SKYLAND PHYSICAL THERAPY

(828) 277-5763 Fax 277-5764
1201 Bleachery Blvd., Ste. 201
Asheville, NC 28803
www.skylandpt.com

Helping you take charge of your health!

Dear Valued Patient,

We welcome you to Skyland Physical Therapy! We are committed to providing you or your family member with one-on-one care, focused on your individual needs. We ask for your help getting you registered in order to maximize the time you have with your therapist.

If you have any trouble filling out these registration forms, we will be glad to assist you. We ask you to please arrive **at least 20 minutes early for your first appointment**, if you have filled these forms out in advance. **Please arrive at least 30 minutes in advance if you wish to fill out forms at our office or need assistance with registration.**

1. Please fill out and bring the enclosed registration forms with you to your first appointment.
    a. **Patient Information Demographics form**
    b. **HALFORD-PACKER MEDICAL HISTORY INTAKE FORM**
        (For children under 13, a different medical history form will be provided at first visit).
    c. **Medicare and Medicare Advantage patients only: Medicare Secondary Payer form**
2. Please bring your **Insurance cards and photo ID** with you
3. Please provide us a **complete list of all medications** with dosages or fill out meds on Intake.
4. Please note our **Cancellation policy:** Unless emergency arises, please give at least 48 hours' notice to cancel or re-schedule. **$25.00 late cancellation fee** applied to late cancels less than 24 hours' notice / no-shows unless emergency.
5. **(HIPAA) Privacy Policy is also provided for download if you wish to review our policy.**
6. **Please call your insurance company prior to your first appointment for full understanding of your physical therapy benefits.** Our office will pre-verify benefits for you to provide full disclosure regarding your out of pocket responsibility for therapy services. While our verification is not a guarantee of benefits, it is the information disclosed when checking with your insurance company on your behalf and will give you an idea of your costs.

Please see the **directions to our clinic on our website or search our address above**, and call us if you have questions. Visit our website at www.skylandpt.com to learn more about us!

We look forward to meeting you and serving your therapy needs.

Sincerely,
Melinda G. R. Halford, PT, MFA, CLT, Cert. MDT
Director, Skyland Physical Therapy

SKYLAND PHYSICAL THERAPY Patient Information Demographics Form

___M ___F

Legal First Name **Legal Last Name** **Nickname** Gender

Date of Birth Month_____Day_____Year_____

*****Have you had any **Home Care Services this year? ___Yes ___No.** If yes, **have** you been discharged? **___Yes ___No**
*Patient gives permission to leave message reminder on voicemail, text and / or email.

Mailing Address **City** **State** **Zip**

X Preferred Contact Numbers ___Cell / Text Phone **___Home Phone** **___Work Phone**

EMAIL ADDRESS (used only for appointment reminders / emailed exercise plan / general health info)

Patient ___does ___does not give permission to discuss medical condition with emergency contact person below:

EMERGENCY CONTACT / GUARDIAN: Name_____Phone_____

Emergency Contact Address: ___Same as mine / Other_____

Pain/ Problem **Date Problem Began (if injury, provide date of injury)**

___Self-Referred **Referral (if applicable)** **First Name** **Last Name** **MD / NP / PA-C / DO / DC**

Primary Care Provider (if different from referral) **First Name** **Last Name** **MD / NP / PA-C / DO / DC**

► **PAYMENT SOURCE: __SELF PAY __INSURANCE: Provide Card (s) / Photo ID to Front Desk**

► **FINANCIAL RESPONSIBILITY: By signing below:** I understand that I am responsible for any amount not covered by insurance. I agree to pay co-payment, deductible, co-insurance if applicable, at every visit. I authorize that payment from my insurance company be paid directly to Skyland Physical Therapy.

► **MEDICAL CONSENT: By signing below:** I consent to be examined and treated by Skyland Physical Therapy.

► **RELEASE OF INFORMATION: By signing below:** I authorize Skyland Physical Therapy and therapists to furnish to referring provider, other primary provider indicated above, insurance carriers / vendors (providing therapy supplies) information needed to process the claims in reference to services received at this facility.

► **PATIENT PRIVACY POLICY** (HIPAA): **By signing below:** I acknowledge that I may request a copy of Skyland Physical Therapy HIPAA Policy and a copy will be provided to me if requested.

► **ATTENDANCE:** Therapy is a process of healing and recovery tailored to the individual and requires a commitment to attend schedule appointments. Scheduled appointments will be reserved for patients who wish to attend and honor scheduled appointments.

► **CANCELLATION POLICY: By signing below**: I agree to attend all scheduled appointments. Unless emergency arises, I agree to give at least 24 hours' notice to cancel or re-schedule **(48 hours preferred to be able to fill spot).**
$25.00 late cancellation fee is applied to late cancels / no-shows unless emergency.

Signature of patient or legal guardian of patient Date

HALFORD-PACKER FUNCTIONAL ASSESSMENT CLINICAL TOOL (H-P FACT) INTAKE FORM

SKYLAND PHYSICAL THERAPY CONFIDENTIAL MEDICAL HISTORY (Adult/Teen)

Date: _____ Legal Name: _____

Problem(s):_____Date(s) Began: _____
Problem is: ___Improving ___Unchanging ___Worsening
How did Problem(s) occur? __No apparent reason

Occupation / Hobbies / Exercise Habits:

What activities are you unable to do / no longer doing since onset of your symptoms or injury?

ACTIVITIES RATING: Please pick ONLY ONE category below in which you have the MOST difficulty as related to your current problem. Rate level of pain or difficulty on a 0-10 point scale
0 = No difficulty / no pain **10** = Extreme difficulty / Unable or avoid activity due to pain or fear

Walking and Moving
____ Getting down and up from floor
____ Going up or down stairs
____ Walk more than 20 min.
____ Walk hills / uneven ground
____ Bending to reach feet or floor
____ Getting in and out of a car
____ Changing position in bed
____ Sit to stand

Balance, Holding a Position
____ Balancing on one leg
____ Stand to floor / floor to stand
____ Sit greater than 30 minutes
____ Stand greater than 20 minutes
____ Bending / stooping / kneeling
____ Getting up from couch, chair, bed
____ Turning neck / trunk reach behind
____ Positioning in bed, comfort for sleep

Using Shoulders / Arms / Hands
____ Pushing / pulling
____ Lifting / carrying
____ Bear weight on arms / hands
____ Reach / arms in all directions
____ Throw / catch / holding arm up
____ Daily tasks using arms / hands
____ Positioning arm / neck in bed
____ Using hands (mouse, text, grasp)

Self-care at Home
____ Kitchen activities
____ Washing clothes
____ Bathing / Grooming / Dressing
____ Performing yard work
____ Cleaning House
____ Computer / desk work
____ Get in and out of bed / chairs
____ Get around home / rooms

Self-care in community / at work
____ Working / volunteering
____ Shopping / loading packages
____ Managing steps, curbs
____ Participating in fitness activity
____ Managing mobility in community
____ Computer / phone / desk work
____ Independent transportation
____ Manage toileting in community

Swelling interferes with function
____ Use of Swollen Arm(s) or Leg(s)
____ Stiffness / heaviness /weakness
____ Pain / skin changes / discomfort
____ Self-care / dress / bathe
____ Cook / clean / yard work
____ Work community activities
____ Difficulty caring for limb
____ Find clothes to fit

Medical History: Please Check all that apply?

__Allergies
__Anxiety / Depression
__Arthritis
__Asthma
__Autoimmune Disorder
__Balance Issues
__Bladder / Bowel issue
__Cancer History
__Cardiac Condition
__Circulation Problems
__Diabetes
__Dizzy Spells
__Emphysema / Bronchitis
__Fibromyalgia
__Fractures
__Headaches / Migraine
__High Blood Pressure
__Kidney Problems
__Lymphedema
__Metal Implants
__Multiple Sclerosis
__Muscular Disease
__Neurological Other
__Neuropathy
__Osteopenia / porosis
__Parkinson's
__Pregnant Currently
__Rheumatoid
__Seizures
__Skin Problem
__Smoking
__Stroke
__Thyroid Disease
__Vein Problems
__Vision Problems
__Other:

Related Surgeries, Broken bones, Accidents, including year:

Imaging (X-ray, MRI, CT Scan) relevant to current problem? __Y __N

HALFORD-PACKER FUNCTIONAL ASSESSMENT CLINICAL TOOL (H-P FACT) INTAKE FORM

SKYLAND PHYSICAL THERAPY CONFIDENTIAL MEDICAL HISTORY (Adult/Teen)

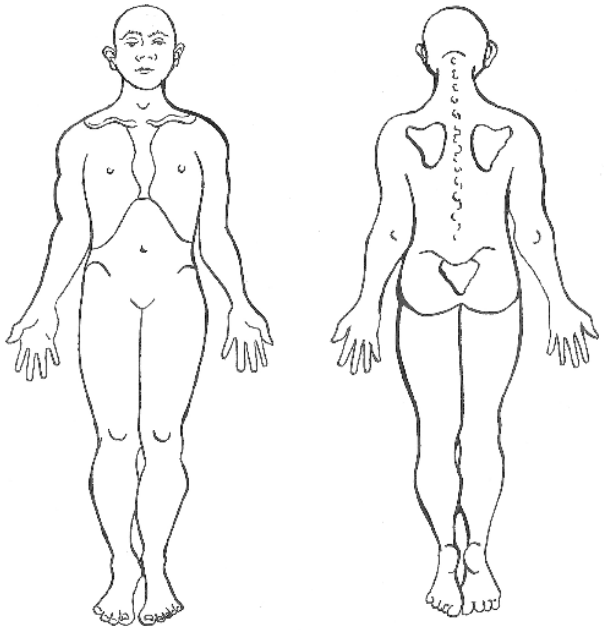
FALLS / BALANCE

Have injury as result of fall in the past year? ___Y ___N
Have you had two or more falls in past year? ___Y ___N
Do you ever feel unsteady on your feet? ___Y ___N

PAIN RANGE: Please circle pain / difficulty from least to worst on the scale below.

0 = No pain or problem **10 = Extreme pain or difficulty**

0 1 2 3 4 5 6 7 8 9 10



Please DRAW on body where your pain / symptoms occur

Mark with letters to indicate:

P = Pain
N = Numbness
S = Swelling
W = Weakness

X if ___ **MEDICATIONS LIST PROVIDED OR FILL OUT BELOW:**

Medication / Supplement Name	**Dosage**	**Times per day**

HEIGHT: _____ WEIGHT: _____ Check below please:

___ My weight is stable or not related to my problem.

___ I have had unusual weight loss or gain in past year.

___ I am currently in a weight loss or weight gain program.

___ I am interested in discussing weight management as part of my physical therapy plan.

Skyland Physical Therapy

For MEDICARE PATIENTS or MEDICARE ADVANTAGE PLANS ONLY

(If not Medicare or Advantage patient skip this form)

Medicare Secondary Payer Questionnaire (required by Medicare)
And Medicare Advanced beneficiary Notice (number 10 below)

1. Is the Patient covered by the Federal Black Lung Program? **__Y __N**

2. Is the Patient entitled to benefits through the VA due to having a service related injury? **__Y __N**

3. Should the illness / injury be covered by Workers Comp? **__Y __N**

4. Was this illness / injury due to a non-work related accident? **__Y __N**
__ Auto __ Non- Auto __ Other

5. Is the Patient entitled to Medicare based on:
Age: _____ **__Y __N**
Disability: _____ **__Y __N** Date of Disability:_____
End Stage Renal Disease? **__Y __N**

6. Are services to be paid by government program such as a research grant? **__Y __N**

7. Is the patient currently employed? **__Y __N**
If no: Date of Retirement: _____
If Yes: Name of Employer: _____
Address: _____
City: _____State: _____Zip: _____

8. Is the Patient's Spouse Currently employed? **__Y __N**
If no: Date of Retirement: _____
If Yes: Name of Employer: _____
Address: _____
City: _____State: _____Zip: _____

9. Is the patient covered by Employers Group Health Plan? **__Y __N**
(Enter Y if EGHP is primary, N if secondary)
If Yes, Number of employees __ 1-19 __ 20-99 __ 100 or more

10. **Advanced Beneficiary Notice of non-coverage (ABN) for Retail Therapy Supplies and Wellness visits:** By signing above I understand that Medicare may not be billed for any therapy supplies sold at this facility as we are not a Durable Medical Equipment company and Medicare will not be billed for any services that are not therapy related such as personal training. These supplies and services may not be billed to Medicare and payment will be the sole responsibility of the receiver if the receiver choses to purchase these services or supplies.

Signature: _____ Birthdate: _____ Date: _____