

Fayetteville Clinic
211 Tallywood Center • Fayetteville, NC 28303
Phone:(910) 484-9663 • Fax: (910) 484-6668



Hope Mills Clinic
4251 Legion Road-107 • Hope Mills, NC 28348
Phone: (910) 429-0600 • Fax: (910) 429-0602

PHYSICAL THERAPY

"HANDS ON ABOVE THE REST"
A PREMIER COMPANY

Thank you for choosing CCRC Physical Therapy for your health care needs. In addition to the forms that you may have already printed and completed, you will also need to choose the form for the body part that we will be treating and print. ** If this injury occurred at your place of employment, then also choose the **Orebro** form in the body parts section.*

Please take the time to list your entire past medical/surgical history and all medications that you are taking, including any vitamins, supplements or over-the-counter medications (with dose and frequency). Please also remember to bring your insurance card(s) and a photo ID. If your insurance requires a co-payment or co-insurance, please be prepared to make that payment on the date of your appointment.

You should anticipate your appointment lasting up to one hour. Remember to dress appropriately so that the therapist can properly examine your affected area(s). Loose fitting clothing such as sweatpants, shorts and a t-shirt are recommended. If you have had any x-rays, MRIs or other diagnostic testing performed for the condition for which you are being seen, please bring a copy of the report(s) or ask your physician to send them to our office.

If you have any questions regarding your appointment, please feel free to contact our office. We look forward to seeing you!

Thank you,

CCRC Physical Therapy

Fayetteville Clinic
211 Tallywood Shopping Center
Fayetteville, NC 28303
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Hope Mills Clinic
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Patient Information: (Please Print)

Patient Name: _____ Date of Birth: _____
Patient Social Security#: _____ Sex: M or F Marital Status: S M D Other
Parent/Guardian Name (if patient is under 18): _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Cell Phone Carrier: _____
Employer: _____ Occupation: _____
Student: Y or N School: _____
Referring Physician: _____ Primary Care Physician: _____
Date of Injury: _____ How did you hear about us? _____
Is condition work related? Y or N If yes, Name of Insurance Company: _____
Adjustor Name: _____ Phone: _____ Fax: _____

Is condition related to an automobile accident? Y or N
Do you have legal representation? Y or N If yes, Name of Attorney: _____
Phone Number: _____ Fax Number: _____

In the event of an emergency or if you are not home and we need to contact you, please list two representatives to whom we may release information:

Name _____ Phone _____
Name _____ Phone _____

Primary Insurance:

Insurance Company: _____
Policy Holder's Name: _____ Date of Birth _____ Sex F or M
SS#: _____ Relationship to Patient: Self Spouse Parent Other
Address if different than patient _____
Group#: _____ Member ID#: _____

Secondary Insurance:

Insurance Company: _____
Policy Holder's Name: _____ Date of Birth _____ Sex F or M
SS#: _____ Relationship to Patient: Self Spouse Parent Other
Address if different than patient: _____
Group#: _____ Member ID#: _____

Any other insurance? _____

I request that payment of authorized benefits be made on my behalf to CCRC Physical Therapy. I understand that I will be financially responsible for any services rendered that are not paid by my insurance company.

Authorization for Release of Information: With respect to the regulations and guidelines set forth by the Federal Government, HIPAA, (Health Information Portability and Accountability Act), I have the right to request a copy of the CCRC Privacy Policy. I have received a copy of the Patient Bill of Rights and \$25 Cancellation Fee/No Show Policy and agree to this policy.

Consent to Treatment: I consent to receive care and/or treatment from CCRC Physical Therapy.

Patient's Signature _____ **Date** _____
(Or Parent/Guardian Signature if patient is under 18)

Name: _____

Date: _____

Do you smoke? Yes No

Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List all allergies _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> headaches |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> falls | <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> changes in bowel or bladder function | |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> COPD/emphysema | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> anxiety | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> anemia |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy/seizures |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> stroke | <input type="checkbox"/> PTSD | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> head injury | <input type="checkbox"/> Reflux/GERD |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> migraine | <input type="checkbox"/> other _____ |

1. During the past month have you been feeling down, depressed or hopeless? YES NO

2. During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

If you answered "Yes" to Question 1 or 2 above, would you like help? YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

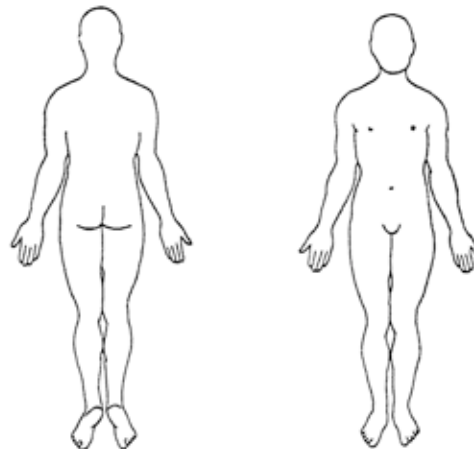
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

Body Chart:

Using the symbols below, please indicate where you are experiencing symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

FOR OFFICIAL USE ONLY:

Age: _____ Height: _____ Weight: _____ Temp: _____ BP: _____ BMI: _____

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PATIENT BILL OF RIGHTS

- You have a right to quality health care
- You have a right to confidentiality
- You have a right to ask for clarification when you do not understand something
- You have a right to feel pain and express pain
- You have a right to speak up if you feel you've been treated unfairly

CCRC Physical Therapy is
RIGHT HERE FOR YOU!!!!

YOUR RESPONSIBILITIES

- You are responsible to give an honest effort to make your therapy work for you, both here and at home.
- You are responsible to give your therapy the TIME to have a chance to benefit you.
- You are responsible for giving a detailed medical history.
- You are responsible for making and keeping your appointments or notifying us if you are unable to attend.
- You are responsible for your account charges.

CANCELLATION POLICY

In order to serve you, our clients, better and in fairness to others seeking to be seen in our office, CCRC Physical Therapy Inc. will charge a \$25 cancellation fee if you cancel your appointment or fail to show up for a scheduled appointment without a 24-hour notice to our office. Thank you for your continued support in making us better at serving your needs.