Welcome to Our Office

5250 E. US 36 Suite 670
Avon IN 46123
317-745-9908
HTSOutpaitnettherapy.com

We are pleased that you have chosen HTS Outpatient Physical Therapy for your outpatient Physical and Occupational Therapy services. This information answers some of the most commonly asked questions about our services. Feel free to ask any additional questions.

Payment For Services: As a courtesy to you, we will obtain authorization and bill your insurance company. **Please note:** All insurance co-pays are expected at the time services are rendered. **It is the patient's responsibility to know their insurance plan and coverage.**

Regarding Appointments: Appointment times range from 45 to 75 minutes. Our facility remains very busy, especially the early morning and late afternoon appointments. It is important for you to attend your appointments regularly. Inconsistency in receiving your therapy treatments can adversely affect your progress and outcome. If you need to cancel your appointment, please call 24 hours prior to your appointment to allow us to provide services to other patients. Patients that consistently cancel or no-show appointments will be discharged and their doctor will be notified of the reason for discharge. **Punctuality** is appreciated so you can receive the maximum benefit from your appointment. Our staff does their best to run on time.

Worker's Compensation Patients Only: Please note that this office will notify your Workman's Compensation Insurance Adjuster of non-compliance after missed appointments.

Reports To Physicians: We send a summary of your initial visit to your doctor. Please let us know 5-7 days in advance of future doctor appointments so we can send a letter informing them of your progress. Your written consent will be required to release medical records to anyone other than your physician and insurance company.

Hours of Operation: 7:00 am – 7:00 pm Monday - Thursday, 8:00am – 5:00 pm Friday
(closed 12:00-1:00 for lunch)

- Voice mail messages can be left during lunch and after hours
- Telephone: (317) 745-9908, Fax: (317) 745-7255

Team Approach: Occasionally you may see a different Physical Therapist or Physical Therapist Assistant. This can offer new perspectives in treating your condition and enhance your progress. Your program and the services provided may change in response to your progress and needs. It is important that you do your home exercise program to improve your rate of progress. We look forward to working with you!

I will allow HTS Outpatient Therapy to use my testimonials. Yes___ No___
I will allow HTS Outpatient Therapy to use my photos for publication. Yes___ No___

Thank you for choosing HTS Outpatient Therapy!

I have received a copy of the Outpatient Guidelines and I consent to treatment by the HTS Staff.

Signature: ________________________Parent or Guardian:__________
Date:__________________

Patient Information Form

Last Name:______________________________ FirstName:________________________ Middle__________
Address:____ City/State:_________________ Zip:_________
Home Phone:___________________ Cell Phone:__________________ Work Phone:_________________
Date of Birth:____________________ SSN:_________________ Email Address:_____________________
Employer:_______________________________________ Marital Status:____________________________

Spouse's Name:____________________________ Work Phone:_________________ DOB_____________
Nearest Friend/Relative not living with you:________________________ Phone:______________________

Physician:_____________________________________ Phone:____________________________________
Whom may we thank for referring you to us?:____

Insurance Company:_________________________ Secondary Ins. Co.:_________________________
Policy No.:_________________________________ Policy No.:_________________________________
Group No.:_________________________________ Group No.:_________________________________

Workmans Comp claim?: Yes __ No__ If Yes, date of injury:_____________________________________
Insurance Co.:_______________________ Adjuster Name:___________________ Claim #:______________
Phone:______________ Fax No.________________ Address:_______________________ DOI:___________

Auto Accident?: Yes__ No__

Who is responsible party?/Legal guardian if a minor?:____
Date of Birth:___________________ Phone No.:_______________________ SSN:_____________________
Address:____ Will be paying today by: Cash__ Check__ CC__

Please provide proof of insurance coverage upon completion of this form.
Assignment and Authorization: I authorize the release of any medical information necessary to process insurance/Medicare claims on my behalf. I authorize payment of medical benefits directly to HTS Outpatient Therapy for services and supplies provided to me. A copy of this authorization shall be considered as a valid as the original and valid for the duration of my care. I understand I am liable for all charges incurred should my insurance not pay for these services (Except for Workers Comp.)

Signature   Date

____________________________________   __________________

PATIENT HISTORY

NAME:______________________ AGE:____ DATE:______________ REFERRING DR:______________

To better serve your individual needs please complete the following. Circle the appropriate choice(s) when indicated.

1) What is your main complaint or problem?____________________________________
Date of onset _______________ How did it occur___________________________________
____
Date of surgery _______________ Type_______________________________________

2) If you have pain, please circle those words which best describe it.

Constant Intermittent Sharp Dull Burning Throbbing Twinge Ache Numb Tingle Tight Pulling

3) Please rate the level of your pain at its best and worst.

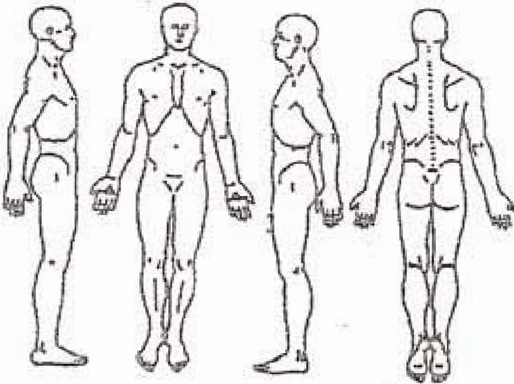
0 1 2 3 4 5 6 7 8 9 10
←NO PAIN---EXTREME AGONY→

4) How do you feel in the: Morning? *better / worse* Afternoon? *better / worse* Evening? *better / worse* Night? *better / worse*

5) What positions or activities make your pain better?_____________________________
____

6) What positions or activities make your pain worse?_____________________________
____

7) Please indicate painful areas by shading models.



8) What tests and/or treatment have you had for this problem? What were the findings?
Previous Therapy or other treatments?

X-ray
MRI
CT Scan
Myelogram
EMG
Other ______________________

9) What medication(s) are you taking for this problem? Please List the names of the medications:
*Anti-Inflammatory Pain killer Muscle relaxer Other*____________________

10) What is your occupation?____
a) Working: *Full-time Part time Light duty Not working*
b) Physical work requirements: *sedentary light moderate heavy very heavy*
c) Job requires prolonged: *sitting standing bending walking lifting squatting driving*

11) What functional activities are you currently having problems with?
*dress/bathe job duties housework cook/eat walk stand sit drive sleep recreation*________________

12) Do you have any medical problems?
*heart blood pressure diabetes cancer arthritis seizures other*____________________

13) Language preferred:________________ Learning prefernce: verbal visual other:______________

14) If female are you currently pregnant or trying to be? Yes No

15) Do you have another appointment with your doctor? Yes No When________________

16) What do you hope to accomplish with physical therapy treatments?____________________
____

HTS OUTPATIENT THERAPY
PRESTWICK POINTE
5250 E US HWY 36, Ste. 670
Avon, Indiana 46123
phone: 317-745-9908 fax: 317-745-7255
(Map located on back)

Office Hours:
7am-7pm Monday-Thursday, 8am-5pm Friday
Additional hours available if necessary

Patient: ______________________ **Date:** ______________

Diagnosis ______________________ **DOB:** ______________

Precautions: ______________________

Freq/Duration: ______________________ ☐ **As Indicated by Therapist**

☐ **PT** ☐ **OT** ☐ **ST**

PHYSICIANS ORDERS:

- ☐ **Evaluate and Treat**
- ☐ **Therapeutic Exercise**
  - Strengthening
  - PROM/AROM
  - Endurance
- ☐ **Home Exercise Program**
- ☐ **Manual Therapy**
  - Joint Mobilization
  - ASTM/CFM
  - Myofascial Release
  - Muscle Energy Technique
- ☐ **Lumbar Stabilization**
- ☐ **Traction (Cervical/Lumbar)**
- ☐ **Gait Training**
- ☐ **Proprioception/Balance**
- ☐ **FCE: Functional Cap. Eval**
- ☐ **Edema Mgmt.**
  - Intermittent Compression Pump
  - Compression Garment Fitting
  - Lymphedema Massage
- ☐ **Orthotics** (custom foot orthotics)
- ☐ **OT: Custom Hand Splinting**
- ☐ **TENS Unit Fitting**
- ☐ **Modalities as indicated**
  - __ Iontophoresis_w/ Dex
  - __ Ultrasound/Phonophoresis
  - __ Electrical Stimulation
  - __ Moist Heat/Cryotherapy
  - __ Paraffin Bath
  - __ Anodyne Therapy
- ☐ **Other:** ______________________

I certify this treatment program as medically necessary.

Physician's Signature: ______________________________ Date: ______