METRO SPORTSMED®
Physical & Occupational Therapy
POWERED BY MOTIONPT GROUP

Medication Form

Patient's Name: _____ Date: _____

Please fill out required information regarding **ALL MEDICATIONS: PRESCRIPTION, OVER THE COUNTER, VITAMINS, AND DIETARY/ HERBAL SUPPLEMENTS** below **COMPLETELY:**

☐ I am currently **NOT** taking any of the above

Medication: Prescription, Over the Counter, Vitamins, Herbals, Dietary Supplements	Dosage	Frequency (times per day)	Route (Oral, Injectable, Transdermal, Inhale) Patients with Medicare MUST complete	Reason for Medication

I acknowledge I have reviewed the above listed information noted with patient.

Clinician Signature: _____ Date: _____

MEDICAL HISTORY	YES	NO	ONSET DATE
Anemia			
Chest pain/Heart Attack/Coronary Artery Disease			
High Blood Pressure			
Arthritis			
Pulmonary Condition			
Cancer			
Diabetes			
Abnormal Bleeding/Clotting			
Vision Deficits			
Depression/Anxiety			
Hearing Problems			
Kidney Disease			
Osteoporosis			
Falls			
Fractures			
Seizures			
Incontinence			
Thyroid Disorder			
Strokes/TIA			
Active Infection			
Other Neurologic Disorder			
Loss of Consciousness			
MRSA/VRE/C-Diff			
Headaches			
Skin Disorders			
Other:			

Surgical History: List and Date

1. _____ 4. _____

2. _____ 5. _____

I acknowledge I have reviewed the above listed information noted with patient.

Clinician Signature: _____ Date: _____

PRIMARY MEDICAL CONDITION REQUIRING REHABILITATION:

_____

Allergies:

☐ **Yes** ☐ **No**

Allergic Reaction: _____

Special Tests Performed:

X-Ray ____ CAT scan ____ MRI ____ Bone Scan ____ Other ____

Date and result: _____

Have you ever had therapy for this problem? Yes ____ No ____

Are you under anyone else's care for this problem now? Yes ____ No ____

Have you had Physical Therapy before? Yes ____ No ____

If yes, please explain:

Social History:

Home Status:

Your current living arrangement is:

Live alone ____ Live with partner ____ Live with family/friend ____ Other ____

Do you live with children 18 years or younger? Yes ____ No ____

Do you have stairs going into your home/building? Yes ____ No ____

If yes, how many? ____

Smoking History:

Current smoker ____ Packs per day ____

Former smoker (Quit Date: _____)

Never smoked ____

Use of Alcohol:

Social ____ Weekly ____ 1 to 2 glasses per day ____ 2+ per day ____

Occupation:

_____

Are you currently working? Yes ____ No ____

Cultural Needs:

What is the primary language spoken in your home?

_____

Do you require an interpreter? (Bilingual patients may need an interpreter)

Yes ____ No ____

Are there any cultural/religious practices that you would like us to be aware of before treatment?

Yes ____ No ____

If yes, please explain: _____

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PAIN

Do you have persistent or frequent Pain? Yes ____ No ____

If **YES**, complete the following:

Location on body: _____

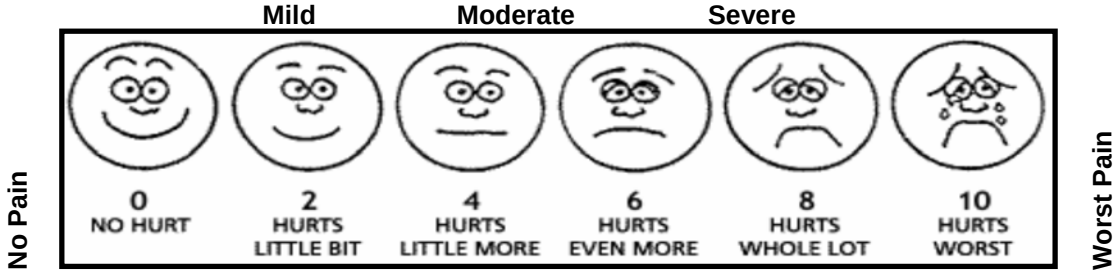
Does pain affect your daily activities? Yes ____ No ____

Does pain wake you at night? Yes ____ No ____

Circle one:

0 1 2 3 4 5 6 7 8 9 10

Mild **Moderate** **Severe**



Do you have durable medical equipment? (i.e. walker, wheelchair, etc.) _____

What exercises of sports do you participate in? _____

List your three major **FUNCTIONAL** difficulties/problems
(i.e. Self Care, Household Chores, Changing Positions, Shopping, Transportation, Walking, Work)

1. _____
2. _____
3. _____

List your three major **SYMPTOM** complaints

1. _____
2. _____
3. _____

List your **SPECIFIC GOALS** for rehabilitation

1. _____
2. _____
3. _____

I acknowledge I have reviewed the above listed information noted with patient.

Clinician Signature: _____ Date: _____

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Acknowledgement of Company Policies and Procedures

Financial Policy Metro SportsMed Physical & Occupational Therapy is affiliated with New York Methodist Hospital. Your clinical care will be provided by our physical and occupational therapy staff at Metro SportsMed Physical & Occupational Therapy. Your billing will be managed by New York Methodist Hospital. All billing statements will come from New York Methodist Hospital. Please make all checks payable to New York Methodist Hospital.

New York Methodist Hospital is contracted with most insurance companies. All bills for treatment services will be submitted directly to your insurance carrier. I authorize payment of medical benefits directly to NY Methodist Hospital and understand I am responsible for payments of all services rendered. If I belong to an HMO/ Managed Care Organization that New York Methodist Hospital participates with, I agree to be responsible for securing necessary referrals and making direct payments as required by my policy. As a courtesy, Metro SportsMed Physical & Occupational Therapy will submit to insurance for physical and occupational therapy authorizations.

Metro SportsMed Physical & Occupational Therapy is bound by Federal and State Law to comply with the payment policies set forth by each insurance plan. These regulations prevent Metro SportsMed Physical & Occupational Therapy from uniformly waiving co-payments and/or deductibles. Copayments must be paid in full before each treatment session. If you choose to issue your co-payments on a weekly basis, payment is due prior to your first treatment session of the week. If you wish to cancel or reschedule an appointment, we require a minimum of 24-hour advance notice. If you have frequent cancellations or fail to keep two appointments without notice, you may be discharged from the program. If you are experiencing financial hardship, you may qualify for financial assistance with the cost of your services. Please ask to speak to a member of our Patient Accounts Department. In the event it becomes necessary to refer your account for collection, you will be held responsible for the attorney fees and collection costs.

Consent For Care and Treatment I, the undersigned, do hereby agree and give my consent for Metro SportsMed Physical & Occupational Therapy to provide me with effective rehabilitative treatment as considered necessary and proper in treating my physical condition. No guarantees have been made regarding the projected outcome of care. I have been given the opportunity to ask questions, and all my questions have been answered satisfactorily.

A Legal Guardian must accompany patients under 18 years of age to their Initial Evaluation. Said Legal Guardian is not required to attend follow up treatment sessions provided that the *"Consent to Treat a Minor"* document has been completed.

Disclosure to Individuals Involved in Patient's Case I acknowledge I have been offered a copy of Metro SportsMed Physical & Occupational Therapy HIPAA Notice of Privacy and Security Practices. I authorize Metro SportsMed Physical & Occupational Therapy to use and/ or disclose my Protected Health information (PHI) to carry out and arrange for my treatment, seek and receive payments for my treatments, and carry out business operations of the office. I give permission to Metro SportsMed Physical & Occupational Therapy's providers and/or their authorized representatives to communicate medical information to me via any or all of the following methods as checked below:

☐ Voicemail/Answering machine: Phone #_____

☐ Fax: #_____ ☐ Email: Email address: _____

I give permission to Metro SportsMed Physical & Occupational Therapy's providers and/or their authorized representatives to discuss my personal healthcare information only with the following individual(s) whom I have listed below:

Name:	Relationship to Patient
1. _____	_____
2. _____	_____

Motor Vehicle Collision/No Fault Policy/Worker's Compensation Policy If you were involved in a motor vehicle accident, you must receive your Independent Medical Examination (IME) and submit all the necessary paperwork within 30 days. If you fail to do so, you will be held responsible for all payments until the time of settlement, judgment, or payment by attorney or the automobile insurance company. If you sustained an injury on the job and are receiving Physical and/or Occupational Therapy under Worker's Compensation you must comply with all requests set forth by Worker's Compensation. If your claim is denied for any reason, you will be held fully responsible for the cost of your care.

I have read all company policies, procedures and guidelines. I hereby agree to treatment under the above stated terms.

Patient Signature: _____Printed Name: _____ Date: _____