CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

Physical Therapy

Name: _____ **Age:** _____ **Gender:** _____ **Dominant Hand:** R __ L __

1. Describe the problem for which you seek physical therapy: _____

_____

2. Do you have pain or discomfort? Yes _____ No _____

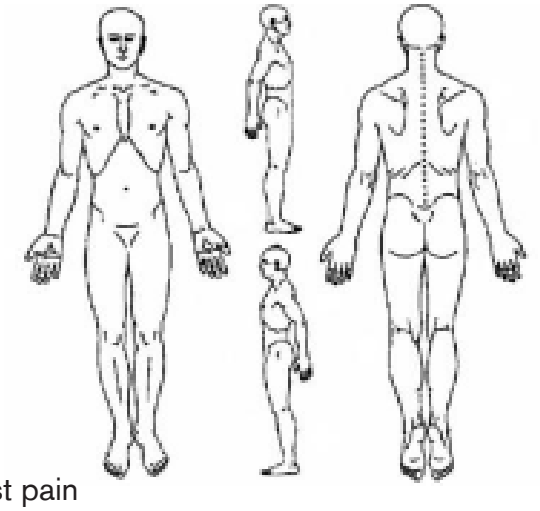
3. Pain is difficult to describe. Circle the words that best describe your symptoms:

Burning Throbbing Aching Stabbing Tingling Shooting Numbing Pressure Dull

4. Nature of Condition (circle one):

Initial Onset (within last 3 months)
Recurrent (multiple episodes of <3 months)
Chronic (Continuous duration >3 months)

Indicate where you have pain or other symptoms



5. Symptoms began on: _____
mm/dd/yyyy

6. How did your symptoms start? _____

_____

7. Average pain intensity (circle one)

Last 24 Hours no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Past Week no pain 1 2 3 4 5 6 7 8 9 10 worst pain

8. How often do you experience your symptoms? (circle one)

1 Constantly (76-100% of the time) 3 Occasionally (26-50% of the time)

2 Frequently (51-75% of the time) 4 Intermittenly (0-25% of the time)

9. How much have your symptoms interfered with your usual daily activities? (circle one)
(including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

10. How is your condition changing since care began at this facility? (circle one)

0 N/A-This is the initial visit 1 Much Worse 2 Worse 3 A little worse

4 No change 5 A little better 6 Better 7 Much Better

11. In general, would you say your overall health right now is (circle one)**:**

1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor

12. Does movement have any effect on your pain? (circle one)

Makes it better Makes it worse No change

13. Do you have trouble with sleep because of your pain? (circle one)

Trouble falling asleep Awakened from sleep No trouble falling asleep

14. Are you presently a victim of abuse? (circle one)

Yes No No comment

15. Describe how you are taking care of the problem now. _____

_____

16. Describe what makes the problem better. _____

_____

17. Describe what makes the problem worse. _____

_____

18. Please list your goals for physical therapy. What would you like to be able to do when you are finished? Please be as specific as possible.

_____

_____

Patient Signature: _____ **Date:** _____

Reviewed By Physical Therapist: _____

Signature

CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

The Modified Falls Efficacy Scale

Name_____ **Date**_____

On a scale of 0 to 10, please rate how confident you are that you can do each of these activities without falling, with 0 meaning "not confident/not sure at all", 5 being "fairly confident/fairly sure", and 10 being "completely confident/completely sure".

Note:

* If you have stopped doing the activity at least partly because of being afraid of falling, score a 0
* If you have stopped an activity purely because of a physical problem, leave that item blank (these items are not included in the calculation of the average MFES score).
* If you do not currently do the activity for other reasons, please rate that item based on how you perceive you would rate it if you had to do the activity today.

		Not Confident					Fairly Confident					Completely Confident
	Activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1.	Get dressed and undressed											
2.	Prepare a simple meal											
3.	Take a bath or a shower											
4.	Get in/out of a chair											
5.	Get in/out of bed											
6.	Answer the door or telephone											
7.	Walk around the inside of your house											
8.	Reach into cabinets or closet											
9.	Light housekeeping											
10.	Simple shopping											
11.	Using public transport											
12.	Crossing roads											
13.	Light gardening or hanging out the washing *											
14.	Using front or rear steps at home											

* Rate most commonly performed of these activities

Score/Item Rated= _____/_____

Average= _____

Dublin Physical Therapy
614-339-8088
Eastside Physical Therapy
614-865-3142
Northwest Physical Therapy
614-339-8081

CENTRAL OHIO
PRIMARY CARE
THE BEST FOR PRIMARY CARE

Sports, Spine and Joint Physical Therapy
614-259-0906
Westerville Physical Therapy
614-392-2812

Valued COPC Physical Therapy Patient:

At Central Ohio Primary Care, it is our goal to give you the best care possible. In order to best serve all of our patients, we request the following:

- If you cannot keep your scheduled appointment, please call us at the number above to cancel the appointment at least 24 hours prior to the visit.
- If you miss an appointment, and fail to call to re-schedule or cancel, you may be assessed a No Show/Late Cancelation fee of $50.00 for an initial evaluation or $25.00 for an established follow-up visit.
- If you have 3 cancellations within a consecutive 3 week period, the Physical Therapist will be notified and will determine if your therapy should resume, or be discontinued.
- If you will be more than 10 minutes late, we may ask you to re-schedule your appointment. This will assure that we are giving you the full time you deserve to address all of your needs during treatment.

Thank you for helping us to provide our patients with the most convenient scheduling possible!

I have read this physical therapy policy and agree to the above.

Today's Date: _____

Printed Name: _____

Signature: _____

CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

Patient Name: _____ DOB: _____ Acct. #_____

Agreement of Financial Responsibility

Thank you for choosing ***Central Ohio Primary Care Physicians, Inc.*** (***COPC***) as your health care provider. COPC is committed to providing quality care and service to all of our patients. The following is a statement of COPC's financial policy, which we require that you read and agree to prior to receiving any treatment from COPC.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. COPC accepts cash, check, credit cards, and pre-approved insurance for which COPC is a contracted provider.

It is your responsibility to know your own insurance benefits, including:

- whether COPC is a contracted provider with your insurance company;
- your covered benefits and any exclusions in your insurance policy; and
- any pre-authorization requirements of your insurance company.

COPC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information to COPC, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by COPC.

If COPC has a contract with your insurance company, COPC will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If COPC does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. COPC will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of insurance and photo ID are required for all patients. COPC will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient