Midland
Physical
Therapy, Inc.

Patient Responsibility Form

1. Please be aware that the patient is responsible for understanding their insurance benefits and how claims will be processed. If you have any questions regarding how claims will be processed, your insurance company should be able to assist you.

2. To comply with the Timely Filing Act for all insurance companies, the health insurance information I provide is to be billed as I am ***NOT*** seeking workman's compensation, auto insurance, or liability insurance for payment. I assume all responsibility for copays and deductibles. I also understand that I will not be able to change my billing information once my treatment begins.

Patient Name (Please Print): _____

Signature of Patient (or responsible party if patient is a minor):

_____ Date: _____

_____

_____

_____

Patient Information Sheet

_____

Last Name First Name M.I. Date of Birth Age

Name preferred to be called by: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____

Patient Email address: _____ **Can we send electronic statements to text/email?** _____
SS#: _____-_____-_____ Marital Status: _____ Student Status: _____

Employer: _____ Is this a work injury? Yes No

Condition/Primary Complaint: _____ Onset Date: _____

Referring Doctor: _____ Family Doctor: _____

Date of Next Doctor Appointment: _____/_____/_____ Who is this appointment with? _____

Have you had physical therapy during this current calendar year? → YES NO Home Care? → YES NO
Have you had any chiropractic services during this calendar year? → YES NO

INSURANCE INFORMATION:
→ Primary Insurance Company (Please Circle):

Aetna | Aetna Medicare Advantage | BCBS | BCBS ConnectCare | Cigna | ConnectCare | Medicare | Medicare Plus Blue | Other: _____
Policy Holder Name (and address if different): _____DOB: _____
→ Secondary Insurance Company (Please Circle):

Aetna | Aetna Medicare Advantage | BCBS | BCBS ConnectCare | Cigna | ConnectCare | Medicare | Medicare Plus Blue | Other: _____
Policy Holder Name (and address if different): _____DOB: _____

How did you hear about us? _____

AUTHORIZATION TO TREAT: *You hereby authorize Midland Physical Therapy, Inc., to render all treatment as prescribed by your physician; as well as the ability to forward information regarding your physical therapy to your family doctor upon request by the patient and/or family physician.*
HIPAA PRIVACY AND DISCLOSURE NOTICE: *We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. A copy of our compliance with HIPAA can be provided upon request.*
FINANCIAL RESPONSIBILITY: *The patient, or responsible party, will owe any patient balance plus any collection fees associated with balance. Any incurred patient balance after insurance payments will be expected to be paid IN FULL at* ***each visit****. For your convenience, we suggest you keep your credit card on file here with us for an easy payment option. If no payment is made within 30 days of statement date, you allow MPT to charge balance to your credit card.* All missed appointments or no shows without a 4-hour cancellation notice are subject to a $25 fee.

SIGNATURE: _____ DATE: _____/_____/_____

NAME OF RESPONSIBLE PARTY (if patient is a minor): _____

Past Medical History

Medications: What pain medications are you currently taking? ***Please include the dosage and frequency.***

☐ *Please check here if you are **NOT** taking any medications whatsoever, prescription or non-prescription.*

Advil/Motrin/Ibuprofen	Aleve	Tylenol
Norco	Vicodin	Gabapentin/Neurontin
Oxycontin	Oxycodone	Flexeril

Please allow us to make a copy of your medications/supplements list. If you do not have a copy on you, please list them here:

Past Medical History (circle all that apply):

Heart Disease
Congestive Heart Failure
High Blood Pressure
Chest Pain/Angina
Pacemaker or Defibrillator
Bleeding Disorders/On Blood Thinner
Circulation/Vascular Disorders
Current Infection
Kidney Disease
Lung Disease
Asthma
Difficulty Breathing
Difficulty Swallowing
Currently Pregnant
Hearing Problems/Visual Problems

Cancer → Location/Type of Cancer:_____
Diabetes
Osteoarthritis
Rheumatoid Arthritis
Osteoporosis/Osteopenia
Allergies
Skin Diseases
Stroke
Epilepsy/Seizures
Head Injury
Weight Loss/Gain
Depression
Broken Bones
Other: _____

Have you had any surgeries? → YES NO If yes, please list surgeries and approximate dates:

Were you hospitalized for this current condition? If so, please list your admission and discharge dates: YES NO

If yes → Admitted: _____/_____/_____ Discharged: _____/_____/_____

Have you ever been in a motor vehicle accident or any type of trauma? → YES NO

Current Condition

What DATE did your symptoms begin? *If your symptoms began over a year ago, please list a specific date involving a* ***RECENT*** *(within one year) change in status requiring physical therapy.* Please be as specific as possible: _____/_____/_____

Where is your pain?

Describe ***HOW*** your symptoms began, or ***WHAT OCCURRED*** to bring on your symptoms/pain? Please be as specific as possible.

What is your goal for therapy? What do you want to achieve?

Have you had any similar problems in the past?

When?

Did you receive any treatment?

Did your doctor give you any other restrictions? → YES NO
If yes, what are they?

What is your occupation?

Were any of the following tests done? MRI XRAY CT SCAN EMG ULTRASOUND OTHER
What were the results?

Activities of Daily Living – Work Activities – Leisure Activities

Circle any of the following basic activities that you may feel limited in, or have pain with, since your recent injury:

Walking	Grocery Shopping	Sleeping
Sitting	Driving	House Cleaning
Standing	Going up/down stairs	Yard Work
Changing positions	Getting in/out of car	Putting on shirt/coat
Showering/bathing	Reaching kitchen shelves/lifting gallon of milk	Putting on shoes/socks/pants

Work Activities

Circle any of the following work duties/activities that you may feel limited in, or have pain with, since your recent injury:

Sitting	Standing	Walking
Lifting	Push/pull	Climbing
Bending	Reaching	Other: _____

Leisure Activities

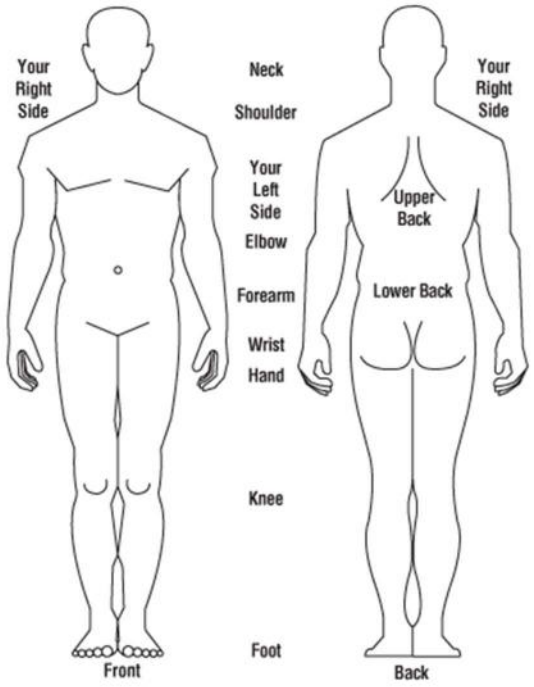
List any leisure time or recreational activities that you may feel limited in, or have pain with, since your recent injury:

_____

_____

Pain Location

Where is your pain located? Please circle on diagram below.



Do you have any numbness or tingling in either arm or leg? → YES NO

R Arm L Arm R Leg L Leg

Please rate your pain on a scale of 0 to 10 (0 = pain free, 10 = worst imaginable pain):

Pain at its worst:	0	1	2	3	4	5	6	7	8	9	10
Current level of pain:	0	1	2	3	4	5	6	7	8	9	10
Pain at its lowest:	0	1	2	3	4	5	6	7	8	9	10

How would you describe your pain? Sharp Dull/Achy Burning Electrical Stabbing

Is it localized or radiating? (Please circle) Localized to one area. Radiates to another area.

Please list anything that makes your pain worse:

Please list anything that alleviates your pain:

Sheila Isles-Truax, PT, FAAOMPT
Kristi Turner, PT, MSPT
Ryan Dietlein, PT, DPT
Sara Jones, PT, DPT

Midland Physical Therapy, Inc.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

I request and authorize ***Midland Physical Therapy, Inc.*** to release healthcare information of the patient named above to ----------→

Name:
Relationship to patient:
Phone number:

This request gives Midland Physical Therapy, Inc. authorization to release the following information to the above-named individual regarding:

- ☐ Scheduling or appointment changes
- ☐ Billing information or questions
- ☐ Any health-related information obtained by Midland PT
- ☐ Other: _____

Patient Signature: _____ Date signed:___/___/___

THIS AUTHORIZATION EXPIRES ONE (1) YEAR AFTER IT IS SIGNED.

Midland
Physical
Therapy, Inc.

Sheila Isles-Truax
P.T., F.A.A.O.M.P.T.

Kristi Turner
P.T., M.S.P.T.

Ryan Dietlein
P.T., D.P.T.

Sara Jones
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Suite A

Midland, MI 48642

COVID-19 (Coronavirus) Patient Intake Questionnaire:

Prior to being seen at Midland Physical Therapy, we request that you complete the below questionnaire. If you answer yes to any of the below, you may be asked to reschedule your appointment.

Have you traveled in the past 14 days?

Yes **No**

If yes, during your travels were you in close proximity with anyone exhibiting signs of illness (cough, sneezing, fever, etc.)?

Yes **No**

Could you have possibly been exposed to anyone diagnosed with COVID-19?

Yes **No**

Do you currently have a fever or any signs of illness (cough, sneezing, etc.)?

Yes **No**

Patient Name (Printed): _____

Patient Name (Signed): _____

Date: _____/_____/_____