**Mangione Physical Therapy, Inc.**

**Please read and complete carefully by printing in ink. Provide all information requested.**

**Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_Male \_\_\_Female \_\_\_Soc. Security #\_\_\_\_\_\_\_\_\_\_\_\_

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_**

#### Home Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status (check one): Married: \_\_\_\_\_\_ Single: \_\_\_\_\_\_ Divorced: \_\_\_\_\_\_Separated \_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Emergency Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last seen by this physician \_\_\_/\_\_/\_\_\_**

**Name of Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient reason for visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did the problem start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What caused the pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had surgery for this problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, what type: \_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_\_\_**

**Please check if you have, or ever had the following:**

\_\_\_Allergies to latex or medication

\_\_\_Infectious Disease

\_\_\_Lasting/Prolonged Pain

\_\_\_Hepatitis

\_\_\_Difficulty breathing/ lung problems/asthma

\_\_\_Osteoporosis

\_\_\_Heart Condition

\_\_\_Sensitivity to hot/cold

\_\_\_Headaches (persistent)

\_\_\_Blood clots

\_\_\_Tuberculosis

\_\_\_Circulation problems

\_\_\_Stomach ulcer

\_\_\_Thyroid problems

\_\_\_Multiple Sclerosis

\_\_\_Diabetes

\_\_\_High blood pressure

\_\_\_Cancer

\_\_\_Stroke

\_\_\_Depression

\_\_\_Chemical dependency (ie alcoholism)

\_\_\_Inflammatory arthritis (Rheumatoid, Ankylosing)

\_\_\_Kidney Disease

\_\_\_Presently pregnant

**Please check if anyone in your immediate family (parents, siblings) has ever been treated for the following:**

\_\_\_Diabetes

\_\_\_Heart disease

\_\_\_High blood pressure

\_\_\_Stroke

\_\_\_Inflammatory Arthritis (Rheumatoid, Ankylosing)

\_\_\_Cancer

\_\_\_Chemical dependency (alcoholism)

\_\_\_Depression

\_\_\_Kidney Disease

**If you checked any of the above or have any other medical conditions, please explain here:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all medications (prescribed or over the counter) you are presently taking and for what reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any special tests related to your current problem, e.g. MRI, x-rays, etc? If so, please list: \_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check here if a physician has ever prescribed steroids for you (e.g., prednisone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check here if a physician has ever instructed you to limit your activity/exercise: \_\_\_\_\_\_\_ If so, how? \_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you exercise regularly? YES NO**

**Have you been admitted to a hospital in the past year? YES NO**

**Mangione Physical Therapy, Inc.**

**Health history- page two**

**Have you recently noted any of the following that are new, unusual or atypical for you:**

YES NO weight loss/gain

YES NO nausea/vomiting

YES NO dizziness/lightheadedness

YES NO fatigue/weakness

YES NO fever/chills/sweats

YES NO numbness/tingling

YES NO tremors/seizures

YES NO vision troubles

YES NO eye redness

YES NO skin rash

YES NO problems sleeping

YES NO hearing problems

YES NO joint/muscle swelling

YES NO easy bruising/bleeding

YES NO persistent cough

YES NO heartburn/indigestion

YES NO blood in stools or urine

YES NO problems urinating

YES NO bowel changes

**How many cups of caffeinated beverages (coffee, soda, tea) do you drink per day? \_\_\_\_**

**Do you or did you used to smoke? \_\_\_\_ If yes, how many packs per day? \_\_\_ If you quit, when? \_\_\_**

**Do you drink alcohol? \_\_\_\_ If yes, how many days per week do you drink? \_\_\_ If one drink equals one beer or glass of wine, how much do you drink at an average sitting? \_\_\_**

**Additional Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mangione Physical Therapy, Inc.

**Financial Policy**

We are legally and contractually obligated to collect all out-of-pocket expenses, including deductibles, co-pays, co-insurance, and non-covered procedures. This is a Pennsylvania state law. Patients will find in their health insurance policy manuals that they are contractually obligated to pay these expenses, which are designated as being the responsibility of the patient. Legally exceptions may be allowed if a patient demonstrates financial hardship. We only accept cash or checks. Any accounts that are delinquent will be forwarded to a collection agency

Checks returned by your bank are subject to a $30.00 processing charge. Accounts unpaid after thirty days from date of billing are subject to a finance charge at a rate of 1.5% per month (18% APR). If your account is referred for collection, you will be responsible for collection costs in the amount of 40% of the outstanding balance, together with court costs.

If a company assigns payment directly to you, payment will be expected at the time of service. It is illegal for a patient to keep insurance reimbursements for our treatment rendered, or for past due balances. It is illegal for you, the patient, to keep reimbursements for our treatment rendered or for past due balances. If a company assigns payment directly to you, payment will be expected at the time of service.

Our billing company will process all in-network claims. Please understand that ultimately it is your responsibility to understand the specifics (inclusions/exclusions) of your contract with your insurance company. We are legally able to evaluate and treat patients deemed appropriate by your therapist for up to 30 days. Some insurance companies require a physician’s referral for reimbursement. Please confirm these requirements with your insurance company before making your appointment.

If you are out of network you are responsible for the balance due at the time of service. We will be happy to provide you with a receipt. You are responsible for all services that are provided that are not covered by insurance.

I understand the above policy and agree to abide by the regulations of my insurance company as well as the police of Mangione Physical Therapy. My signature below also serves as authorization to release information to my insurance company.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name(print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization for Communications**

I authorize the release of my information to Mountain Valley Medical Billing Services, Inc., for billing purposes (filing claims/patient balance billing, etc.). I authorize any contact from Mountain Valley Medical Billing Services in an effort to collect any outstanding balances.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize the provider of service to contact me via phone, fax, cell phone or any other means of contacting me at home or work for purposes of: appointment scheduling or changing, test results, billings, releasing of medical information related to my condition. It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about any scheduled appointments or other related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information your decision will have no adverse effect on your care from Mangione Physical Therapy or on your relationship with our staff.

Your signature indicates your authorization of this activity.

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

Please print

**Authorization Regarding “OPEN” Environment Treatment**

It is the practice of this office to provide Physical Therapy in an “OPEN” environment. “OPEN” environment involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing details of care are discussed within earshot of other patients and staff.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information.

Your signature indicates your authorization of this activity.

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

Please print

Authorizations may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Mangione Physical Therapy, Inc.

Pain Rating, Global Rating, and Patient Specific Functional Scale (PSFS)

# Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Limitation**: Over the past 24 hours, how much has pain limited you from performing any of your normal activities?

0 1 2 3 4 5 6 7 8 9 10

Activities have not been limited Activities have been severely limited

**Pain Intensity**: Over the past 24 hours, how bad has your pain been?

0 1 2 3 4 5 6 7 8 9 10

No Pain Pain as bad as can be

**Global Rating**: On a scale of 1-100, please rate your function of your injured body part:

Global Rating: \_\_\_\_\_\_\_\_\_\_\_\_\_ 0 = no function 100 = full function

**Functional Activity Rating**: Please identify 3 important activities that you are unable to do or are having difficulty with as a result of your injury:

**Activity 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Please rate activity

0 1 2 3 4 5 6 7 8 9 10

Unable to perform Able to perform at same level as prior to injury

**Activity 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Please rate activity

0 1 2 3 4 5 6 7 8 9 10

Unable to perform Able to perform at same level as prior to

**Activity 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Please rate activity

0 1 2 3 4 5 6 7 8 9 10

Unable to perform Able to perform at same level as prior to

Mangione Physical Therapy, Inc.

#### Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PAIN DRAWING

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain that are not related to your present condition.

**Stabbing //// Burning** xxx **Pins & Needles** OOO **Numbness +++**

## Stiffness & Tightness 888 Aching ^^^

