FORTÉ
THERAPY
Leading the way to a stronger more active you

Patient Name: _____ Date of Birth: _____ Sex: M F
First Last

Address: _____
Street City State Zip

Home Phone: _____ Alt #: _____ E-mail: _____
We will call with a reminder, the day before an upcoming appointment. I prefer a call at ☐ Home or ☐ Alt # listed ☐ not to be reminded.

Emergency Contact Name: _____ Phone: _____
Not someone of the same residence

How did you hear about Forté Therapy? _____

Primary Insurance:

Insurance Co Name: _____

ID #: _____ Grp: _____

Policy Holder: _____

Relationship to patient: _____

Policy Holder Birth Date: _____

Secondary Insurance:

Insurance Co Name: _____

ID #: _____ Grp: _____

Policy Holder: _____

Relationship to patient: _____

Policy Holder Birth Date: _____

Are you seeking Physical therapy due to a Work-Related Injury: ☐ Yes ☐ No If yes, please continue this section:

Date of injury: _____ Claim #: _____ Doctor for claim: _____

Insurance Co: _____ Phone: _____
If unknown, employer at the time of injury

Brief summary of incident: _____

Are you seeking Physical Therapy due to an auto accident: ☐ Yes ☐ No If yes, please continue this section:

Date of injury: _____ Claim #: _____ Doctor for claim: _____

Insurance Co: _____ Phone: _____

Brief summary of incident: _____

Medical History

Please print your answers to the following questions:

What do you spend most of your time doing? _____
Work, recreation, hobbies, chores, etc.

_____

Referring Physician (MD): _____ MD Phone: _____

Your next appointment with MD: _____/_____/_____ What issue brings you here today? _____

When did you first notice your condition (date of onset)? : _____/_____/_____ or about_____

Was onset gradual or sudden: ☐ Gradual ☐ Sudden

How did this injury occur? _____

Please check all answers that describe how your injury occurred? *(if postsurgical, please reference the original injury)*

☐ Lifting ☐ Auto Acc. ☐ A fall ☐ Overuse ☐ During recreation/sports

☐ Trauma ☐ Throwing ☐ Degenerative ☐ Unknown ☐ An incident at work

☐ Blow to the face/head ☐ Other: _____

Have you had any falls in the past 12 months? _____ If yes, how many times? _____

If yes, please describe: _____

Are you seeing (*or have you been seen by*) any other specialist for your current condition (*e.g.: doctor, psychologist, chiropractor, physical therapist etc.*)? Please list: _____

Tests for this condition? ☐ X-ray ☐ MRI ☐ CT Scan ☐ Other: _____

Who may we contact for the report findings? _____ Phone: _____

Since this condition began your symptoms have: ☐ decreased ☐ increased ☐ not changed

Are your symptoms worse in the: ☐ morning ☐ afternoon ☐ night ☐ same all day

Does the pain wake you at night? ☐ Yes ☐ No

Since onset of your current symptoms have you had:

- ☐ Any difficulty with control of bowel or bladder function
- ☐ Fever/chills
- ☐ Any numbness in the genital or anal area
- ☐ Numbness in arms or legs
- ☐ Any dizziness or fainting attacks
- ☐ Weakness
- ☐ Unexplained weight change
- ☐ Night pain/sweats
- ☐ Malaise (vague feeling of bodily discomfort)
- ☐ Problems with vision/hearing
- ☐ None of these

What aggravates your symptoms? (*please check all that apply*)

☐ Sitting	☐ Rising from seating	☐ Lying down	☐ Walking	☐ Up/Down Stairs
☐ Cough/Sneeze	☐ Reaching overhead	☐ Reaching forward	☐ Reaching across	☐ Reaching behind
☐ Stress	☐ Recreation	☐ Repetitive motion	☐ Deep breath	☐ Paper work/reading
☐ Standing	☐ Household chores	☐ Squatting	☐ Sleeping	☐ Sustained bending
☐ Looking up	☐ Swallowing	☐ Talking, chewing, yawning		

☐ Other: _____

Occupation: _____ Employer: _____ Phone: _____

Physical Activities at work (*check all that apply*):

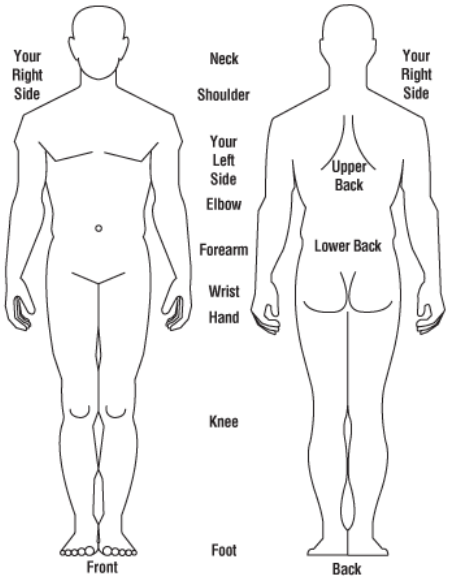
☐ Sitting ☐ Standing ☐ Computer use ☐ Repetitive lifting ☐ Heavy equipment operation
☐ Driving ☐ Phone use ☐ Other _____

What are your goals for treatment? _____

(e.g. reduce pain, pain free, increased motion, strength, return to normal activities)

Please list any allergies that you have (*e.g. medications, latex, food, bees*): _____

Please mark where you have symptoms on the figures below



Current Medications (*pain pills, injections and/or skin patches, etc*): _____

_____

What relieves your symptoms? (*check all that apply*): ☐ Sitting ☐ Rest ☐ Massage ☐ Heat

☐ Cold ☐ Stretching ☐ Standing ☐ Walking ☐ Exercise ☐ Lying down ☐ Medication ☐ Nothing

☐ Wearing a splint/orthosis ☐ Other _____

Past Medical History: Have you ever been diagnosed with any of the following conditions? (*check all that apply*)

☐ Heart Problems	☐ Depression	☐ High Blood Pressure	☐ Blood Disorder(s)
☐ Stroke	☐ Lung Problems	☐ Kidney Problems	☐ Thyroid Problems
☐ Epilepsy/seizures	☐ Diabetes	☐ Allergies	☐ Multiple Sclerosis
☐ Head Injury	☐ Osteoporosis	☐ Stomach Problems	☐ Rheumatoid Arthritis
☐ Broken Bones	☐ Parkinson's Disease	☐ Circulation/vascular	☐ Arthritis
☐ Other _____		☐ Cancer (type) _____	

All of the above information is true to the best of my knowledge.

_____ _____

Legal Signature (Guardian if warranted) Date

NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS- HIPAA

Forte Therapy assures that patients are treated according to their rights defined by HIPAA.

1. **Complaints:** If you desire more information concerning your rights to privacy; are concerned that we have violated your privacy rights; or disagree with a decision that we have made about access to Protected Health Information; you may contact Jennifer Dyreson or Tricia Bachman at 509-474-9197. You may also file a written complaint with the Director's Office of Civil Rights at the US Department of Health and Human Services. Upon request, you will be provided with the current address for the Director. You have the right to file a complaint with us or with the Office of the Director.
2. **Right to Request Additional Restrictions:** You may request restrictions on our use and disclosure of Protected Health Information (1) for treatment, payment, and health care operations, (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully; we are not required to agree to the requested restriction.
3. **Right to Receive Confidential Communication**s: You may request, and we will accommodate, any reasonable written request for receipt of Protected Health Information.
4. **Right to Inspect and Copy Your Health Information:** You may request access to your medical record file, as well as your enrollment, payment, claims adjudication, case, medical management records, and your billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you request a copy or copies of your health record you will be required to sign a release and will be charged a cost-based fee of $.50 for each page furnished. Payment is due upon receipt of requested records.
5. **Right to Amend Your Records:** You have the right to request that we amend Protected Health Information maintained in your medical record file, enrollment, payment, claims adjudication, case, medical management records, or billing records. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.
6. **Right to Receive a Paper Copy of this Notice:** Upon request, you may obtain a paper copy of the Notice, even if you agreed to receive such notice electronically.

_____ _____

Legal Guardian or Patient Signature Date

12/2022

CONSENT TO CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Forté Therapy to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and medical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Forté Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment.

FINANCIAL POLICY STATEMENT

I agree to make payments, for which I am responsible, in a timely manner. As well as being responsible for all costs associated with collecting monies, including court costs, collection agency fees, and attorney fees, should my account default for a period over 90 days.

We bill your insurance carrier solely as a courtesy to you. If you would like to know your PT benefit, please inquire at the front desk after having furnished complete and accurate information. We are happy to pass along the information obtained from your insurance company. Please note we cannot guarantee the accuracy of the information obtained from your insurance it is used as a reference. **Ultimately you are responsible for your bill, knowing and understanding your insurance benefits. At any time, you can obtain your benefit information directly from your insurance company.** You will have 30 days to pay on any balance billed to you after 30 days a minimum of $5 or 1% may be assessed whichever is greater. If your insurance carrier should request a refund of the payment they previously made; you will be responsible for repayment to Forté Therapy. Please keep us informed of any insurance changes by providing a hard copy for your file.

The above may not apply for those patients that are considered Workers Compensation. Please be advised if you do claim Worker's Compensation benefits and your claim is denied; you will be held responsible for the total amount of charges for services rendered to you.

If payment is made directly to you for services billed by us, please recognize the obligation to promptly submit the funds to Forté Therapy or you will be billed for the full amount due. If you pay by check and your check is dishonored or returned for any reason, you expressly authorize Forté Therapy to add a NSF fee of $25.00 to your account for check processing. Appointments missed or cancelled with less than 24 hours' notice will be billed at $50.

INFORMATION PRIVACY

Forté will use and disclose your health information to treat you and to receive payment for care we provide. A detailed notice of Privacy Practices are included to help you better understand our policies in regard to your personal health information. The terms of the notice may change however a current notice is posted in our facility. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBILITIES:

_____ DATE _____

Signature of Adult Patient or Legal Guardian