LAYTON PHYSICAL THERAPY CO., INC.
REHABILITATION SERVICES

LAST NAME_____FIRST_____MI_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____EMAIL_____

SEX: M F AGE_____DOB_____SS#_____-_____-_____

PLACE OF EMPLOYMENT_____OCCUPATION_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMERGENCY CONTACT_____PHONE_____RELATIONSHIP_____

PRIMARY HEALTH INSURANCE COVERAGE

INS. COMPANY_____

EFFECTIVE DATE_____

POLICY HOLDER_____

POLICY HOLDER SS#_____

BIRTHDATE_____

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE COVERAGE

INS. COMPANY_____

EFFECTIVE DATE_____

POLICY HOLDER_____

POLICY HOLDER SS#_____

EMPLOYER_____

RELATIONSHIP TO PATIENT_____

MOTOR VEHICLE ACCIDENT (MVA)

DATE OF ACCIDENT_____

BILL TO: ATTY____ AUTO INS____ HEALTH INS____ SELF____

NAME OF INS. CO./ATTY_____

ADDRESS_____

_____PHONE_____

Auto Ins. Only:
INSURED'S NAME_____

WORKERS' COMPENSATION CLAIM

EMPLOYER_____

DATE OF INJURY_____

INJURY SITE_____

TELEPHONE_____

CONTACT NAME_____

HAVE YOU PREVIOUSLY RECEIVED PHYS. THERAPY SERVICES FOR THIS OR ANY OTHER CONDITION? _____YES_____NO

WHERE?_____ HOW MANY?_____

I acknowledge that I have provided Layton Physical Therapy Co., Inc. with all insurance and/or workers compensation information necessary to insure proper billing for services rendered. I hereby authorize the release of necessary information to authorized agencies, employers, and/or insurance companies. I authorize payment to be made directly to Layton Physical Therapy. Although Layton Physical Therapy may bill my insurance carrier, I understand that payment is not guaranteed and that I will be held responsible for any unpaid amounts, or non-covered services, as well as my co-payments, co-insurance, deductibles, and/or attorney fees should collection proceedings be necessary. I give Layton Physical Therapy permission to treat me per physician's orders.

_____ _____

SIGNED PATIENT (PARENT IF MINOR-GUARDIAN-LEGAL REPR.) **DATE**

Layton Physical Therapy Co., Inc.
Pre-Examination History and Injury Report

NAME:_____ DATE:_____

Have you had any falls in the past 12 months? _____Yes _____No If yes, how many times? _____

If Yes, please describe the nature of the fall(s): _____

If Yes, please describe if any injury(ies) occurred: _____

Are there any factors that may complicate your ability to participate in therapy? _____Yes _____ No If Yes, please explain:

_____

What were you doing prior to this injury that you are unable to do currently? _____

_____

Do you exercise? _____No _____Moderately _____Daily _____Heavy

Work Activity: _____Sitting _____Standing _____Light Labor _____Heavy Labor

Habits: _____Smoking # per day _____ _____Alcohol _____Coffee/Caffeine ____cups per day

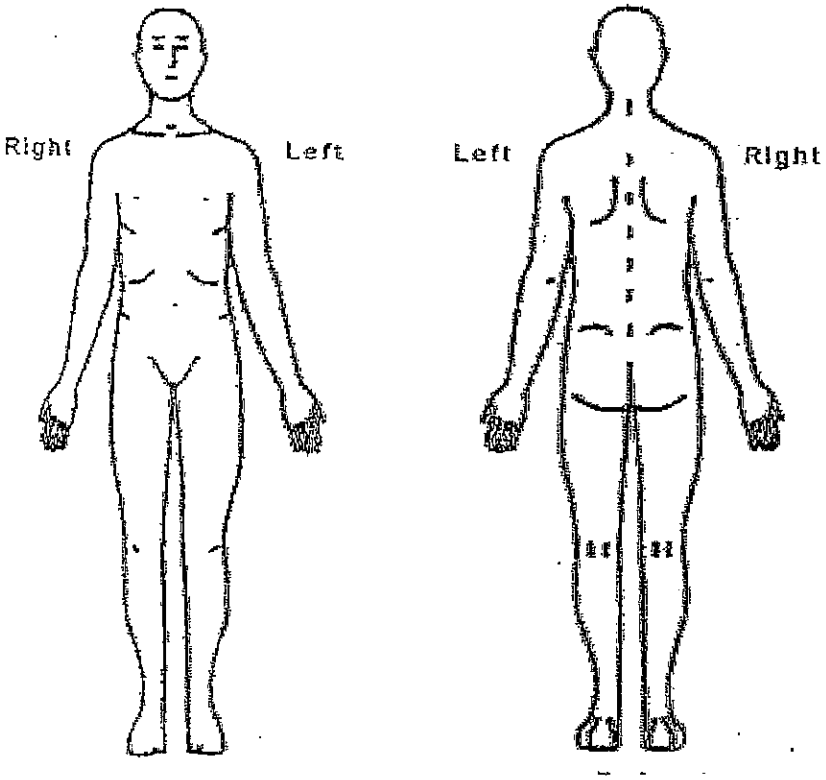
Current Height: _____Current Weight: _____

Please circle any of the following tests you have had concerning your present condition:

X-RAYS MRI CAT SCAN BONE SCAN EMG MYELOGRAM OTHER: _____

Date/Results of test(s): _____

Please indicate pain on body diagram:



Describe your pain: (please circle)

Constant	Comes & Goes	Shifts
Deep	Superficial	Dull
Sharp	Stabbing	Aching
Cramping	Throbbing	Burning
Numbness	Tingling	Other: ___

Describe any activities that increase pain.

_____

_____

_____

_____

Describe activities that decrease pain:

_____

_____

_____

_____

Rate your pain:

0 = No Pain; 10 = Severe Pain

Pain Scale: _____

0 5

Patient Goals for Therapy

What are your goals for participating in therapy? _____

_____

_____

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient Signature: _____ Date: _____

Layton Physical Therapy Co., Inc.
Past Medical History Questionnaire

Patient Name:_____ **Date:**_____

Do you now or have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Anemia			Dizziness/Fainting			Parkinson's		
Anxiety			Fibromyalgia			Pneumonia		
Arthritis/Osteo/Rheumatoid			Headaches			Seizures/Epilepsy		
Asthma/Breathing Difficulties			Head Injury/Concussion			Shoulder Problems		
Back Problems			Heart Attack			Shortness of Breath		
Balance Disorders			Heart Disease			Skin Disorder		
Cancer			Hernia			Spinal Cord Injury		
Cerebral Palsy			Hepatitis			Spinal Stenosis		
Chest Pain/Angina			High/Low Blood Pressure			Stroke/TIA		
COPD			Multiple Sclerosis			Thyroid Problems		
Deep Vein Thrombosis			Muscular Dystrophy			Tuberculosis		
Depression			Neck Problems			Tumor		
Diabetes Controlled			Neuropathy			Vascular Disease		
Diabetes Uncontrolled			Osteoporosis			Wounds		
If you answered "yes" to any of the above, please explain and give approximate date(s):								

Please indicate Yes or No if you are or ever had:

	Yes	No		Yes	No		Yes	No
Abnormal Posture			Hearing Loss			Radiating Pain		
Changes in Bowel or Bladder			Hypersensitivity to Heat/Cold			Recent Weight Loss or Gain		
Cortisone Injections			Metal Implants			Surgeries - Orthopedic		
Difficulty Sleeping			Pacemaker			Surgeries - Other		
Difficulty Walking			Post Mastectomy Lymphedema			Vision Problems		
Fractures			Pregnant/Abnormal Periods			Other:		
If you answered "yes" to any of the above, please explain and give approximate date(s):								

Do you have any allergies?	No	Yes, list allergies:
Are you presently taking any medications, including over the counter, prescriptions, vitamins/herbs/minerals?	No	Yes
If yes, list dosage and frequency:		

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient:

By signing this form you grant to us and disclose your protected health information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to the health care information we maintain on you, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your consent by giving notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon the Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it. This form also serves as your Acknowledgment of Receipt of Notice of Privacy Practices. You may refuse to sign this acknowledgment if you wish.

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____	_____	_____	_____
Patient's Signature or Signature of Patient's Rep.	Birth Date	Soc. Sec. No.	Date

_____	_____
Printed Name of Patient's Representative	Relationship to Patient

Our Privacy officer can be contacted as follows:

Cynthia J. Layton
7923 Munson Rd., Suite 6
Mentor, OH 44060
Ph: (440) 209-1836
Fax: (440) 209-1840 e-mail: laytonpt@cs.com

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

_____ The patient refused to sign.
_____ Due to an emergency situation it was not possible to obtain an acknowledgment.
_____ We weren't able to communicate with the patient.
_____ Other (Please provide specific details)

_____
_____
_____

_____	_____
Employee Signature	Date

MEDICARE SECONDARY PAYER QUESTIONNAIRE: Beneficiary Information

Medicare Beneficiary: _____ Patient Account # _____
HIC# _____ DCN: _____ Provider #: 366576
Dates of Service From: _____ Through: _____ Person who supplied information: _____
Relationship to Patient: _____ Provider Rep. Name: _____ Date: _____

1. Workers' Compensation (WC):
Per the patient, should the illness/injury be covered by a WC claim? _____Yes _____No
If yes, this should be an MSP or conditional claim, not Medicare primary. Please note WC is primary only for claims related to a WC injury.
Original Date of illness/injury: _____ Claim Number: _____
Name of WC Plan: _____
Mailing Address: _____ City _____ State _____ Zip _____
Name of Employer: _____
Mailing Address: _____ City _____ State _____ Zip _____

2. Federal Black Lung (BL):
Is the patient covered by the BL program? _____Yes _____No
Dates Benefits Began: _____ (BL is primary only for claims related to BL)

3. Department of Veterans Affairs (DVA):
Is the patient entitled to benefits through the DVA? _____Yes _____No
If yes, does the patient want the DVA to be contacted for authorization of these services? _____Yes _____No

4. Public Health Services (PHS):
Are the services to be paid by a Government Program such as a Research Grant? _____Yes _____No
If yes, the Government Program will pay primary benefits for these services.
What is the name of the PHS? _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

5. Accident:
Are these services the result of a non-work related accident? _____Yes _____No
If yes, what type of accident was this or give a description of the accident (for example: auto, slip and fall, malpractice, product liability, homeowners)?
Date of accident: _____ location of accident (home, restaurant, etc.): _____

A. Non-liability Insurance:
Is non-liability insurance available (for example: premises medical, auto medical coverage, no-fault, homeowner's premises)? _____Yes _____No
If yes, name of the insurance company: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Who is listed as the insured? _____ Claim Number: _____

B. Liability Insurance:
Does the patient feel someone else is responsible for the accident/injury? _____Yes _____No
If yes, name of the responsible party's Insurance Company: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Name of responsible insured party _____ Claim Number: _____

6. Employer Group Health Plan (EGHP):
Is the patient covered by any EGHP, including Federal Employee Health Benefits or any retirement policy? ____Yes ____ No
If no, this Questionnaire is complete. If yes, please continue.

7. Working Aged:
Is the Patient 65 years or older? Yes _____ No _____ (If no, please continue with Question #8)
Is the patient currently employed by an employer of 20 or more employees? _____Yes _____No
If yes, name of the employer: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Is the spouse currently employed by an employer of 20 or more employees?
If yes, name of the employer: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
If the patient or spouse is employed by an employer of 20 or more employees, is the patient covered by the EGHP?
_____ Yes _____ No
If yes, name of the EGHP: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Name of the policy holder: _____
Relationship to patient: _____ Group Identification #: _____
If the beneficiary is no longer employed, please give a retirement date: _____
If the spouse is no longer employed, please give a retirement date: _____
Note: If the patient is covered through their own or a spouse's EGHP of 20 or more employees, the EGHP should be primary. Please go on the ESRD/Dual Entitlement questions. (Please continue with Question #9.)

8. Disability
Is the patient under the age of 65? _____ Yes _____ No (If no, please continue with Question #9)
If yes, is the patient entitled to Medicare due to a disability other than End Stage Renal Disease? _____ Yes _____ No
(If no, please continue with Question #9)
If yes, is the patient currently employed by an employer of 100 or more employees? _____ Yes _____ No
Name of Employer: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Is a family member currently employed by an employer of 100 or more employees? _____ Yes _____ No
Name of Employer: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
Is the patient covered by that Large Group Health Plan (LGHP)? _____ Yes _____ No
Name of Insurance Company: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Name of Policy Holder: _____
Relationship to the Patient: _____ Group Identification # _____
Note: If the patient is covered by their own or a family member's LGHP of 100 or more employees, the LGHP should be primary. Please go on to the ESRD/Dual Entitlement questions. (Please continue with Question #9.)

9. End Stage Renal Disease (ESRD):
Is the patient entitled to Medicare due to end stage renal disease? _____ Yes _____ No
(if No, please continue with Question #10.)
Is the patient covered by any EGHP through a current or former employer of any size? _____ Yes _____ No
Name of group health plan: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Name of Policy Holder: _____
Relationship to the Patient: _____ Group Identification #: _____
Name of employer: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Is the patient within the 30-month coordination of benefit period? _____ Yes _____ No
What is the month/year of the first regular dialysis? _____
If the patient participated in a self-dialysis training program, provide date training started: _____
Has the patient had a kidney transplant? _____ Yes _____ No
If yes, date of transplant: _____
Note: If the patient is within the 30-month coordination of benefits period, the GHP should be primary. (Please continue with Question #10).

10. Dual Entitlement:
Is the patient entitled to Medicare on the basis of either ESRD and age or ESRD and Disability? _____ Yes _____ No
Was the patient's initial entitlement to Medicare (including simultaneous entitlement), based on ESRD? _____ Yes _____ No
Does the Working Aged or MSP Disability provision apply (i.e., is the GHP primary based on the age or disability Entitlement)?
_____ Yes _____ No

Note: If yes to the last question, the GHP remains primary for the 30-month COB period.