cancer,Radiation,Chemotherapy	[]Endometriosis	[]Fibroids/Ovarian Cysts
[]Constipation	[]Bowel/Bladder Weakness	[]History of UTI's
[]High/Low Blood Pressure	[]Heart Attack/ Stroke	[]Uncomfortable Intercourse
[]Menopause–Date Began:_____		[]Leaking Urine (when):_____
[]Musculoskeletal Problems:_____		

Have You had any Diagnostic, Medical, or Rehabilitative Services in the Past Year for this Issue?

[] Chiropractor_____ [] Massage Therapy_____ []Occupational Therapy_____
[] Physical Therapy: If yes, how many visits:_____ []MRI/ CT/ XRAYS_____

Mark Areas of Discomfort:



By signing below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Signature:_____ Date:_____

Trumble Physical Therapy
840 HANSHAW ROAD ITHACA, NY 14850

PATIENT INFORMATION

Name: Today's Date:

Is this your legal name? If not, what is your legal name? Preferred Name: Date of Birth Age:

Yes No

Billing Address: (P.O Box, Street, City, State, Zip)

Home Phone: Cell Phone: Email:

Primary Care Physician: Referring Physician: Appointment reminders via: __Voicemail __Email __Text

How did you hear about us?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance: ID#: Subscriber: Relationship to you:

Subscriber DOB:

Secondary Insurance: ID#: Subscriber: Relationship to you:

Subscriber DOB:

Address (If different from above):

*****Co-Payments are due at the time of service along with any payments towards deductibles and Co-Insurance if applicable.

IN CASE OF EMERGENCY

Name: Relationship to patient: Home/Cell phone: Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Trumble Physical Therapy. I understand that I am financially responsible for any balance; including supplies or equipment not covered by my insurance as well as any finance charges or collection fees. I also authorize Trumble Physical Therapy or my insurance company to release any information required to process my claims and communicate with each other.

**If for any reason you are unable to attend your physical therapy appointment, if possible, please provide us with at least 24 hrs. notice. Thank you.

Patient/Guardian signature Date

HIPAA Release Form

The Privacy Rule protects your protected health information while letting you exchange information to coordinate your care. The Privacy Rule also gives you the right to examine and get a copy of your medical records, including an electronic copy of your electronic medical records, and to request corrections. Under the Privacy Rule, patients can restrict their health plan's access to information about treatments they paid for in cash, and most health plans can't use or disclose genetic information for underwriting purposes. The Privacy Rule does allow this facility to report child abuse or neglect to the authorities

In regards to **Medical Records at Trumble Physical Therapy**. Our standard is sending reports to the Health Care practitioner who referred you to **Trumble Physical Therapy**. Notes can also be sent to your Primary MD if you wish.

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I,_____, give my permission for _____**Trumble Physical Therapy**____ to share protected health information listed in **Sec II** (below) with the person(s) or organization(s) listed.

Section II – Health Information includes: evaluative and daily treatment notes
I would like to give the above healthcare organization permission to share my health information to-

- ☐ The Health Care Practitioner that referred you _____
- ☐ The other Medical Practitioners (primary, chiro, out of town MD)

  _____
- ☐ Your insurance or HSA for billing or authorization information
- ☐ Family Members _____

May we phone, email or text to confirm apts.	Yes	No
May we leave a message on ans machine or phone	Yes	No
May we discuss medical condition with Family (list above)	Yes	No

This consent was signed by (print) _____

Signature _____

Cancellation Policy/No Show Fee

Our goal at Trumble Physical Therapy is to provide the best quality service to our patients. When you book your appointment, you are holding a space on our calendar that is no longer available to our other valued patients. In order to be respectful of your fellow patients, please call us as soon as you know you will not be able to make your appointment. Less than 24 hours notice will result in a **25.00 Cancellation fee.**

Cancellations can be made via email, trumblephysicaltherapy@gmail.com or by phone at (607) 257-0567, 24 hours a day, 7 days a week.

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Name Date