Cascade Dizziness & Balance PT

PATIENT REGISTRATION – PLEASE PRINT CLEARLY

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Social Security # _____

Gender: Female Male Marital Status: Married Single Other _____

Employer _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Referring Provider: _____

Primary Care Provider: _____

INSURANCE INFORMATION—PLEASE PROVIDE INSURANCE CARDS FOR COPYING

Patient's Relationship to Insured: Self / Spouse / Child / Dependent

If Insured is not the patient, please complete this section

Name of Insured _____
(Subscriber Name) Last First Middle Initial

Birthdate: _____ Gender: Male/Female

Patient's Relationship to Insured: Self / Spouse / Child / Dependent

Insured Address: _____

_____

Employer: _____

Cascade Dizziness & Balance PT

We thank you very much for your assistance. This completed form will provide both you and our billing department with important information regarding your physical therapy insurance benefits, and enable us to process your claim in a timely basis.

Please note that co-pays are collected at the time of visit.

Patient's or authorized person's signature:

- I authorize the release of any medical records or other information necessary to process this claim.
- I authorize payment of medical benefits to Cascade Dizziness Physical Therapy PLLC.
- I am financially responsible for any balance due.

Signed _____ Date _____

For scheduling and contact purposes, we would like to know your preferences on different means of communication.

Please check the appropriate boxes for which you authorize:

☐ I authorize the office to leave detailed messages on my answering machine on the phone number provided

☐ I authorize appointment reminder text messages to be sent to the cell phone number provided.

Signed _____ Date _____

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Consent for Care and Financial Agreement

I (patient or legal guardian of minor patient) grant permission for licensed physical therapists at Cascade Dizziness Physical Therapy PLLC to perform such examinations and therapeutic procedures as may be professionally necessary or advisable for appropriate evaluation and treatment of my condition.

As permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the release of any and all medical information to my physician(s) and other healthcare providers as may be necessary for communication regarding my care. Additional person I would like my health information to be made accessible to are noted below.

As permitted by HIPAA, I authorize the release of any and all medical records to my insurance company at their request. Other release is subject to my written consent.

I understand that all treatment fees are to be paid at the time of service unless other billing arrangements are made with Cascade Dizziness Physical Therapy PLLC. We are a preferred provider with most major insurance companies. In cases where your insurance is not billed or Cascade Dizziness Physical Therapy is not a preferred provider, Cascade Dizziness Physical Therapy will provide, on request, a superbill receipt that you may use to submit to your insurance carrier and/or keep for your personal records.

If my insurance company (or other responsible party) rejects payment or shows that a portion is the responsibility of the patient, I agree to make full payment within 30 days of the first billing unless other arrangement are mutually agreed upon. Exception will be made in cases where Cascade Dizziness Physical Therapy has a contract with the insurer which precludes this.

I request that all fees paid by my insurance company or other party be paid directly to Cascade Dizziness Physical Therapy. **Co-pays are due at the time of service.**

I authorize the following persons to have access to my health information:

_____

_____

- I have read and understand the above policy.
- I have received, read and understand my privacy rights and practices (HIPAA)

Signature _____ Date: _____

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Cancellation/No Show Policy

In order to provide the best care possible to all our patients, we ask that you abide by our cancellation policy. If you have any questions about the policy, please speak with your therapist.

Thank you for your consideration in the matter.

- Cancellations must be made **24 business hours** before your appointment. (Monday appointments must be cancelled by Friday)
- Cancellations by email are **not** accepted. Cancellations may be made by leaving a voicemail message. If you scheduled your appointment online, you can also use that system to cancel your appointments as well.
- Cancellation fees are **$50 per appointment.**
- If you no-show 2 times, all future appointments will be cancelled.
- These charges cannot be billed to insurance. Special circumstances, such as illness and emergencies, will be handled on a case-by-case basis. If you wish to dispute a cancellation fee, please consult with your therapist at your next appointment.

Signature: _____ Date: _____

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General Health Questionnaire

Date: _____

Patient: _____ Age: _____

Diagnosis/Primary Symptom: _____

Other Healthcare Providers Who Have Consulted on This Problem: _____

Please describe your current problem that has brought you to PT: _____

_____

_____

Please indicate any diagnostic tests (MRIs, calorics, etc) that have been done for this problem:

_____

_____

Please complete this questionnaire so that we may provide you with the best possible care. Please check all that apply and comment below as necessary.

Medical History

- ❑Allergies
- ❑Anemia
- ❑Anxiety
- ❑Arthritis
- ❑Autoimmune Disorder
- ❑Cancer
- ❑Cardiac Conditions
- ❑Cardiac Pacemaker
- ❑Chemical Dependency
- ❑Circulation Problems
- ❑Currently Pregnant
- ❑Depression
- ❑Diabetes
- ❑Dizzy Spells
- ❑Emphysema/ Bronchitis
- ❑Fibromyalgia
- ❑Fractures
- ❑Gallbladder Problems
- ❑Headaches
- ❑Hearing Impairment
- ❑Hepatitis
- ❑High Cholesterol
- ❑High/ Low Blood Pressure
- ❑HIV/ AIDS
- ❑Incontinence
- ❑Kidney Problems
- ❑Metal Implants
- ❑MRSA
- ❑Multiple Sclerosis
- ❑Muscular Disease
- ❑Osteoporosis
- ❑Parkinson's
- ❑Rheumatoid Arthritis
- ❑Seizures
- ❑Smoking
- ❑Speech Problems
- ❑Strokes
- ❑Thyroid Disease
- ❑Tuberculosis
- ❑Vision Problems
- ❑PTSD

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Within the past year, have you experienced any of the following symptoms?

❑Chest pain
❑Heart palpitations
❑Unexplained cough
❑Shortness of breath
❑Dizziness or blackouts
❑Coordination problems
❑Loss of balance
❑Difficulty walking
❑Joint pain/swelling
❑Pain at night
❑Difficulty sleeping
❑Loss of appetite
❑Nausea/vomiting
❑Bowel problems
❑Weight loss/gain
❑Urinary problems
❑Weakness in arms or legs
❑Headaches
❑Hearing changes
❑Vision changes
❑Numbness/tingling _____
❑Other_____

Living Information

Does your home have: □stairs □railing □uneven terrain □other concerning obstacles_____
Do you use: □cane □walker □wheelchair □crutches □other assistive devices_____
Do you live: □alone □with a spouse/partner □with a roommate □other _____

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ If so, how much? _____

Do you exercise? _____ If so, how often? _____

For women, is there a chance you are pregnant? _____

Do you have any orthopedic injuries/problems? _____

_____

Please list any surgeries or hospitalizations: _____

_____

Please list any medications/supplements you are taking <u>with dosages and frequency</u>:

_____

_____

_____

Any additional comments or information that would be helpful to your therapist:

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Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes" or "no" or "sometimes" to each question. Answer each question as it pertains to your dizziness or unsteadiness only.

Item	Question		Yes	No	Sometimes
1.	Does looking up increase your problem?	P			
2.	Because of your problem, do you feel frustrated?	E			
3.	Because of your problem, do you restrict your travel for business or recreation?	F			
4.	Does walking down the aisle of a supermarket increase your problem?	P			
5.	Because of your problem, do you have difficulty getting in and out of bed?	F			
6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties?	F			
7.	Because of your problem, do you have difficulty reading?	F			
8.	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	E			
10.	Because of your problem, are you embarrassed in front of others?	E			
11.	Do quick movements of your head increase your problem?	P			
12.	Because of your problem, do you avoid heights?	F			
13.	Does turning over in bed increase your problem?	P			
14.	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	F			
15.	Because of your problem, are you afraid people may think you are intoxicated?	E			
16.	Because of your problem, is it difficult for you to walk by yourself?	F			
17.	Does walking down a sidewalk increase your problem?	P			
18.	Because of your problem is it difficult for you to concentrate?	E			
19.	Because of your problem, it is difficult for you to walking around your house in the dark?	F			
20.	Because of your problem, are you afraid to stay home alone?	E			
21.	Because of your problem, do you feel handicapped?	E			
22.	Has your problem placed stress on your relationships with members of your family or friends?	E			
23.	Because of your problem, are you depressed?	E			
24.	Does your problem interfere with your job or household responsibilities?	F			
25.	Does bending over increase your problem?	P			
			X4	X0	X2
	Total				

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The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants:
For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale form 0% to 100%, with 0% equal to "no confidence" and 100% equal to "completely confident". If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as it you were using these supports. If you have any questions about answering any of these items, please ask your physical therapist.

"How confident are you that you will not lose your balance or become unsteady when you…

1. walk around the house? ___%
2. walk up or down stairs? ___%
3. bend over and pick up a slipper from the front of a closet floor ___%
4. reach for a small can off a shelf at eye level? ___%
5. stand on your tiptoes and reach for something above your head? ___%
6. stand on a chair and reach for something? ___%
7. sweep the floor? ___%
8. walk outside the house to a car parked in the driveway? ___%
9. get into or out of a car? ___%
10. walk across a parking lot to the mall? ___%
11. walk up or down a ramp? ___%
12. walk in a crowded mall where people rapidly walk past you? ___%
13. are bumped into by people as you walk through the mall? ___%
14. step onto or off an escalator while you are holding onto a railing? ___%
15. step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ___%
16. walk outside on icy sidewalks? ___%

Total: ___ %

*Powell, LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. *J Gerontol Med Sci* 1995; 50(1): M28-34

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VESTIBULAR SYMPTOMS

Please circle all the words that describe your symptoms/feelings

Reeling	Whirling	Catch up vision
Giddy	Undulating	Visual disturbance
Tinnitus/Ringing	Ear pain/pressure	Pain
Warm	Anxious	Falling
Unable to concentrate	Floating	Sick
Off balance/unsteady	Dazed	Confused
Clumsy	Fluttering	Heavy headed
Nausea	Swimmy headed	Spinning
Swaying	Disoriented	Blurred Vision
Headache	Weak	Jumpy vision
Listing	Fuzzy headed	Vertigo
Head rush	Drunk	Faint
Vomiting	Foggy headed	Lightheaded
Staggering	Fatigued	Light sensitive

Other Symptoms: _____

Are your symptoms constant or intermittent?

SECONDS MINUTES HOURS DAYS