MTS PHYSICAL THERAPY & WELLNESS

YOUR BEST SELF WITHIN REACH

Welcome to MTS Physical Therapy. We are excited to be a part of your journey toward well-being. No matter if you are a returning patient or brand new to our service, we would like to share some information that we feel will help get you started on the best path.

The forms within in this new patient packet will provide valuable information to your therapist and care team. Please fill them out accurately and completely. Your therapist will use your current health information to determine the ideal care plan for your time with us in our clinics and after you leave our walls.

MTS WELLNESS

At any time, ask your therapist about our MTS Wellness Program. We offer many different services, including our fully equipped gyms, a wide variety of group exercise classes and much more. We also offer special rates while you are in patient care. You can visit our website (mtsphysicaltherapy.com) for more information.

keethealth

MTS has partnered with KEET Health because KEET feels the same way we do about your health. KEET Health allows us to engage with you through their software during your care in our clinic and throughout the time you begin following our recommendations at home. Keet Health will assign questionnaires to you that will help us understand how you are progressing during our time with you. Lastly, KEET allows us to share a large library of at home exercises that will be tailored to your needs.

Please take these next steps to fully participate in your care:

1. Download KEET Health app.
2. Please maintain access to your email address provided to ensure you get the latest updates to your care.

You can download KEET Health app by searching KEET Health in the Apple App Store, Google Play Store or by visiting their website directly at mts.keethealthapp.com/login.

Prior to your visit with us your insurance will be verified and if necessary, authorization obtained. An appointment reminder call will be made, and your financial responsibility will be reviewed with you at that time. You can anticipate these calls to come from the following phone number: 337-571-1204.

Please see the below to know how to be prepared for your visit and the time spent with your Therapist:

IN CLINIC EVALUATION	VIRTUAL EVALUATION
Script from your physician to evaluate and treat, unless faxed by physician.	Driver's license and/or parent or legal guardian.
Your completed paperwork, if not already completed through email.	Your insurance cards.
Driver's license and/or parent or legal guardian.	Be sure to be in a well-lit area with minimal interruption.
Your insurance cards.	
Any copays or monies owed by you for your visit.	

It is required that you arrive or virtually sign in <u>15 minutes before</u> your initial appointment time and have all the above listed items with you, or it will be necessary to reschedule your appointment.

If you have any questions or we can be of any assistance, please call your clinic office.

We look forward to seeing you and working with you to achieve your best self.

Sincerely,

Your MTS Team

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PHYSICAL THERAPY
& WELLNESS

PATIENT INFO

Date of Birth: _____ Clinic Name: _____

Patient First & Last Name: _____ Middle Initial: ____

Gender: M F Email address:_____

Patient Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Provider: _____

Social Security Number: _____

Marital Status: _____ Employment Status: _____

Place of Employment: _____

Employment Address: _____

City:_____ State: _____ Zip Code: _____

Accident Type: _____ Work Related Accident: Yes No

EMERGENCY CONTACT INFO

Emergency Contact Full Name: _____

Relationship: _____ Phone Number: _____

RESPONSIBLE PARTY/GUARDIAN INFO

First & Last Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFO

Primary Plan Name: _____ Primary Policy Number: _____

Secondary Plan Name: _____ Secondary Policy Number: _____

Do you have an active membership with our MTS Wellness Program? Yes __ No __
Patients receive a Preferred Rate while in therapy

Patient/Responsible Party Signature: _____ Date: _____

PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand MTS-LGH Therapy Services LLC's Notice of Information Practices. I understand that MTS-LGH Therapy Services LLC may use or disclose my personal health information for the purpose 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 MTS-LGH Therapy Services, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby authorize the use and disclosure of my personal health information for purposes as noted in MTS-LGH Therapy Services LLC Notice of Information Practices. I understand that I retain the right to revoke this authorization by notifying the practice in writing, at any time.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

I hereby consent to the release and disclosure of my personal health information to MTS-LGH Therapy Services LLC. This authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of designing a plan of treatment. I understand that MTS-LGH Therapy Services LLC is permitted to send me unencrypted emails that contain personal health information if advised by me and I am aware of the risk.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Preferred Physicians involved in your care:

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

NO SHOW POLICY

In order for MTS-LGH Therpay Services LLC to effectively give the best possible treatment and care for our patients, it is imperative that our patients attend their scheduled appointments as referred by their physicians. If you are unable to attend your scheduled appointment, as a courtesy to our office, please call 24 hours prior to your appointment time to cancel. If you consistently miss scheduled appointments our office will not be able to schedule your next appointment and will discontinue treatment. This will require you to obtain a new referral for treatment from your physician.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

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Date: _____

Patient Name: _____ DOB: _____ Referring Physician: _____

What caused you to seek physical therapy/medical attention? _____

Is your condition is related to: Employment Accident Auto Accident Home Accident Other

Date of condition/accident: _____ State Accident occurred: _____

What is your major complaint? Be as detailed as possible:

_____

_____

_____

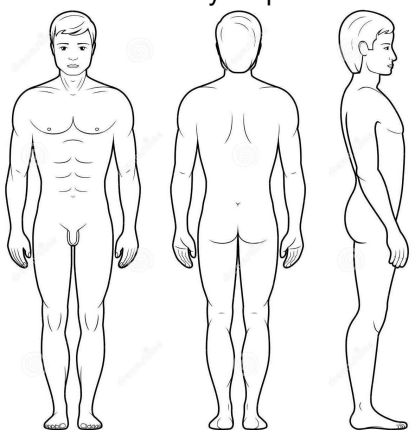
If you have pain, what is your pain level?
(0=No Pain, 10=Extreme Pain)

AT WORST: _____

AT BEST: _____

CURRENTLY: _____

Mark the location of your pain with an X:



What makes your pain better? _____ What makes your pain worse? _____

Is this pain getting: _____ Better ____ Worse _____ Not Changing

What type of treatments have your received for this condition? Please check.

Xrays	Injection
Surgery	Bone Scan
Chiropractic care	CT/CAT Scan
MRI	Physical Therapy
Medications	Home Health

Please describe treatment received (agency, etc.):

_____

_____

Have you fallen in the last 12 months? Yes No If yes, how many times? ____

Did your fall result in injury? Yes No

Please check all problems diagnosed by a doctor that you are currently being treated for:

Bronchitis/Emphysema/Lung Disease	Sciatica	Gout
Pneumonia	Fibromyalgia	Implants
Abnormal Chest Xray	Bursitis	High/Low Blood Pressure
Chronic Fatigue Syndrome	TMJ Dysfunction	Dizziness/Fainting Spells
Thrombosis/Phlebitis	Muscular Dystrophy	Pregnant
Carpal Tunnel Syndrome	Blood Borne Pathogens	HIV
Hepatitis A	Hepatitis B	Hepatitis C
Lupus	Tuberculosis	AIDS
Epilepsy	Diabetes	Tumors/Cancer
Osteoporosis/Penia	Immunosuppression	Heart Disease
Pacemaker	Sprains/Dislocations/Broken bones	Blood Thinners

Please list medications:

Medication	Purpose of medication	Medication	Purpose of medication

Please list any previous surgeries: _____

_____

What were you doing prior to this injury that you are unable to do currently?

Squatting	Standing	Holding/Carrying objects
Lifting	Driving	Dressing/Grooming
Kneeling	Gripping/Pinching	Stairs
Sitting	Reaching	Position changes
Walking	Work Tasks	Other:

What household duties are you difficulty performing?

Cooking	Vacuuming	Yard work
Cleaning	Laundry	Grocery shopping
Other:		

Are your symptoms:

Constant	Aching	Deep
Shooting	Burning	Superficial
Come and Go	Numbness/Tingling	Dull
Sharp	Other:	

CONSENT FOR TELEHEALTH
AUDIOVISUAL COMMUNICATION

(Print Patient's Name):_____

In order for MTS-LGH Therapy Services, LLC to effectively give the best possible treatment and care for our patients, we may choose to use audiovisual communication to enhance interventions. I agree to participation in intervention via audiovisual communication with the possibility of communication recording via a secure platform of communication. I understand if there are any recordings of information that it will be stored via HIPPA compliant means.

EMERGENCY CONTACT AND AUTHORIZATION

I designate (Name and contact number)_____ (relation to patient) _____ as the emergency contact in the instance that anything would happen during the telehealth session that would require emergency communication. I authorize the release and distribution of information concerning my illness or injury and outpatient treatment by MTS Physical Therapy & Wellness to the above mentioned individual with the **following restrictions:** *(If no restrictions, leave blank.)* _____.

MEDICAL EMERGENCY

If an emergency situation is identified during a telehealth visit, the clinician will contact the local emergency responder in the location from which the Telehealth communication is originated. If transportation is required, the patient may arrange own transportation and if unable to agrees to utilize ambulance services. The MTS Physical Therapy and Wellness staff will not be involved at any time in transporting patients. MTS Physical Therapy and Wellness staff will not be directly involved in any emergency assessment. For the purposes of this service, an emergency will be defined as:

- Loss of consciousness
- Fall with injury
- Observable distress or changes in cardiopulmonary status
- Observable distress or changes in neurological status

I understand, if at any time I am uncomfortable with participating in Telehealth, I have the option to no longer participate and it will be acknowledged and addressed by MTS Physical Therapy & Wellness.

_____ _____

Patient/Member Signature **Date**

Unable to consent because: _____Of minor age _____Other:_____

I therefore consent for the above.

_____ _____

Consenter's Signature Date

_____ _____

Consenter's Printed Name Relationship

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