ENCHANTMENT PHYSICAL THERAPY

1101 GOLF COURSE RD SE, UNIT 201
RIO RANCHO, NM 87124
PH# (505) 896-0835 FAX# (505) 896-9539

DATE _____ GENDER: Male/Female Marital Status: Married/Divorced/Single/Widowed

Patient Name_____ Social Security#___-___-_____
Date of Birth____/___/_____

Home Address_____City_____State_____

Mailing Address _____ City_____ State_____
Zip Code_____

Phone#( )_____
Cell#( )_____

Email: _____

Employer Name_____

Address_____Part/Full Time_____

City_____State_____Zip_____
Phone#( )_____

Occupation_____Date of Injury/Pain_____

**Patient Emergency Contact_____Relationship_____

Address_____City_____State_____Zip_____
Telephone#( )_____

Is this a WORK injury? YES_____NO_____If YES Date of Injury_____
Is this an AUTO injury? YES_____NO_____If YES Date of Injury_____

If an ATTORNEY has been retained please list
Name:_____Phone#( )_____

Address:_____City_____State_____Zip_____

Would you like to receive SMS reminders for appointments? YES_____ NO_____

Enchantment Physical Therapy Medical Screen Form

NAME: _____ DATE: _____

Explain injury briefly.

_____

_____

What are your goals?

_____

Do you have…
Cancer or cancer history…y/n
High blood pressure…y/n
Heart attack…y/n
Heart surgery…y/n
Stroke…y/n
Osteoarthritis…y/n
HIV/AIDS…y/n
DVT(deep vein thrombophlebitis).....y/n

Diabetes…y/n
Heart disease…y/n
Angina or chest pain…y/n
COPD…y/n
Osteoporosis…y/n
Rheumatoid arthritis…y/n

Hepatitis…y/n

In the past 3 months have you had…
A change in your health…y/n
Fever, chills, or sweats…y/n
Numbness or tingling…y/n
Changes in appetite…y/n
Difficulty swallowing…y/n
Changes in bowel or bladder function…y/n

Nausea or vomiting…y/n
Unexplained weight change…y/n
Shortness of breath…y/n
Dizziness…y/n
Urinary tract infections…y/n
Upper respiratory infections…y/n

Do you have a history of…
Allergies or asthma…y/n
Bronchitis…y/n
Rheumatic fever…y/n
Seizures…y/n

Headaches…y/n
Kidney disease…y/n
Ulcers…y/n
Have you had surgery…y/n
If yes explain…
_____
_____
_____

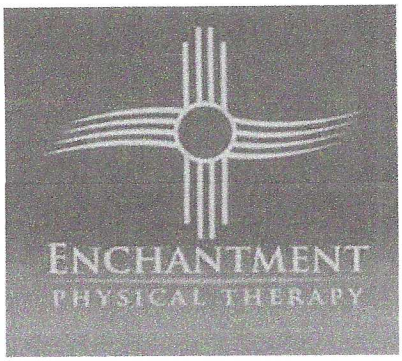
Are you currently…
Pregnant…y/n
Depressed…y/n
Under stress…y/n

Do you drink alcohol? y/n
Do you use tobacco? y/n

Are your symptoms (check one)
___Getting Worse ___The same
___Improved

List all medication currently taking
_____
_____
_____
_____
_____
_____

Do you have problems with…
___Hearing ___Vision
___Speech ___Communication



ACKNOWLEDGEMENT OF PRIVACY RIGHTS

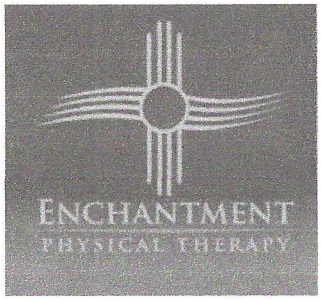
My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I understand I must request in writing any changes in disclosures or restrictions of information other than stated in above policy. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ **Date:**_____

Patient Signature: _____



Cancellation and No Show Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If tha happens, we respectfully ask for scheduled appointments to be canceled at least 24 hours in advance.

When a patient doesn't keep their appointment as scheduled, three people are hurt:

1. You, because you won't get the treatment you need as prescribed by your physician.
2. Another patient could have been scheduled for treatment if there had been proper notice.
3. The therapist, who now has a space in their schedule since the time was reserved for you personally.

There will be a fee of $20.00 assessed if we do not receive a **24-48 hour** call to cancel an appointment. This will not be covered by insurance but will have to be paid by you personally.

It is your responsibility, when you contact us, to have an alternative time in mind that will ensure you get the ful treatment for that week. In some cases, this may not be possible, but we will make every effort to accommodate your reschedule request.

- Please understand that your pain may increase and decrease as your course of treatment progresses. At times you may:
  a) Feel worse and think the treatment is not working or making you worse
  b) Feel better and don't think you need to come anymore

Neither of these is a legitimate reason to not come.

You may need to be seen by a different therapist than one that normally treats you if you rearrange your ıppointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. IHS/CHS, NM Medicaid patients please know that you can take advantage of your scheduled appointments, your physical therapy treatment is paid full coverage with no copay or deductible.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Patient Name: _____

Patient Signature: _____ Date: _____

INSURANCE INFORMATION

*Primary Health Insurance Carrier_____
Phone( )_____

Co-pay $_____
Deductible $_____
Pt.%_____

*Workers Compensation Carrier_____
Phone# ( )_____

Claims Adjustor_____
Date of Injury_____

Employer at time of injury_____

_____ _____
Patient Signature Date