PEMI-BAKER COMMUNITY HEALTH

HOME HEALTH • HOSPICE • REHAB THERAPIES • AQUATIC & FITNESS

PATIENT AGREEMENT

PERMISSION FOR EVALUATION AND TREATMENT: I hereby give permission to the professional staff of Pemi-Baker Community Health to perform any test(s) and give any treatment(s), deemed appropriate by the professional(s) responsible for my care.

TEAM APPROACH: Pemi-Baker Community Health encourages general wellness. Our goal is to help patients return to their greatest functional capacity. I understand that I may be treated by more than one of the healthcare personnel over the course of care at the discretion of the Professional performing the initial evaluation. I understand that there is a high level of communication between the providers of my care, verbal and written, in providing the optimum attention. If I feel most comfortable with one provider, I have the freedom to request an individual provider as my choice. Your physical therapy initial evaluation will be provided by a Physical Therapist who is licensed in the state of NH to provide care to a broad range of patients and diagnoses. Subsequent treatments may be provided by a Physical Therapist or a Physical Therapist Assistant who is a NH licensed professional providing care for a broad range of patients and diagnoses. All physical therapy at the Pemi-Baker Community Health is supervised and reviewed by the evaluating Physical Therapist.

NO SHOW/CANCEL POLICY: I understand that attendance is important to the success of my rehabilitation goals. If necessary I agree that I will cancel appointments at least 24 hours in advance. I understand that if I have three no-shows for my scheduled visits I will be discharged from physical therapy

PAYMENT AGREEMENT: I permit Pemi-Baker Community Health to bill my insurance carrier directly and request any payments for service to be made directly to Pemi-Baker Community Health. I certify the insurance identification information given by me is accurate. I understand that I am responsible for and agree to pay **all** applicable copays, deductible amounts and charges not covered by my insurance at the time of treatment.

RELEASE OF INFORMATION: I hereby authorize Pemi-Baker Community Health to release any information necessary in coordination of my care to my insurance company(s), my attending physician(s) and/or case manager(s).

NOTICE OF PRIVACY PRACTICES: I have been shown and offered a copy of the Pemi-Baker Community Health **Notice of Privacy Practices.** I understand and accept the Pemi-Baker Community Health HIPPA information and know that I can contact the Executive Director with any concerns or complaints.

PERSONAL PROPERTY STATEMENT: I hereby release Pemi-Baker Community Health of any responsibility for the loss or theft of any personal items left in any section of Pemi-Baker Community Health. Locks are available at the front desk and need to be returned at the end of your exercise session.

PATIENTS' BILL OF RIGHTS: I hereby acknowledge that I have received a copy of the Patients' Bill of Rights, pursuant to RSA-151:21.

I understand all statements made above and agree to its terms.

_____ _____

Patient Signature (or guardian if patient is under 18) Date

_____ _____

Witness Date

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Name: _____ Referring provider: _____

Date seen by Physician: _____ Next Physician appointment: _____

Are you taking medication regularly? Yes _____ No ____
If yes, please list medications: _____

Do you have a "Do Not Resuscitate" (DNR) order we need to follow in case of an emergency? Yes ____ No ____

Do you have or have you been treated for any of the following conditions? (please circle Yes or No)

Arthritis	Yes	No	Frequent Headaches	Yes	No
Allergies	Yes	No	Hearing Impairment	Yes	No
Environmental	Yes	No	Hepatitis/Jaundice	Yes	No
Medication	Yes	No	Hernia	Yes	No
Latex	Yes	No	High Blood Pressure	Yes	No
Anxiety	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Lung Disease	Yes	No
Bowel/Bladder problems	Yes	No	Major injuries/illness	Yes	No
Cancer	Yes	No	Neurological conditions	Yes	No
Cardiac History	Yes	No	Nutritional deficiency	Yes	No
Chest Pain	Yes	No	Operations	Yes	No
Chronic Cough	Yes	No	Osteoporosis	Yes	No
Chronic skin disease	Yes	No	Pacemaker	Yes	No
Communicable Disease	Yes	No	Phlebitis	Yes	No
Congestive Heart Failure	Yes	No	Reflux/Heartburn	Yes	No
Convulsions/Seizures	Yes	No	Shingles (Zoster)	Yes	No
Depression	Yes	No	Shortness of Breath	Yes	No
Diabetes	Yes	No	Thyroid condition	Yes	No
Dizziness	Yes	No	Vision Problems	Yes	No
Falls	Yes	No			
Fainting Spells	Yes	No	Other: _____		
Fractures	Yes	No			

If you answered yes for any of the above conditions, please explain: _____
_____
_____
_____
_____

*** If you discover you have any of the above conditions during your course of treatment please notify a staff member immediately***

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Our practice is to demonstrate and discuss your home program. Please identify any specific learning styles you may prefer:

_____ None _____ Written Description ____ Pictures ____ Participation

_____ Other: _____

Have you had any previous therapy (Cardiac Rehab, Pulmonary Rehab, Physical Therapy, Occupational Therapy, Speech Therapy) here or at another facility in the last year?

____ No ____ Yes (explain): _____

1) Date of onset of symptoms: _____ Have you had a similar problem in the past? ____ Yes ____No
2) How did the problem occur? (fall, auto accident, etc.) _____
_____
3) Medical Treatment so far? (casting, surgery, diagnostic tests, etc. Please include dates) _____
_____
_____
4) Are your present symptoms _____ Constant _____ Intermittent
5) Is the pain worse Morning Midday Evening Night
   Is the pain better Morning Midday Evening Night
6) Do certain activities make the pain worse? Please specify: _____
   Do certain activities make the pain better? Please specify: _____
7) Are you getting Better Worse Staying the same
8) If pain is present, use the pain scale below to tell us the rating of your pain at its worst and best.

_____

0 1 2 3 4 5 6 7 8 9 10

No pain **Unbearable pain**

9) Please check what you are presently having difficulty with:

Dressing Upper body	Yes	No	Stairs	Yes	No
Dressing Lower body	Yes	No	Bending	Yes	No
Cooking	Yes	No	Squatting	Yes	No
Eating	Yes	No	Lifting	Yes	No
Washing	Yes	No	Work Duties	Yes	No
Grooming	Yes	No	House/yard work	Yes	No
Shaving/brushing teeth	Yes	No	Child Care	Yes	No
Bathroom Mobility	Yes	No	Recreation/hobbies	Yes	No
Sleeping	Yes	No	Grasping/gripping	Yes	No
Reaching out in front/overhead	Yes	No	Getting in/out of car	Yes	No
Driving How Long?	Yes	No	Sitting How Long?	Yes	No
Standing How Long?	Yes	No	Walking How Long?	Yes	No

What do you hope to achieve from therapy? _____

FUNCTIONAL TASKS RECORDING FORM

Write down 10 tasks that you want to improve and/or keep doing better and more often!
Please rate the degree of difficulty you have doing each of these activities (**within the last week**):

	1 Not Difficult	**2 Minimally Difficult**	**3 Somewhat Difficult**	**4 Moderately Difficult**	**5 Very Difficult**	**6 Extremely Difficult**	**7 UNABLE**	**NA**
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

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PATIENT INTAKE

NAME (last, first): _____ DOB: _____ SS# _____

MAILING ADDRESS: _____
(Street) (City/Town, State, Zip Code)

PHONE (HOME): _____ (WORK): _____ (CELL): _____

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ FACILITY: _____

DX: _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY (AS OF JANUARY 1ST)? Yes ___ No__ WHERE? _____

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____

ADDRESS: _____ **HOME PHONE**: _____

_____ **CELL PHONE**: _____

CONSENT TO SHARE INFORMATION (Other than health care provider and insurance companies)

Please list all individuals that may obtain your information, including any and all legal guardians if a (a minor) or (unable to consent):

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

I give my consent for Pemi-Baker Community Health to share my Hospice Election and Advanced Directives with local EMS and hospitals. _____ (Initial)

Notice of Privacy Practices:

By my signature below, I give my permission for Pemi-Baker Community Health to share all information know to them with the individuals listed above.

Patient signature: _____ Date: _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undershigned certifies that he/she has read and agrees to the above as the responsible part of the patient.

Responsible Party Signature: _____ Date: _____