ABERDEEN PHYSICAL THERAPY & WELLNESS, LLC.

New Patient Intake Packet

Name: _____

If you have questions or concerns with any of the forms below or if you need help, please ask at the front desk.

I have read/completed the following:

___ Welcome Letter
___ HIPAA Form
___ Patient Information Form
___ Medical History Form
___ Informed Consent Form
___ Mental Health Survey
___ Elder Abuse Screening Inventory (65+)

Signed,

_____ _____

Signature Date

ABERDEEN PHYSICAL THERAPY & WELLNESS, LLC.

200 North Poplar Street
Aberdeen, NC, 28315
Phone: (910)-944-1169
Fax: (910)-944-1566

Terry Young, PT, DPT, Cert. DN
Rick Young, PT, MPT, AIB/VRC, CMPT/MT, CODN
Evie Locklear, PTA
Billie Mitchell, Office Coordinator
April Brown, Insurance Coordinator
David P. Griffith, Administrative Assistant

Dear Friend,

Thank you for choosing us for your physical therapy needs. We are here to provide you with the best care possible. Our experienced, licensed staff has over 70 years of combined experience providing high quality physical therapy services, and we have been providing those services to Moore County residents since 2001. We strive to keep an evidence-informed staff to provide our patients with the most current treatments available.

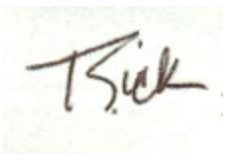
We take the time to listen to your concerns and your symptoms to determine the appropriate physical therapy treatment plan to help in your recovery. Our team, from the front office to our therapists, will do everything possible to make you feel comfortable.

It is our goal to provide you with excellent care and the knowledge you need to improve your physical wellness. We are pleased that you selected us for your physical therapy needs.

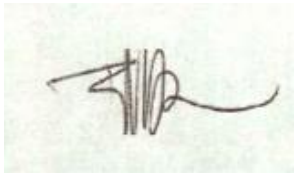
Feel free to call Billie or April at (910)-944-1169 with any questions you may have.

We look forward to working with you!

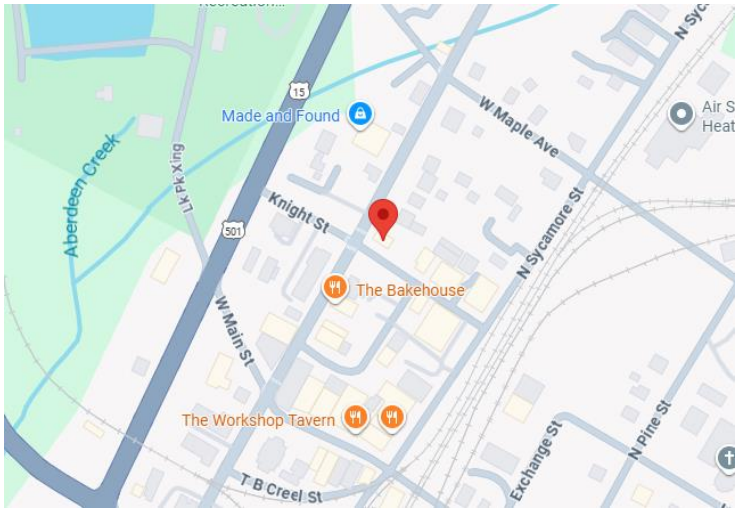
Sincerely,



Rick Young, PT



Terry Young, DPT



What to Wear to Physical Therapy:
If you are being seen for lower back, knee, or leg problems, please wear shorts and a t-shirt.
For neck, shoulder, or upper back problems, please wear a tank top or sleeveless shirt.
If your visit for any kind of sport, running, or movement assessment, please bring/wear your walking or running shoes.

Aberdeen Physical Therapy & Wellness, LLC

PATIENT PRIVACY AND PROCEDURE STATEMENT

Aberdeen Physical Therapy & Wellness, LLC maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have a grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 910-944-1169.

FINANCIAL POLICY STATEMENT

Please be aware you are responsible for the entire bill when services are rendered, however, we will bill your insurance carrier or other provider of medical benefits as a courtesy to you. Required co-payments and co-insurances are to be made at the time services are rendered. If your medical benefits are not paid within ninety (90) days, the balance will be due in full from you.

If you are a Worker's Compensation patient the above policy does not apply to you. However you may be responsible for your charges if your Worker's Compensation claim is controverted.

If you fail to make timely payment for any amount for which you are responsible, you will additionally be responsible for all costs of collection, including collection agency fees.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Aberdeen Physical Therapy promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 910-944-1169.

Late Cancellations:

Late cancellations will be considered as a "no-show".

No-Show Policy

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-show" will result in a fee of $25.00 billed to the patient's account. This amount will not be covered by insurance and will be patient responsibility.

NON COVERED SERVICES

Some services that we provide may not be covered by your insurance company. If this is the case, you will be notified in advance at which point you may decline the service or make financial arrangements with our office for payment.

We accept cash, checks, Visa, Mastercard, and Discover as payment options.

Signature:_____ Date: _____

Aberdeen PT and Wellness, LLC

New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Patient Information

Account #	Social Security #	Title	Last Name	First Name	MI

Street Address (Road or Street)	(Apartment Number or Second Address Line)

City	State	Zip

Home Phone:	Cell Phone:	**Email Address:**

Birthday	Gender/Pronouns	Referring Physician full name	Primary Care Physician

Marital	Employment	Student	Relationship to Insured
☐M-Married ☐W-Widowed ☐S-Single ☐D-Divorced ☐ Separated	☐ R-Retired ☐ F-Full ☐P-Part ☐ N-None	☐ P-Part ☐ F-Full ☐ N-None	☐SE-Self ☐SP-Spouse ☐OT-Other ☐CH-Child

Preferred Method of Appointment Confirmation: ☐ Phone Call ☐ Email ☐ Text

Employer Name	Employer Street Address (Road or Street)

Zip Code	City	State	Business Phone	Ext

INSURANCE INFORMATION

Primary Insurance Company Name Mailing Address

Insurance Telephone # Policy # Group #

Secondary Insurance Company Name Mailing Address

Secondary Telephone # Policy # Group #

COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT NAME

Social Security #	Title	Last Name	First Name	MI

Birthday	Sex (M, F)	Relationship to Insured:

ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related:	Accident Related:	Date of first symptom or accident:
☐ Yes ☐ No	☐ Auto ☐ Other ☐ No	

Give Details of Accident:

I authorize the release of any medical or other information necessary to process insurance claims.

Signed Date

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed Date

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

HIPAA Info

- ☐ Patient agrees to release of medical or other information to process claim
- ☐ Patient agrees to accept assignment of payment
- ☐ Patient gave office the permission to leave a message on their answering machine
- ☐ Patient gave permission to discuss their medical condition with another person

Allergies	O Yes	O No	Dizzy Spells	O Yes	O No	MRSA	O Yes	O No
Anemia	O Yes	O No	Emphysema/Bronchitis	O Yes	O No	Multiple Sclerosis	O Yes	O No
Anxiety	O Yes	O No	Fibromyalgia	O Yes	O No	Muscular Disease	O Yes	O No
Arthritis	O Yes	O No	Fractures	O Yes	O No	Osteoporosis	O Yes	O No
Asthma	O Yes	O No	Gallbladder Problems	O Yes	O No	Parkinsons	O Yes	O No
Autoimmune Disorder	O Yes	O No	Headaches	O Yes	O No	Rheumatoid Arthritis	O Yes	O No
Cancer	O Yes	O No	Hearing Impairment	O Yes	O No	Seizures	O Yes	O No
Cardiac Conditions	O Yes	O No	Hepatitis	O Yes	O No	Smoking	O Yes	O No
Cardiac Pacemaker	O Yes	O No	Low/High Blood Pressure	O Yes	O No	Speech Problems	O Yes	O No
Chemical Dependency	O Yes	O No	High Cholesterol	O Yes	O No	Strokes	O Yes	O No
Circulation Problems	O Yes	O No	HIV/AIDS	O Yes	O No	Thyroid Disease	O Yes	O No
Currently Pregnant	O Yes	O No	Incontinence	O Yes	O No	Tuberculosis	O Yes	O No
Depression	O Yes	O No	Kidney Problems	O Yes	O No	Vision Problems	O Yes	O No
Diabetes	O Yes	O No	Implants(metal, cosmetic)	O Yes	O No			

Describe any other conditions or precautions:
If "Yes" to ANY of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? O Yes O No **Date of Fall:**_____
Two or more falls in the last year? O Yes O No **Dates of Falls:**_____

Surgical History

Body Region: _____ **Surgery Type:** _____**Date of Surgery:**___/___/____
Body Region: _____ **Surgery Type:** _____**Date of Surgery:**__/___/_____
Body Region: _____ **Surgery Type:** _____**Date of Surgery:**__/___/_____
Body Region: _____ **Surgery Type:** _____**Date of Surgery:**__/___/_____

Current Medications ☐ Currently not taking any medications

Drug: _____**Dosage:** _____ **Frequency:** _____**Route:** _____**Reason:**_____
Drug: _____**Dosage:** _____ **Frequency:** _____**Route:** _____**Reason:**_____
Drug: _____**Dosage:** _____ **Frequency:** _____**Route:** _____**Reason:**_____
Drug: _____**Dosage:** _____ **Frequency:** _____**Route:** _____**Reason:**_____
Drug: _____**Dosage:** _____ **Frequency:** _____**Route:** _____**Reason:**_____

Emergency Contact: _____ _____ **Relationship:** _____

Phone: ( ) _____ **Address:**_____

Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Aberdeen Physical Therapy and Wellness does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to full cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

_____	_____	_____
Print Patient Name	Signature	Date

ABERDEEN PHYSICAL THERAPY & WELLNESS, LLC.

Name:_____ Date of Birth: _____

Today's Date: _____

Mental Health Survey

Part of routine screening for your health includes reviewing mood and emotional concerns.

During the past two weeks, have you been bothered by any of the following problems?

Feeling down, depressed, irritable, or hopeless?	☐ Yes	☐ No
Little pleasure or interest in doing things?	☐ Yes	☐ No

If you answered, "Yes," to either question above, please answer all questions below.

During the past two weeks, how often have you been bothered by any of the following problems?	**(0) Not At All**	**(1) Several Days**	**(2) More Than Half of the Days**	**(3) Nearly Every Day**
Feeling down, depressed, irritable, or hopeless				
Little interest or pleasure in doing things				
Trouble falling asleep or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself—or feeling that you are a failure or have let yourself or your family down				
Trouble concentrating on things like reading the newspaper or watching television				
Moving or speaking so slowly that other people have noticed Or the opposite- being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

If you are experiencing any of the problems listed on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others? (Circle one.)

Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult

For Office Use Only—Total Score: ☐

ELDER ABUSE SUSPICION INDEX © (EASI)

EASI Questions Q.1-Q.5 asked of patient; Q.6 answered by doctor *(Within the last 12 months)*			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) **Doctor:** Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

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