ADMISSION INFORMATION

Patient Name: _____	D.O.B._____
Address_____	SSN: _____
City _____ State_____ Zip_____	Phone #1: _____
Employer_____	Phone #2 _____
	Work phone: _____

GUARANTOR INFORMATION (if different than above):

Guarantor Name: _____Guarantor D.O.B._____

Address_____City_____State_____Zip_____

Home Phone #: _____ Cell #_____ Guarantor SSN: _____

PRIMARY INSURANCE INFORMATION **(Copy of Insurance card will be made at first appointment)**

Subscriber Name: _____ Subscriber D.O.B.: _____

SECONDARY INSURANCE INFORMATION **(Copy of Insurance card will be made at first appointment)**

Subscriber Name: _____ Subscriber D.O.B.: _____

ADDITIONAL INFORMATION

Referring Physician's Name_____Diagnosis_____

Emergency Contact_____Relationship:_____Tel #:_____

EMAIL CONTACT

Your therapist may wish to contact you **during or after** your course of treatment. Please supply us with your email address.

Email address: _____

Nesin Therapy Services is hereby authorized to provide therapy services to the above named patient under the care of the above named physician and to administer treatments deemed necessary.

✖ **Patient Signature** _____ ✖ **Date**_____

✖ **Guarantor Signature** _____**Relationship to patient**_____
(if other than Patient)

ADMISSION INFORMATION

GUARANTEE OF ACCOUNT **Patient Name** (Printed): _____

Nesin Therapy Services, P.C. (NTS) will bill your primary and secondary insurance. You are responsible for co-pays, deductibles and any portion not covered by your insurance. NTS prefers payment for co-pays and deductibles at time of service. At minimum, a monthly payment on your account balance is expected. If your carrier has not paid on your account within 90 days, the entire balance may become your responsibility and you may seek settlement directly from your insurance(s).

Therapy supplies purchased from NTS **are not covered** by any insurance company.

A 24 hour cancellation notice must be given to the office staff. An answering machine on our primary telephone number(s) allows you to leave a message after business hours and weekends. The cancellation charge of **$50.00** will be applied to your account for lack of notice. This policy will be waived only in the event of an emergency.

By signing this form, I also accept responsibility for reasonable costs incurred if my account becomes delinquent. Should it become necessary to send this account to an attorney for collections, I will be responsible for all reasonable attorney fees.

I have read, understand and agree to the above.

X_____ _____

Signature of Patient and/or Authorized Representative Date

Authorization/ Release of Information

My protected health information will be used by **Nesin Therapy Services, P.C.** or disclosed to others for the purposes of treatment, obtaining payment, supporting the day-to-day health care operations of the practice or appointment reminders. NTS Notification of Privacy Practices (HIPAA) has been made available for me to read or take home.

I understand **the information obtained by this authorization** will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize. A copy of my records can be released to the patient and/or guarantor upon request. A reasonable charge may be applied.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.
A copy of this signature is as valid as the original.

X_____ _____

Signature of Patient and/or Authorized Representative Date

Personal Representative, Family or other Entities Authorized Access

Name or specifically indentify these persons and/or entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations. If the patient is 14-18 years of age, this section must include the parent(s) names and be signed by the patient/minor.

Name of Authorized person or Entity	Relationship	Phone #
Name of Authorized person or Entity	Relationship	Phone #

You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

X_____ _____

Patient Signature Date

Initial Self-Evaluation

Please be thorough – this will allow the therapist to spend less time asking questions.

Name: _____ Age: _____ Occupation:_____

What are we seeing you for? _____

Date symptoms began:_____ How did symptoms start?_____

Surgical date (if applicable): _____ Diagnostic testing: ☐ X-ray ☐ MRI Other: _____

Who are you currently seeing for this or any other conditions? (Check all that apply)

☐ Family Dr. ☐ Cardiologist ☐ Osteopath ☐ Podiatrist ☐ OB/GYN

☐ Internist ☐ Orthopedist ☐ Neurologist ☐ Chiropractor ☐ *****Home Health*****

Other: _____

Medical History

Have you ever been diagnosed with or are currently being treated for any of the following conditions?
Please check all that apply

☐ Arthritis ☐ Cancer Type: _____ ☐ Heart disease

☐ Diabetes ☐ Stroke Date: _____ ☐ Pacemaker placement

☐ Epilepsy ☐ Multiple Sclerosis ☐ Pregnant Weeks: _____

☐ High blood pressure ☐ Other: _____

Surgeries/Procedures (please briefly note ALL types and approximate date):

_____

_____

Accidents or other injuries: _____

Please list all prescription and non-prescription medications you are currently taking:_____

_____

_____

Pain Rating

Rate pain on a scale from 0 to 10 (0 = no pain at all, 10 = enough pain to go to emergency room)

1. Primary location of pain / symptoms _____

Pain at worst: _____/10 Current pain level: _____/10 Pain at lowest level _____/10

2. Secondary location of pain / symptoms (if applicable) _____

Pain at worst: _____/10 Current pain level: _____/10 Pain at lowest level _____/10

Describe your symptoms in **primary** location:

☐ Burning ☐ Sharp ☐ Dull / Achy ☐ Throbbing ☐ Shooting ☐ Numbness

☐ Other: _____

Describe your symptoms in **secondary** location (if applicable):

☐ Burning ☐ Sharp ☐ Dull / Achy ☐ Throbbing ☐ Shooting ☐ Numbness

☐ Other: _____

PLEASE SELECT THE *TOP 5* PROBLEMS THAT YOU ARE HAVING AND COMPLETE THOSE SECTIONS ONLY (please rank problems using 1-5):

- ☐ Sitting: How long can you sit before you need to change positions or get up? _____ min.
- ☐ Driving: How long can you drive before you have to stop? _____ min.
- ☐ Standing: How long can you stand before you have to change positions or sit? _____ min.
- ☐ Walking: How long can you go for a walk before you have to stop or sit down? _____ min.
- ☐ Stairs: How many steps before you have to stop? _____ Worse going ☐ up ☐ down
- ☐ Sleeping: How many times do you wake up due to pain? _____ times per night
- ☐ Housework: List an example of activity that causes pain _____
- ☐ Yard work: List an example of activity that causes pain _____
- ☐ Work: List an example of activity that causes pain _____
- ☐ Reaching: List an example of activity that causes pain _____
- ☐ Gripping: List an example of activity that causes pain _____
- ☐ Dressing: ☐ upper body ☐ lower body ☐ socks / shoes
- ☐ Pushing / Pulling
- ☐ Lifting
- ☐ Bending
- ☐ Squatting
- ☐ Other: Please describe _____

What eases your symptoms? (Check all that apply)

- ☐ Heat to affected area
- ☐ Ice to affected area
- ☐ Medication
- ☐ Change positions
- ☐ Other: _____
- ☐ Rest
- ☐ Exercise (stretching, etc.)
- ☐ Walking
- ☐ Lying down – position_____

What are your functional goals for therapy? (What activities do you want to be able to return to doing?)

_____

_____