



Matthews

1352 Matthews Township Parkway, Unit 102,
Matthews, NC, 28105
Phone | 704-283-6700
Fax | 704-283-6713
WWW.AMBASSADORPT.ORG

Patient Information:

Full Legal Name _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____ SSN _____ Gender _____

Single _____ Married _____ Widowed _____

Email Address _____

Phone:

Home _____ Is it OK to leave a detailed message at this number? Yes...no

Work _____ Is it OK to leave a detailed message at this number? Yes...no

Cell _____ Is it OK to leave a detailed message at this number? Yes...no

Emergency Contact:

Name _____ Relationship _____

Phone number _____

Consent of Treatment and Authorization to Release Information

I hereby authorize Ambassador Physical Therapy through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature

Relationship (self, guardian, other)

Date

I further authorize Ambassador Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above names patient's examination and treatment necessary to secure payment for services provided.

Signature

Relationship (self, guardian, other)

Date

Notice of Privacy Practices

A personal copy of the Notice of Privacy Practices is available to you for your convenience upon your request.

I, _____, acknowledge that I have read the Notice of Privacy Practices of Ambassador Physical Therapy.

Patient Signature

Date

Disclosures to Individuals Involved in Patient's Care

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please provide below such persons involved in your care, which may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, neighbors and colleagues.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I authorize Ambassador Physical Therapy to disclose my health or billing information that is directly related to my current treatment at Ambassador Physical Therapy to the individual(s) listed above for purposes of their role in my treatment or payment for the health services that I have received.

Patient Signature

Date

Attorney Information: (Complete if applicable)

Name _____ Law Firm _____ Phone _____

Address _____ City _____ State _____ Zip _____

Work Injury Claim: (Complete if applicable)

Insurance Name (work comp) _____ Adjuster/Claim

Manager _____ Phone _____ Ext _____

Address _____ City _____ State _____ Zip _____ Claim Number

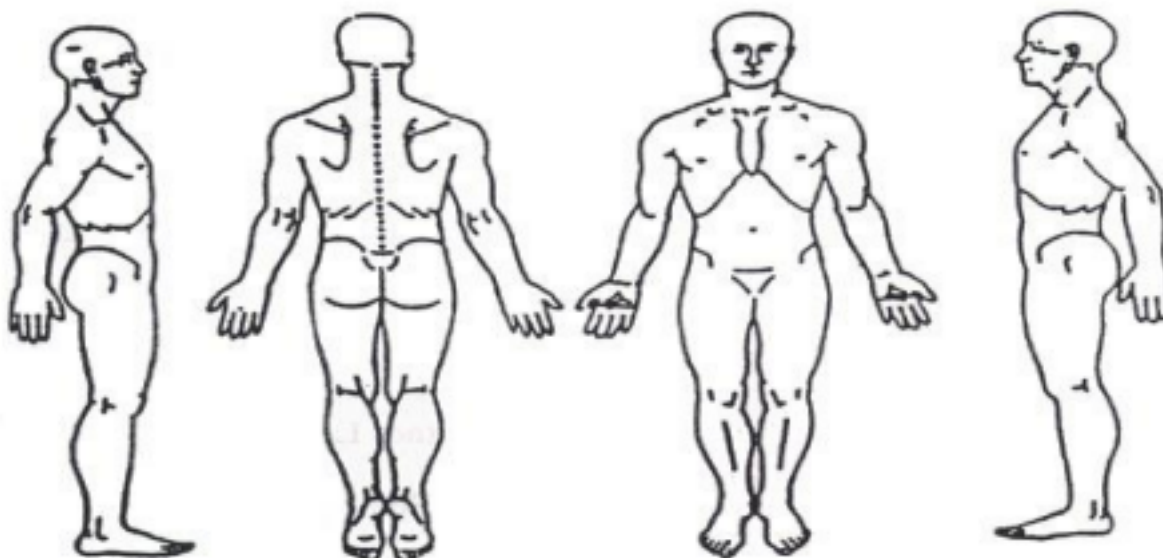
_____ Accident Date _____

- I hereby assign all insurance benefits for services rendered to be paid directly to *Ambassador Physical Therapy*
- I understand that if my insurance company/third party payer denies payment or makes partial payment I am responsible for the balance due.
- I hereby authorize the release of medical records to Ambassador Physical Therapy and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

Patient Signature

Date

Please clearly indicate by circling where your pain is located using the picture below.



What best describes your pain?

Sharp____ Dull Ache____ Numb____ Shooting____ Burning____ Tingling____

How often do you experience symptoms?

Constantly(76-100%)____ Frequently(51-75%)____ Occasionally(26-50%)____ Intermittently(>25%)____

Instructions: Rate your major area of pain on the 0-10+ pain rating scale with Zero (0) being no pain at all and ten (10+) being the worst possible pain you could EVER imagine.

- Pain NOW ____/10+
- Pain at its best ____/10+ It gets better when _____
- Pain at its worst ____/10+ It gets worse when _____

Are you currently? (check all that apply) Pregnant ____ Depressed ____ Under stress ____

Have you or an immediate family member ever been diagnosed with? (Circle YES or NO)

	SELF	FAMILY		SELF	FAMILY
Cancer	yes...no	yes...no	Diabetes	yes...no	yes...no
High blood pressure	yes...no	yes...no	Heart disease	yes...no	yes...no
Angina/chest pain	yes...no	yes...no	Stroke	yes...no	yes...no
Osteoporosis	yes...no	yes...no	Osteoarthritis/Rheumatoid	yes...no	yes...no
Allergies/asthma	yes...no	yes...no	Headaches	yes...no	yes...no
Bronchitis	yes...no	yes...no	Kidney disease	yes...no	yes...no
Rheumatic fever	yes...no	yes...no	Seizures	yes...no	yes...no
Ulcers	yes...no	yes...no	Sexually transmitted disease	yes...no	yes...no

In the past 3 months have you had or do you experience any of the following? (Circle YES or NO)

A change in your health	yes...no	Nausea/Vomiting	yes...no
Fever/chills/sweats	yes...no	Unexplained weight change	yes...no
Changes in appetite	yes...no	Difficulty swallowing	yes...no
Urinary tract infection	yes...no	Shortness of breath	yes...no
Dizziness	yes...no	Upper respiratory infection	yes...no
Change in bowel function	yes...no	Change in bladder function	yes...no
		Hearing____ Vision____ Speech____	

Do you have a problem with? (check all that apply) Communication____

