





LeMars Physical Therapy  
 789 Holton Drive  
 PO Box 921  
 LeMars, IA 51031  
 (712) 546-1718  
[www.lemarspt.com](http://www.lemarspt.com)

### Patient Injury and Medical History Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Why were you referred to physical therapy? (example: knee injury) \_\_\_\_\_

Is this a result of an injury that you had at work?      No      Yes

What date did you start to have problems? \_\_\_\_\_

What were you doing when this problem started? \_\_\_\_\_

Have you seen a doctor?      No      Yes

What type of tests have you had?(circle)      Xray      MRI      CT Scan      Blood Work  
 Other (please describe) \_\_\_\_\_

Did you find anything out from the tests?      No      Yes (describe) \_\_\_\_\_

Have you had any other treatments for this? (circle)      Ice      Heat      Rest  
 Medicine(what kind) \_\_\_\_\_      Chiropractor      Massage therapy  
 Therapy (where) \_\_\_\_\_

Do you have any of these health problems right now? (circle)      Cancer      Diabetes  
 High Blood Pressure      Pregnant      Asthma      Shingles  
 Arthritis(type and where) \_\_\_\_\_      HIV      Hepatitis

Have you ever had any of these health problems? (circle)      Cancer      Diabetes  
 High Blood Pressure      Asthma      Hepatitis  
 Broken bone (where and when) \_\_\_\_\_  
 Surgery (for what and when) \_\_\_\_\_

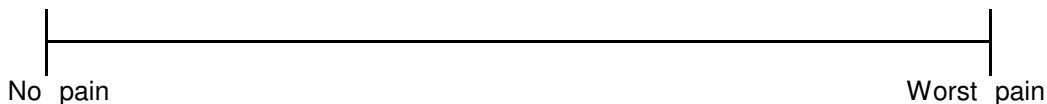
Are you having pain?      No      Yes

If so, where? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Please mark on the line below, where your pain is at right now.





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## **Important Notices for Patients Receiving Physical Therapy and/or Occupational Therapy**

### **Medicare**

If you have received Medicare Home Health in the last three months, **please tell us.** Medicare has implemented a cap in 2006, one cap that allows a total of \$1740.00 of allowed amount for both Physical Therapy and Speech Therapy and another cap of \$1740.00 for Occupational Therapy.

### **XIX-Iowa**

There is a limitation of **\$1740.00 per year** for Physical Therapy Services. **No Supplies are covered.** A co-payment may be required with your coverage as well and must be collected on the date the service is received.

### **Workman's Compensation**

If under treatment on a Workman's Compensation claim, Physical and/or Occupational Therapy Services may be covered. These services must be authorized. If not, you will be responsible. If you do not attend your appointment and do not cancel, your employer will be notified.

### **General Notices**

Certain restrictions may apply with your insurance company for Physical and/or Occupational Therapy Services. We advise you to contact your insurance company by using the toll-free number on the back of your insurance card to verify coverage. Some questions you may want to ask:

- Does my insurance cover Physical and/or Occupational Therapy?
- Are there any restrictions on where I can receive these services?
- Does the therapy need to be pre-authorized?
- **My treatment may call for "Iontophoresis" is this a covered under my Insurance Policy?**

**If I cannot make my appointment, it is my responsibility to call and cancel. I understand that if I do not call to cancel, I risk being removed from any further scheduled appointments that I have made.**

**If your insurance company has any questions they may call Amy @ 712-546-1718.**

**I have read the above questions and I understand it is my responsibility to know my insurance policy and that I will check with my insurance should I have any questions or concerns.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date



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## Patient Consent Form - HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to LeMars Physical Therapy or by reviewing the current copy in our waiting room binder.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Optional: Please restrict access to my personal health information (PHI) from:

\_\_\_\_\_  
Name Address Phone Number

\_\_\_\_\_  
Name Address Phone Number