

Cool Springs Physical Therapy  
1051 East Cornell Road  
Mercer, PA 16137  
724-662-2800

**Please Print**

Patient Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital Status: S M W D Spouses Name: \_\_\_\_\_

Phone# \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work/School Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Do you have a follow up visit with your physician? \_\_\_\_Y \_\_\_\_N If yes? When? \_\_\_\_\_

Please list one emergency contacts outside of your residence:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Is this a worker's compensation injury? Yes/No Is this an Auto Accident? Yes/No**

**If you answered "Yes" to either of the above questions, please provide our office with your current claim numbers and any additional documentation that is relevant to your care.**

**I understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. This may include, but not limited to, deductibles and all copays. Payment is expected when services are rendered unless prior arrangements have been made.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

GENERAL MEDICAL INFORMATION

Name: \_\_\_\_\_

Have you ever had any of the following medical conditions? If you are taking medications for any of the following conditions, please put a check under the medications side.

	Yes	Medications		Yes	Medications
Allergies	_____	_____	Hypotension	_____	_____
Anemia	_____	_____	Incontinence	_____	_____
Angina	_____	_____	Irregular Heartbeat	_____	_____
Aneurysm	_____	_____	Kidney Disease	_____	_____
Arthritis/Gout	_____	_____	Migraine Headaches	_____	_____
Asthma	_____	_____	Multiple Sclerosis	_____	_____
Cancer	_____	_____	Osteoporosis	_____	_____
Depression	_____	_____	Pacemaker	_____	_____
Diabetes	_____	_____	Respiratory Problems	_____	_____
Emphysema	_____	_____	Skin Infection	_____	_____
Heart Attack	_____	_____	Stroke	_____	_____
Hepatitis	_____	_____	Thyroid Condition	_____	_____
High Cholesterol	_____	_____	Tuberculosis	_____	_____
Hypertension	_____	_____	Vestibular Disease	_____	_____
Hypoglycemia	_____	_____	Viral Infection	_____	_____
Others:	_____				

**1. Please Provide us with a current list of medications to copy**

2. Do you have any allergies to cortisone, adhesive tape, or latex? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Have you had any x-rays, CT-Scans or MRI's related to current diagnosis? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Where and when were these diagnostic tests completed? \_\_\_\_\_
4. Have you had any operations related to your current diagnosis? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Please list and give dates: \_\_\_\_\_
5. Have you ever broken any bones? \_\_\_Yes \_\_\_No Related to why you are here? \_\_\_\_\_ Yes \_\_\_\_\_ No
6. Have you had any unexplained weight gain or loss in the last month? \_\_\_\_\_ Yes \_\_\_\_\_ No
7. Have you had pain that keeps you awake at night in the last month? \_\_\_\_\_ Yes \_\_\_\_\_ No
8. Have you had prior physical therapy or chiropractic care? \_\_\_\_\_ Yes \_\_\_\_\_ No  
In the last year? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Below is for Office Use only.**

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<u>Diagnosis:</u>	<u>CoMorbidity:</u>	<u>Physical Therapist:</u>
1. _____	1. _____	_____
2. _____	2. _____	
3. _____	3. _____	
4. _____	4. _____	

**COOL SPRINGS PHYSICAL THERAPY**  
**NOTICE OF PATIENT INFORMATION PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

**COOL SPRINGS PHYSICAL THERAPY'S LEGAL DUTY**

**Cool Springs Physical Therapy** is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

**Cool Springs Physical Therapy** uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Cool Springs Physical Therapy** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

**Cool Springs Physical Therapy** may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, **Cool Springs Physical Therapy** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

**Cool Springs Physical Therapy** may change its policy at any time. When changes are made, a new Notice of Information Practices will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

**PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purpose.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Cool Springs Physical Therapy** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

**CONCERNS AND COMPLAINTS**

If you are concerned that **Cool Springs Physical Therapy** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Cool Springs Physical Therapy's** health information practices or if you have a complaint, please contact the following person:

I have read and fully understand **Cool Springs Physical Therapy's** Notice of Information Practices. I understand that **Cool Springs Physical Therapy** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that **Cool Springs Physical Therapy** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Cool Springs Physical Therapy** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **Cancellation / No Show Policy**

Here at Cool Springs Physical Therapy we realize that once in a while circumstances require you to cancel or miss an appointment and we are happy to reschedule your appointment when this happens.

While canceling appointments can create scheduling problems for us, it also interrupts your rehabilitation program designed to treat your injury/condition. Frequent cancellations and/or no shows make our treatments less effective toward reaching your goals and the goals of your referring physician. Please attend all treatments, if possible, so that together we can reach your full potential and maximum recovery.

It has been shown that patients who attend physical therapy appointments on a regular basis have better outcomes. Actually, two of the most important outcome predictors are:

1. Regular attendance of physical therapy treatments
2. Compliance with home exercise program

As a courtesy to our staff, all our patients, and in order to better serve ALL of our patients, please call us at least 24 hours in advance with your cancellation. In addition, if you arrive at the wrong time for your appointment, we will make every effort to provide your entire treatment as long as we do not inconvenience those patients already scheduled for that time.

We are pleased that you chose Cool Springs Physical Therapy and Aquatic Therapy Center for your physical therapy rehabilitation. Please partner with us to help make your recovery here at Cool Springs a successful experience.

I have read and understand that if I must cancel an appointment I should do so at least 24 hours in advance.

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Signed

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Date

# HOW DID YOU HEAR ABOUT COOL SPRINGS PHYSICAL THERAPY?

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

Date: \_\_\_\_\_

Please check ONE that applies

\_\_\_\_\_ I am a Returning Patient

\_\_\_\_\_ Doctor Referral

\_\_\_\_\_ Family / Friend Referral

\_\_\_\_\_ Insurance Company

\_\_\_\_\_ Location

\_\_\_\_\_ School / College: \_\_\_\_\_

\_\_\_\_\_ Computer / Internet / Website: \_\_\_\_\_

\_\_\_\_\_ Employer

\_\_\_\_\_ Sign on Building

\_\_\_\_\_ Health Fair

\_\_\_\_\_ Fitness Club

\_\_\_\_\_ Billboard

\_\_\_\_\_ Bulletin Board (YMCA)

\_\_\_\_\_ Flyer / Brochure

\_\_\_\_\_ Sponsorship Event

\_\_\_\_\_ Other: \_\_\_\_\_

**THANK YOU!**