BROOKEVIEW PHYSICAL THERAPY

The leaders in personalized, hands-on care.

47454 Route52, Kermit WV 25674 Phone: (304) 393-4072 Fax: (304) 393-4074

MELISSA LEDSON, MPT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE_____ Fax:_____
TO RELEASE INFORMATION FROM THE RECORDS OF

NAME_____ BIRTHDATE _____

ADDRESS _____

RECORDS TO BE RELEASED AND APPROXIMATE DATE OF SERVICE

_____

_____

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time, by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date here:

Date of signature_____ Signature_____

Date of signature_____ Signature of Witness _____

PLEASE FAX TO BROOKEVIEW PHYSICAL THERAPY AT:
304-393-4074
** AS SOON AS POSSIBLE**

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Name: _____Today's Date: _____

Age:_____ Height: _____ Weight: _____ Referring Physician's Name: _____

Are you currently working outside the home? ☐ Yes ☐ No If yes, since when? _____

When is your next scheduled visit with your referring physician? _____

Place an x in the box if you have ever had any of the following conditions:

Allergies	☐Yes ☐No	Dizzy Spells	☐Yes ☐No	MRSA	☐Yes ☐No
Anemia	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Anxiety	☐Yes ☐No	Fibromyalgia	☐Yes ☐No	Muscular Disease	☐Yes ☐No
Arthritis	☐Yes ☐No	Fractures	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Asthma	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Parkinson's	☐Yes ☐No
Autoimmune Disease	☐Yes ☐No	Headaches	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Cancer	☐Yes ☐No	Hearing Impairment	☐Yes ☐No	Seizures	☐Yes ☐No
Cardiac Condition	☐Yes ☐No	Hepatitis	☐Yes ☐No	Smoking	☐Yes ☐No
Cardiac Pacemaker	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Speech Problems	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High/Low Blood Pressure	☐Yes ☐No	Strokes	☐Yes ☐No
Circulation Problems	☐Yes ☐No	HIV/AIDS	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Currently Pregnant	☐Yes ☐No	Incontinence	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Depression	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Vision Problems	☐Yes ☐No
Diabetes	☐Yes ☐No	Metal Implants	☐Yes ☐No		

Place an x in the box if you have recently experienced any of the following symptoms:

	Headaches		Muscular pain with exertion
	Falls		Muscular pain at rest
	Difficulty sleeping		Constant pain unrelieved by rest or movement
	Tremors		Change in bowel or bladder habits
	Balance problems		Unusual fatigue or weakness
	Blurred or double vision		Unusual skin coloration
	Dizziness		Unexplained weight loss
	Shortness of breath		Tingling, numbness or loss of feeling
	Hoarseness/difficulty swallowing		Pain with coughing or sneezing

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Fall History: Is this injury a result of a fall in the past year? □Yes □No
Have you had two or more falls in the past year? □Yes □No
Is Patient at risk for falls? □Yes □No

Please list any major surgeries and hospitalizations

Body Region: _____Surgery Type: _____Date: _____
Body Region: _____Surgery Type: _____Date: _____
Body Region: _____Surgery Type: _____Date: _____

Current Medications:

Drug: _____Dosage: _____ Frequency: _____ Reason Taking: _____
Drug: _____Dosage: _____ Frequency: _____ Reason Taking: _____
Drug: _____Dosage: _____ Frequency: _____ Reason Taking: _____

Are you allergic to any medication? ☐ Yes ☐ No if yes, please list _____

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Place an x in the appropriate box if any of these diagnostic tests have been performed IN THE LAST YEAR.

	Test	Date	Where was test performed?	Results
	X-Ray			
	MRI			
	CAT Scan			
	EMG?NCV			
	Bone Scan			

Description of problem:_____

Was it due to an injury? ☐ Yes ☐ No If yes, what was the approximate date and how did it happen?
_____

Was it a gradual onset? ☐ Yes ☐ No If yes, when did it begin? _____

Is the problem work related? ☐ Yes ☐ No If yes, please explain how it is related? _____
_____

Were you involved in a motor vehicle accident? ☐ Yes ☐ No If yes, please describe the accident? ___
_____

Is litigation (law suit) involved ☐ Yes ☐ No If yes, who is your attorney? _____
_____

Have you had any previous injuries involving the same area? ☐ Yes ☐ No If yes, please describe the injury and approximate date(s).
_____
_____

Place an x in the box(s) that best describe your pain.

	Constant		Increasing		Night Pain		Dull/achy pain
	Intermittent		Decreasing		Stiffness		Pain upon waking up
	Occasional		Static		Sharp Pain		After standing or walking too long

Pain is aggravated by: _____
Pain is eased by: _____
Have you been treated by a physical therapist ☐ Yes ☐ No
Have you been treated by a chiropractor? ☐ Yes ☐ No If yes, approximate date? _____

I, the undersigned, state that I have answered the questionnaire to the best of my knowledge.

_____ _____
Signature Date

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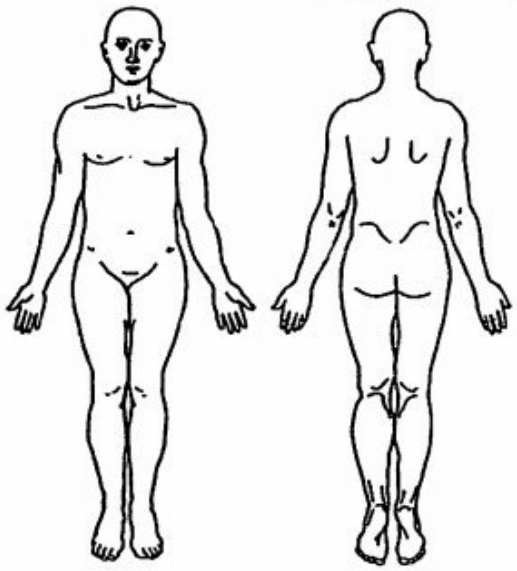
Please use the diagram below to indicate where you feel your symptoms right now. Use the key below to indicate the different types of symptoms.

KEY: Pins and Needles = OOOOO

Stabbing = / / / / /

Burning = XXXXX

Deep Ache = ZZZZZ



1. What is your pain level right NOW on a scale from 0 (no pain) to 10 (extreme pain)?

_____

2. What has been your WORST pain level in the last 24 hours on a scale from 0 to 10?

_____

3. What has been your BEST pain level in the last 24 hours on a scale from 0 to 10?

_____

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Patient Information and Consent Form

Please write neatly as it is important that we input this information correctly to bill your insurance carrier.

Name: _____ Date of Birth: _____

Address: _____ ***M ☐ F ☐ Age:*** _____

City: _____ ***State:*** _____ ***Zip:*** _____

Social Security #:_____ ***Phone #:***_____

Cell# _____ ***Work #:*** _____

Approximate Date of Injury: _____ ***Referring Physician:***_____

Primary Care Physician: _____

Spouse:_____

Parent/Guardian (if under 18)_____

Emergency Contact: _____***Relationship to patient:***_____

Address: (if different from patient) _____***Phone #:***_____

******Work Information******

Employer Name: (even if workers comp.) _____

Phone #_____ ***Address:*** _____

******Insurance Information******

PLEASE COMPLETELY ANSWER ALL INSURANCE QUESTIONS

Insurance 1 :(Primary) _____

Policy or ID #:_____ ***Group #:***_____

Insured: (Responsible party)_____ ***Date of Birth:*** _____

Social Security #:_____ ***Relationship to Patient:*** _____

Insurance 2: (Secondary) _____

Policy or ID #:_____ ***Group #:***_____

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Insured: (Responsible party)_____ Date of Birth: _____

Social Security #:_____ Relationship to Patient: _____

It is the policy of this practice that all physicians and staff have access to any and all medical records housed at this facility. All records at this facility are strictly confidential. Our staff will not release any medical information to anyone other than the patient or legal guardian, including spouses.
If you wish for a spouse to receive information concerning your medical records you must sign a release. (See below) Our practice is small and due to that fact, we will consider that everything done in this facility is part of your complete medical record. We will not distinguish between psychiatric, laboratory or doctors notes. As far as we are concerned it is all part of your medical record. If any other facility requests a copy of this record, we will send a complete copy of medical records including laboratory and psychiatric treatment, in addition to doctor's and nurse's notes. I understand that I reserve the right to review my medical record at any scheduled time and have the right to discuss and possibly correct any information I feel is incorrect. Our computer billing system is HIPAA compliant and is a secure system and only allows access to billing information by your insurance carrier(s). I have read and understand the above and acknowledge this with my signature.

I give Brookeview Physical Therapy permission to discuss my information with any person listed below:

1. Name: _____Relation:_____

2. Name: _____Relation: _____

3. Name: _____Relation: _____

PATIENT/GUARDIAN SIGNATURE

I give permission to treat, release of information, benefit assignment, payment authorization full disclosure statement and agreement to pay for professional services. I request Melissa Ledson and staff to provide me and/or my family with medical care. I also authorize "physician" to release my information necessary to process my insurance/Medicare claim acquired in the course of my examination or treatment to allow a photo copy of my signature to be used to process my insurance/Medicare claim for the period of a LIFETIME. I claim any insurance benefits due me for services rendered by "physician" and authorize and direct my carrier to issue payment check(s) directly to physician. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of nonpayment of any carrier.

_____

PATIENT/GUARDIAN SIGNATURE

I give Brookeview Physical Therapy permission to leave messages concerning scheduling on my home voice mail.

_____

PATIENT/GUARDIAN SIGNATURE

Our office can notify you of upcoming events and appointment reminders. If you would like to be notified of these things please provide your email address.

_____@_____