Bloomington Orthopedic & Spine Center

Theraplay LLC
4651 W Vernal Pike, Bloomington, IN 47404
Telephone (812) 332-7529 Fax (812) 339-7529

Patient Information

Date: ____________________ **Date of Birth:** ____________________ **Age:** ____________________

First Name: ____________________ **Middle:** ______________ **Last Name:** ____________________

Address: ____

City: ____________________ **State:** ______________ **Zip Code:** ____________________

SSN: __________________ **Sex:** ☐ **Male** ☐ **Female** ☐ **Nonbinary**

REMINDER: ☐ **Email** ☐ **Phone** ☐ **Text/Provider:** ______________ **Occupation:** ____________________

Cell: __________________ **Home:** ____________________ **Email Address:** ____________________

Are you willing to receive customer satisfaction surveys and company newsletters via email from us? ☐ **YES** ☐ **NO**

Are you willing to receive electronic billing statements from Theraplay LLC? ☐ **Yes** ☐ **No**

Emergency Contact Name: ____________________ **Phone:** ____________________

Relationship to Patient: ____________________

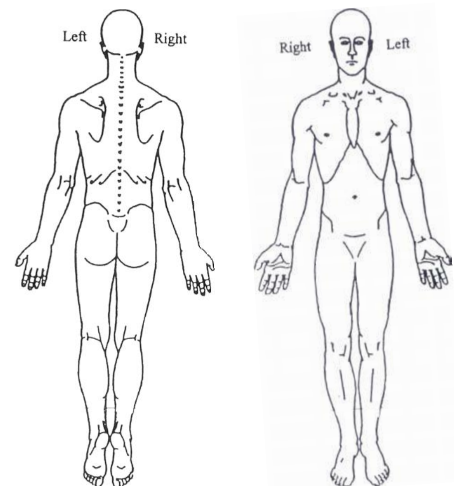
Health History

Primary Care Doctor: ____________________ **Referral Doctor:** ____________________

Date of next doctor's appointment: ____

Medical Condition	Yes	Medical Condition	Yes	Medical Condition	Yes
High Blood Pressure		Cancer: Type		Subluxed/Dislocated joints	
Heart/Circulation disorders		Kidney Disease		Slipped/Ruptured Disc	
Stroke		Hepatitis		Scoliosis	
Chest pain/Discomfort		Immune deficiency disease		Painful Grinding	
Fatigue/Energy Loss		Tuberculosis		Sprains/Strains Joints	
Diabetes		Hernia		Broken Bones	
Headaches		Loss of Bladder/Bowel		Falls	
Seizures		Arthritis		Limited Range of Motion	
Dizzy Spells		Fibromyalgia		Ankle Swelling	
Anemia		Osteoporosis		Others:	

Mark the location of your pain with an "x"



Please CIRCLE the number that represents your pain level.
0 = no pain & 10 = severe pain

AT WORST:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
AT BEST:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
CURRENTLY:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Are your Symptoms:

☐ **Constant** ☐ **Come & Go** ☐ **Ache** ☐ **Superficial**

☐ **Dull** ☐ **Shooting** ☐ **Sharp** ☐ **Burning**

☐ **Deep** ☐ **Numbness/Tingling** ☐ **OTHER:** __________

1. **Are your symptoms:** ☐ **Improving** ☐ **Getting Worse** ☐ **Staying the same**
2. **Have you ever had these symptoms before?** ☐ **YES** ☐ **NO** **Description:** ____________________________
3. **Does your pain seems to be WORSE at certain time of a day?** ☐ **YES** ☐ **NO**

   If Yes, ☐ **Morning** ☐ **Night** ☐ **Other:** ____
4. **Does your pain progress as the day goes along?** ☐ **YES** ☐ **NO**
5. **Do you have difficulty falling asleep?** ☐ **YES** ☐ **NO**
6. **Do you wake up due to pain?** ☐ **YES** ☐ **NO** **If Yes, # of times per night:**_____________________________
7. **Is there any particular activity that aggravates your symptoms?** ______________________________________
8. **Have you ever had treatment before for these symptoms?** ☐ **YES** ☐ **NO**

   If YES, please describe:

   ☐ **Medication: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** ____

   ☐ **Injection: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** ____

   ☐ **Therapy: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** ____

   ☐ **Chiropractor: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** ____
9. **Have you had any testing:** ☐ **CT scan** ☐ **MRI** ☐ **EMG/Nerve Conduction Test** ☐ **X-ray**

   ☐ **OTHER** **WHERE:** ____
10. **Did you have surgery?** ☐ **YES** ☐ **NO** **Date of Surgery**____

    If yes, what procedure did you have done? ____
11. **Do you have any metal (excluding teeth) in your body?** ☐ **YES** ☐ **NO** **i.e. pins, plates, and pacemaker.**

    Where? ____
12. **Allergies:** ☐ **YES** ☐ **NO** **If Yes, please describe** ____
13. **For women, are you pregnant?** ☐ **YES** ☐ **NO**
14. **Injury related to:** ☐ **WORK** ☐ **MVA** ☐ **Other** **Date of Injury:**________________________
15. **Have you had Physical Therapy treatment this year?** ☐ **YES** ☐ **NO**

    If yes, please indicate type of treatment and duration: ____
16. **For MEDICARE PATIENTS ONLY: Are you currently receiving Home Care Services?** ☐ **YES** ☐ **NO**

    Do you have a Homecare Discharge Letter? ☐ **YES** ☐ **NO** **Discharge Date:** ____________________
17. **PATIENT GOALS FOR THERAPY:**

    ____

    ____

    ____

NO SHOW AND LATE CANCELLATION POLICY: Appointments not cancelled 24 hours prior to scheduled appointment time and no show appointments will be assessed a fee of $25.00. These charges are the patient's responsibility and will be billed directly to them. Following 3 no shows/late cancellations, any further appointments will be removed from the schedule.

I acknowledge I am aware of the no show and late cancellation policy and will be responsible for any fees assessed for this policy.

Signature of Patient or Legal Guardian: ________________________________ Date: ____/____/______

ASSIGNMENT & RELEASE: I, assigned Theraplay LLC, all medical benefits, if any, otherwise payable to me for services rendered. <u>I understand that I am financially responsible for all charges whether or not paid by insurance.</u> In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney's fees.

I hereby authorize Theraplay LLC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature of Patient or Legal Guardian: ________________________________ Date: ____/____/______

NOTICE OF PRIVACY PRACTICE: I understand that, under the Health Insurance Portability & Accountability Act ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand (or have been given the option) your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

☐ I chose not to obtain a copy of this organizations *Notice of Privacy Practices* but I am aware of my right to do so at any time.

Signature of Patient or Legal Guardian: ________________________________ Date: ____/____/______

CONSENT TO TREAT: I, hereby request and consent to THERAPLAY LLC to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment. I authorize the physical therapist to perform any additional or different treatment, which is deemed necessary should, during treatment, a condition be discovered which was not known previously. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition with the treating physical therapist. I consent and authorize THERAPLAY LLC (including students in training) to administer treatment under the direction and supervision of the Physical Therapist.

By signing below, I acknowledge the above consent and indicate my agreement with the prescribed PHYISCAL THERAPY program discussed with my Physical Therapist.

Signature of Patient or Legal Guardian: ________________________________ Date: ____/____/______