Sharon Potts Physical Therapy

Privacy Policy

Information gathered during the course of therapy is confidential. In the course of treatment, information is documented in regard to symptoms, test results, current medications, past medical history, etc. This information gathering is necessary for accurate evaluation and documentation of your care. This information will be kept on file here at my office and in my electronic medical record site at WebPT. You may request a copy of this information to have for your own reference and for reimbursement purposes. Under the following circumstances this information may be shared in written or verbal form

-with your doctors, nurses or physician's assistants to discuss your treatment and condition

-with your insurance company's representative, if necessary

-with your spouse unless your request against this sharing

-with your parents if you are under 18 years of age

-with my billing site, Kareo for purposes of reimbursement

-with my WebPT, my EMR site

If you have any specific requests in regard to your information, please indicate in the space here

_____

_____

_____

_____

_____

_____

I, _____have read the above policy and acknowledge that information in regard to my health, medical care, diagnosis, work and personal habits, etc. Will likely be gathered and maintained in this medical file. I accept the above policy and the gathering of the information that it may aide in the optimal treatment for my condition.

Signature_____

Date_____

Sharon Potts Physical Therapist Patient Registration

Patient Name_____ Date of Birth_____

Address _____ Home Phone_____

_____ State_____Zip_____ Work Phone_____

Occupation_____ Employer_____

Emergency Contact_____ Phone_____

Referring Physician_____ Phone_____

Primary Care Physician_____ Phone_____

Current Reason for therapy_____

Past Medical
History_____

_____

_____

_____

Current
Medications_____

_____

_____

_____

Have you had any other Physical Therapy treatment this year?_____

Have you had any chiropractic treatment this year?_____

Are you the primary insured or your spouse?_____ if spouse please provide date of birth_____

Anything else that you would like to tell
me?_____

_____

May EMC add you to our e-mail list? Y N email_____

Authorization for Release of Information and Payment

I, _____, authorize the release of any medical or other information to process my medical claims for physical therapy that I have received at Sharon Potts Physical Therapist. I also request payment of government/insurance benefits to Sharon Potts Physical Therapist as the party that accepts assignment of these services. I authorize the payment of these services to Sharon Potts Physical Therapist.

Signature_____

Print Name_____

Date_____

Sharon Potts Physical Therapist

304 B Harry S. Truman Parkway

Suite 304B

Annapolis, Maryland 21401

Phone 410-353-8308 Fax 410-897-0220

Patient Questionnaire- please take a few minutes to give me some information about why you are here and how your function may be affected-thank you!

1. I am here because_____

2. This has been a problems since_____ Injury date_____

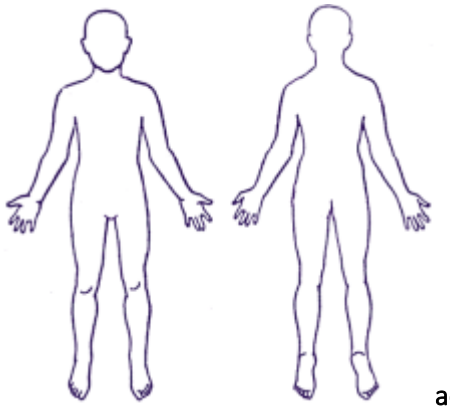
3. I am UNABLE to do the following tasks_____

_____

4. I have pain when I_____

5. Please mark where your pain is and its descriptor

F B



aching burning radiating sharp tight throbbing Constant Intermittent

I would rate it at its LEAST PAINFUL

No pain 1 2 3 4 5 6 7 8 9 10 take me to the ER!

RIGHT NOW it is

No pain 1 2 3 4 5 6 7 8 9 10 take me to the ER!

I would rate it at its MOST PAINFUL

No pain 1 2 3 4 5 6 7 8 9 10 take me to the ER!

I also experience

Numbness/tingling popping crackingnausea dizziness visual changes

Leg giving way tripping falls pain that keeps me awake at night

6. My usual form of exercise is _____ _____times per week

7. I feel my function has been affected in the following areas

Walking dressing bathing getting out of chairs/bedstairs

Standing cooking cleaning doing my hair driving going out in community

8. My Goals for therapy are

---

9. In the past six months, I have had episodes of

Chest tightness_____ pain between my shoulder blades _____

dizziness/lightheadedness_____ unexplained sweating_____

A fall_____ Shortness of breath_____