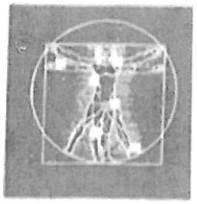

MARYLAND CENTER FOR PHYSICAL THERAPY

Jennifer J. Schlesinger, P.T.
President

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Joan Fairbank, M.P.T
Michael Burns, P.T.A.

DATE _____ **M S W D SP (Marital Status) M F (Sex)**

PATIENT NAME _____ **Birthdate** _____
(Last) (First) (Initial)
Address _____ **City** _____
State _____ **Zip Code** _____ **How long at residence?** _____
Social Security Number _____ **(For billing purposes)**
Home Phone Number _____ **Work/Cell** _____
Email Adress _____
Employer _____ **How long?** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Spouse's Name _____ **Birth date** _____
Address (if different) _____ **Phone** _____
Employer _____ **Phone** _____
Who referred you to our office? _____
Who should we notify in a case of an emergency? _____
Relationship to this person _____ **Phone** _____

INSURANCE INFORMATION

Primary Insurance **Secondary Insurance**

Records Release: I hereby authorize the release of any information, including medical and billing information to my referring doctor, insurance company, the responsible party named above, and immediate family on behalf of myself and/or dependants.

Guarantee of Account: I understand that medical insurance policies are an arrangement between an insurance carrier and myself. I understand that charges for some services may be more than what some insurance companies choose to call "usual and customary" and that unless I am covered by and in compliance with a health plan which MCPT has a participation agreement to provide covered services, that I am responsible for all charges applied to my account.

Assignment of Benefits: I hereby authorize Medicare benefits and other insurance benefits to be paid on my behalf to MCPT for any services furnished me by that therapist/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date _____ **Signed: X** _____

10085 Red Run Boulevard, Suite 307 Owings Mills, Maryland 21117 (410) 363-7123 FAX: (410) 363-0054

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

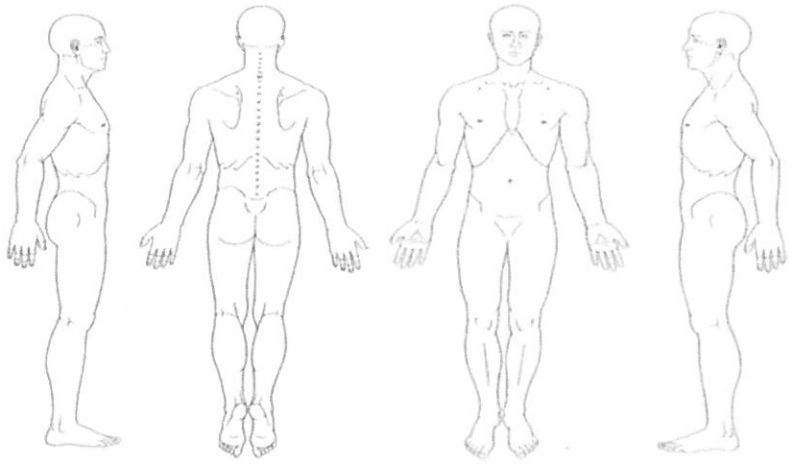
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

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

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

11. What increases your pain?

12. What decreases your pain?

13. What functional limitations do you have as a result of the above problem(s)?

14. Do you have another doctor other than the one that prescribed physical therapy (primary care/orthopedist)?

15. How did you hear about out practice? (Doctor, Insurance Company, Family member, Friend, etc.)

Name:_____ **Date:**_____

Medical History

What is your: Height:_____ Weight:_____ Age:_____ Birth Date:_____

Allergies	Yes	No	Depression	Yes	No	Multiple Sclerosis	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Osteoporosis	Yes	No
Anxiety	Yes	No	Dizzy Spells	Yes	No	Parkinsons	Yes	No
Arthritis	Yes	No	Emphysema/Bronchitis	Yes	No	Rheumatoid Arthritis	Yes	No
Asthma	Yes	No	Fractures	Yes	No	Seizures	Yes	No
Cancer	Yes	No	Gallbladder Problems	Yes	No	Speech Problems	Yes	No
Cardiac Conditions	Yes	No	Hepatitis	Yes	No	Strokes	Yes	No
Cardiac Pacemaker	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Chemical Dependency	Yes	No	Incontinence	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Kidney Problems	Yes	No	Vision Problems	Yes	No
Currently Pregnant	Yes	No	Metal Implants	Yes	No			

Describe any other conditions or precautions:

Falls: History of 2 or more falls in the past year: Yes No

History of 1 fall with injury in the past year: Yes No

Surgical History

Body Region: _____ Surgery Type:_____ Date of surgery:_____

Body Region: _____ Surgery Type:_____ Date of surgery:_____

Body Region: _____ Surgery Type:_____ Date of surgery:_____

Body Region: _____ Surgery Type:_____ Date of surgery:_____

Body Region: _____ Surgery Type:_____ Date of surgery:_____

Current Medication

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Drug:_____ Dosage:_____ Reason for Taking:_____

Depression Scale

Name:_____

Instructions:

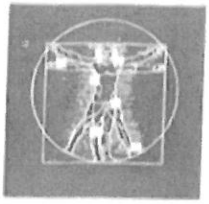
Choose the best answer for how you have felt:

1. **Are you basically satisfied with your life?** Yes **No**
2. **Have you dropped many of your activities and interests?** **Yes** No
3. **Do you feel that your life is empty?** **Yes** No
4. **Do you often get bored?** **Yes** No
5. **Are you in good spirits most of the time?** Yes **No**
6. **Are you afraid that something bad is going to happen to you?** **Yes** No
7. **Do you feel happy most of the time?** Yes **No**
8. **Do you feel helpless?** **Yes** No
9. **Do you prefer to stay at home, rather than going out and doing new things?** **Yes** No
10. **Do you feel you have more problems with memory than most?** **Yes** No
11. **Do you think it is wonderful to be alive now?** Yes **No**
12. **Do you feel pretty worthless the way you are now?** **Yes** No
13. **Do you feel full of energy?** Yes **No**
14. **Do you feel that your situation is hopeless?** **Yes** No
15. **Do you think that most people are better off than you are?** **Yes** No

Score Meaning:

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression
A score ≥ 10 points is almost always indicative of depression
A score > 5 points should warrant a follow-up comprehensive assessment



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CONSENT TO TREATMENT

FOR THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedures.

I/We voluntarily request J. Schlesinger & Associates, P.A., and its licensed Physical Therapy providers, to evaluate my condition and explain their assessment and recommendations for treatment.

I/We understand that certain procedures will be planned for me and I/we voluntarily consent and authorize and evaluation and treatment.

I/We understand that my physical therapist may assess other or different conditions as treatment progress which may require additional and recommended different procedures than those initially planned. I/We authorize J. Schlesinger & Associates, P.A., and its licensed providers to perform or assist with such other procedures, which are advisable in my physical therapist's professional judgment.

I/We understand that no warranty or guarantee has been made to me as to result or cure.

I/We will be given an opportunity to ask questions about my condition and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and can rescind consent if I/we believe that I/we do not have sufficient information to give this informed consent.

I/We certify this form has been explained to me if requested, or that I/we have read it, or have had it read to me and that I/we understand its contents.

_____ _____ _____ _____

Patient/Legal Guardian (Date) Witness (Date)

Authorization for Release of Medical Records

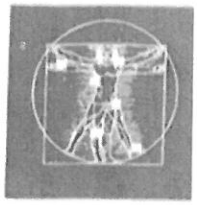
Date:_____

This is to authorize J. Schlesinger and Associates, P.A./Maryland Center for Physical Therapy to release any and all medical reports, test results, information or opinions regarding my physical condition or treatment rendered to me which the Maryland Center for Physical Therapy may deem necessary to my health care providers, insurance company, or attorney. This includes reports of MRI's, C.T. scans, x-rays, etc. or any medical records they may have in their possession, including medical reports, prescriptions, or referrals received from other health care providers regarding my condition or treatment.

This authorization is valid for a period of one year from the above date.

_____ _____ _____

Patient/Legal Guardian (Date) Witness (Date)



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Hot/Cold Pack Disclaimer

I, _____, understand that heating pads can cause a second or third degree burn if they are too hot. Cold packs may also cause these types of burns. I understand that it is my responsibility as the patient to alert the treating Physical Therapist and/or the Technician if the heating pad and/or cold pack get too hot or cold. Patient safety is our first priority. Every effort is made to provide adequate padding to prevent a burn, but we must rely on you, the patient, to inform us if it is too warm or cold. Heat provided should be comfortable warmth and not be perceived as "hot."

The Maryland Center for Physical Therapy and/or J. Schlesinger and Associates, P.A. does not accept responsibility for injury resulting from any heating pad or cold pack. Please feel free to direct all questions and concerns to your therapist.

_____
Patient/Legal Guardian Initials

Attendance Policy

The attendance policy for the Maryland Center for Physical Therapy is as follows:
The patient must give our office 24 hours notice for cancelling an appointment.

After the patient cancels an appointment without proper 24 hour notice 1 time, the patient will be responsible for paying a $25.00 Cancellation Fee. If the patient fails to show for an appointment, the patient will be responsible for paying a $40.00 No-Show Fee.

If the patient fails to pay these fees, he/she will be taken off the schedule and will no longer be able to receive treatment at this facility until the fees are paid. Thank you for your compliance with this policy.

_____
Patient/Legal Guardian Initials

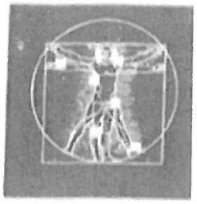
Receipt of H.I.P.P.A Pamphlet

I have received a pamphlet explaining my privacy rights by H.I.P.P.A. (Health Insurance Portability and Accountability Act). I understand my rights as stated in the pamphlet. Any questions about my rights were explained to me.

_____
Patient/Legal Guardian Initials

_____ _____

Patient/Legal Guardian (Date) Witness (Date)



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Assignment of Insurance Benefits and Financial Responsibility Guarantee

Patient Name:_____ **Service Date:**_____

I/We hereby assign any and all insurance benefits due and payable to me/us by any insurance policy to J. Schlesinger and Associates, P.A. for services rendered. I/We further understand and agree that this Assignment is non-revocable. I/We authorize and third party of their insurer, who admits to liability, or who is adjudged liable for my injuries, to pay benefits directly to J. Schlesinger and Associates, P.A.. Further, I authorize my insurance carrier any medical records or other documents requested by the carrier which are deemed necessary by the carrier may not be disclosed to any other party without my expressed written consent. I understand that any benefit quotes or coverage information given to us by any member of the staff, faculty, or representative or the provider is not guaranteed and is only what the provider has been told by my insurer, review agencies, and/or third-party payers. If I do not give immediate notice to the provider of any third-party (e.g., insurer or HMO) that may pay for services but requires preauthorization or timely filing, I agree to pay for any charges not otherwise paid.

In the event the undersigned receives services from J. Schlesinger and Associates, P.A. without providing a written authorization from his/her primary care physician prior to services being rendered in accordance with all charges not paid by the insurance carrier due to non-compliance on your part. I/We understand that I/we are financially responsible for charges not covered by this assignment.

I/We understand that I/we personally guarantee to be financially responsible to pay J. Schlesinger and Associates, P.A. for any and all charges not covered by this Assignment.

I/We understand that if this account is assigned to an attorney or collection agency for collection and/or suit, J. Schlesinger and Associates, P.A. is entitled to an additional thirty three percent (33%) of account balance for attorney's fees and cost of collection.

I/We hereby agree that the statute of limitations with respect to any claim for services provided will not begin until there is a denial in writing by me of any balance, claimed to be due and owing to J. Schlesinger and Associates, P.A..

As a Guarantor, I fully accept the medical services provided to the above-named patient as full consideration for my signing of this document.

I/We have read this document and execute it with full knowledge and understanding of its content.

I authorize J. Schlesinger and Associates, P.A. to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____ _____

Patient/Legal Guardian Date Witness Date