Patient/Client information

First name: _____ Middle initial:_____Last name:_____

Date of Birth: _____

Parent/Guardian's name:_____

Address: _____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

E-mail address: _____

Referring Physician: _____

Primary Care Physician: _____

Patient/Client Employer: _____

Person to contact in case of emergency:_____Phone:_____

Relationship to patient/client: ( ) Parent/Guardian ( ) Spouse ( ) Child ( ) Other_____

Insurance Information:

Insurance Company: _____

Policy Holder Name: _____

Policy holder date of birth: _____
(if different from above)

Whom may we thank for referring you? _____

Patient Client Signature_____Date:_____

CONTROLOGY

Pilates & Physical Therapy

Patient Authorization

1. I authorize use of this form on ALL of my insurance submissions.
2. I request that payment of authorized benefits be made on my behalf to Contrology Physical Therapy, Inc. for services rendered by that office.
3. I understand that my signature authorizes that payment be made and that my medical information be released in order to pay the medical claim.
4. I understand that I am responsible for any deductible, co-payments and non-covered services.
5. I understand that I am responsible for any unpaid balance on my account.
6. I permit a copy of this authorization to be used in place of the original.
7. I understand that I will be charged a $85.00 fee for any appointments broken without 24 hour notification.
8. A missed Pilates class will be charged the cost of the session.

Patient signature:_____Date:_____

Patient consent

The therapist has discussed the proposed treatment, risks, expected benefits and reasonable alternatives of the proposed treatment. My questions have been answered to my satisfaction and I hereby consent to the proposed treatment.

Patient signature:_____Date:_____

5835 Post Road, Suite 112 East Greenwich, RI 02818
Tel: 401-885-0051 Fax: 401 885-0054
www.contrologypt.com contrologypt@gmail.com

Patient Health Questionnaire

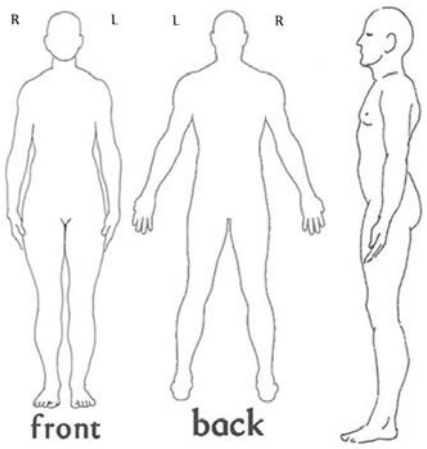
Name:_____Date:_____

Please describe your current complaint or limitation_____
_____

What is your goal for therapy?_____
_____

Please describe the nature of your pain
( ) sharp pain
( ) dull (pain) ache ( ) constant (76-100%)
( ) throbbing ( ) frequent (51-75%)
( ) numbness ( ) occasional (26-50%)
( ) shooting ( ) intermittent (25% or less)
( ) burning
( ) tingling

>>>> please mark on the picture where have pain or symptoms >>>>



Indicate the intensity of your pain at rest: No pain 0 1 2 3 4 5 6 7 8 9 10 unbearable

Indicate the intensity of your pain with movement: No pain 0 1 2 3 4 5 6 7 8 9 10 unbearable

Your symptoms are worse in ( ) morning ( ) afternoon ( ) night ( ) increased during the day
( ) same all day

When did your problem begin? _____days ago, _____months ago, _____years ago

Describe how your problem began:_____
_____

Did you have any surgeries? ( ) yes ( ) no Date of surgery if applicable __/__/__
In the past have you been treated for the same problem? ( ) yes ( ) no
If yes, who did you see for that condition? _____

What makes your problem better? ( ) nothing ( ) lying down ( ) standing ( ) sitting ( ) movement/exercise
( ) inactivity
What makes your problem worse? ( ) nothing ( ) lying down ( ) standing ( ) sitting ( ) movement/exercise
( ) inactivity
Occupation_____( ) FT ( ) PT

Has your work status changed because of this condition? ( ) yes ( ) no

OVER >>>>>

Do you have or have had any of the following conditions?

High blood pressure
Angina
Heart attack
Stroke
Asthma
HIV/Aids
Cancer Location_____ Date_____
Tumor
Systemic Lupus
Hepatitis
Epilepsy
Diabetes
Rheumatoid Arthritis
Arthritis
Pregnancy
Other_____

Tobacco packs per day_____

List any allergies:_____

List any medication you are currently taking:_____

_____

Height_____ Weight_____

Patient signature_____ Date_____

PATIENT HIPAA AWARENESS

With my permission, Contrology Physical Therapy, Inc. may use and disclose protected health information (PHI) about me to carryout treatment, payment and healthcare operations (TPO). Please refer to Contrology Physical Therapy, Inc. Notice of Privacy Practices for a more complete description of such used and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Contrology Physical Therapy, Inc reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Contrology Physical Therapy, Inc. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office Contrology Physical Therapy, Inc may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and/or Confidential.

With my permission, the office of Contrology Physical Therapy, Inc may email to my home or 3other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Contrology Physical Therapy, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to aggress to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Contrology Physical Therapy, Inc to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian_____

Print Patient's Name_____

Print Name of Patient or Legal Guardian_____ Date_____

Credit Card Authorization Form

(Please fill in the form below and return it to us)

By signing this form I, _____authorize Contrology PT Inc., to charge my credit card or any copays/deductibles, or for the amount that is not higher than $ 196 per visit.

Card Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover Other:_____

Cardholder Name* _____

Card Number* _____

Expiration Date (MM/YY)* _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

Billing Address: _____

_____

_____

* Obligatory fields.

CARDHOLDER SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form. This payment authorization is for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company. I understand that the payment is non-refundable.

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