LEPRE
PHYSICAL THERAPY
THE SCIENCE OF HEALING THE ART OF CARING

Dear Patient,

I would like to take this opportunity to offer my sincere appreciation for choosing Lepre Physical Therapy. We know that there are many options available when selecting a Physical Therapist. We also understand that this is an important decision that will affect your health for the rest of your life, and hold that responsibility dear to our hearts.

For over 35 years, Lepre Physical Therapy has been serving the Rhode Island community. At our five conveniently located state-of-the-art patient clinics, we are committed to providing you with the personalized care to meet your individualized rehabilitation goals. Appointments are available within 24-48 hours.

Our licensed, highly educated Physical Therapists will listen to your symptoms and concerns during your initial evaluation. They will complete a thorough assessment, and formulate a comprehensive, individualized treatment plan, which will put you on the path to mobility, increased performance, and independence. We will also instruct you in a home exercise program, to reinforce efforts made in the clinical setting. Together, we will work as a Team, to optimize your functional outcome, and transition you to the lifestyle you expect from our care.

We hope you enjoy our easily accessible, friendly office atmosphere, our exceptional clinical care, and your total experience at Lepre Physical Therapy. If you have any feedback you would like to share, please feel free to contact me at 1-800-93-LEPRE or stephenlepre@me.com. I am also available to meet with you, in person, should the need arise during the course of your Physical Therapy services.

Sincerely,

Stephen P. Lepre

Stephen P. Lepre, PT, MEd
Founder & Director, Lepre Physical Therapy

Name: _____ **Date:**_____

Leisure activities, including exercise routines:_____

Occupation, including activities that comprise your workday:_____

Age: _____ **Height:** _____ **Weight:**_____

Are you on a work restriction from your doctor? YES NO **Are you latex sensitive? YES NO**

Do you smoke? YES NO **Do you have a pacemaker? YES NO** **Do you have hearing loss? YES NO**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

ALLERGIES: List any medication(s) you are allergic to: _____

_____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke/ head injury
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list all medications you are currently taking: (including dosages and frequency):

-Blood Pressure Medication	-Heart Medication	-Anti-coagulants (blood thinners)
_____	_____	_____
-Muscle Relaxants	-Pain Killers	-Diabetes Medication (i.e. insulin)
_____	_____	_____
-Steroids	-Anti-inflammatories	-Other Medications (state condition)
_____	_____	_____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**
Please List all surgeries you have had (include dates):

_____

_____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) _____

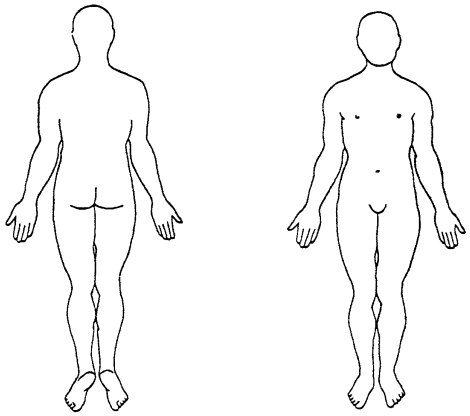
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify important positions or activities that make your symptoms worse:

_____

_____

Easing Factors: Identify important positions or activities that make your symptoms better:

_____

_____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

I certify that the above information is accurate to the best of my knowledge.

_____ _____

(Patient Signature) *(Date)*

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Name_____ **Date of Birth**_____/_____/_____

Address_____

City_____**State**_____**Zip Code**_____

OFFICE POLICIES AND PROCEDURES

We have developed this information to make you aware of our billing policies at the time of your initial office visit. Please review these policies carefully.

Physical therapy services are reimbursed under the provisions of most health insurance policies. **You, as the subscriber, are primarily responsible for knowing the terms of your policy**. Our office personnel are familiar with various coverages offered by health insurance companies, and will assist you. If you (the subscriber) should receive a check from your insurance company that is intended for this practice (the provider) for services rendered, you should immediately remit this to our office for credit to your account. Failure to do so will result in our office billing you for the complete balance and you will be responsible for payment of this amount in full.

Liability cases are accepted when accompanied by a health insurance plan and/or auto insurance with a medpay plan. We will accept the insurance plan's allowable, along with the copays and/or deductibles, as payment in full for any covered services rendered to our patients. However, once the health insurance plan indicates that it will no longer pay for physical therapy benefits the service will no longer be considered a covered service.

Worker's compensation patients will be accepted according to the Worker's Compensation Law enacted in 1992. Should your claim be denied by your Worker's Compensation company, we will bill your medical insurance carrier and you will be responsible for any deductibles and co-payments. If you do not have a third party insurance, please speak with the Billing Supervisor to make arrangements for payment of your account. Failure to attend physical therapy may jeopardize your worker's compensation benefits.

Medicare patients who do not have supplemental insurance will be billed for their yearly deductible and 20% of the Medicare allowable. If Medicare denies payment, the patient will be billed for 100% of the allowable.

Medicaid does not pay for physical therapy in a private practice.

***If this is a Worker's Compensation case, please make sure you have informed the front office. ***

NO SHOW AND CANCELLATION POLICY

Your scheduled appointment is reserved for you. If you are unable to keep your appointment, you must cancel at least twenty-four(24) hours in advance. If you neglect to cancel your appointment, a $25 fee will be charged to your account. If you are going to be late for your appointment, you should call to inform us of your expected arrival time. Your appointment may need to be rescheduled at the discretion of the physical therapist, to ensure that your late arrival will not interfere with the treatment of the patient scheduled after you.

CO-PAYMENTS are due at the time of service. Please contact the customer service department of your insurance company for information regarding your outpatient physical therapy benefits , co-pay amounts and deductible amount(if applicable).

CO-PAYMENTS: (estimate):

Initial evaluation with Treatment: $_____

Each Follow-up appointment: $_____

I, _____, fully understand the contents of your office policies and procedures
(please print name)
and agree to abide by them. I also understand and agree to pay for the charges that may be made towards my account for physical therapy services rendered by this office, consistent with the terms of my health insurance policy.

Signature_____Date_____

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

AUTHORIZATION SIGNATURE FORM

- I request that payment of insurance benefits for services rendered to me be paid directly to Lepre Physical Therapy.
- I authorize Medicare (if applicable) to send claims to my secondary insurance for crossover benefit payments.
- I authorize Lepre Physical Therapy to release medical information to my insurance carrier to determine benefits payable.
- I understand that I may revoke this authorization at any time with a renewed and dated signature.

My insurance is;

Primary_____

Secondary_____

_____ _____
Signature Date

I wish to **REVOKE** the above release for payment/release of medical information

_____ _____
Signature Date

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Lepre Physical Therapy's Notice of Information Practices. I understand that Lepre Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Lepre Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Lepre Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Signature _____

How were you referred to Lepre Physical Therapy

Doctor _____

Friend or Family _____

Advertisement/Internet _____

Former Patient _____

Other _____

EMERGENCY CONTACT, NAME AND NUMBER _____

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In our efforts to provide excellent care, we ask for your assistance. If at any time during your treatment you are experiencing pain or discomfort, it is important that you inform your therapist or the nearest staff member immediately. This includes any time you are being directly treated by your therapist, exercising, or set up on a modality. Modalities consist of heat/cold packs, electrical stimulation, ultrasound, light therapy/laser, and iontophoresis. This includes any and all types of pain/discomfort, such as sharp, shooting, burning, tingling, numbness, etc. Some people feel that the more pain they are in, the more benefit they are getting from the treatment. However, the popular saying "no pain, no gain" is not always the case during your treatment. If any pain or discomfort is expected during a particular treatment, you should be informed in advance. If you have not been forewarned and you are in pain, please be proactive in your own care and notify a staff member right away. It is our intention to provide the safest and highest level of care possible and we thank you in advance for your cooperation in this matter.

Sincerely,

The Staff of Lepre Physical Therapy

_____ _____

Patient Signature Date

_____ _____

Physical Therapist Signature Date