MEDICATION LIST

Patient Name:_____

Use the chart below to list all **brand-name** and **generic prescription** medications you currently take. Please also include any **over-the-counter vitamins/supplements**. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the label in milligrams (mg). This is called the dose, or strength. The label on liquids and shots lists the dose. Please notify your PT of any changes in this list.

Medication/Vitamin Name	**Dose** (such as 2 mg, 1tsp)	**Method**	**How Often** (such as 3x/day)

The above medications have been discussed and reviewed with the patient by their PT at 1st Visit:

Physical Therapist Signature: _____ Date: _____

The above medications have been discussed and reviewed with the patient by their PT at re-evaluation or 10th visit:

Physical Therapist Signature: _____ Date: _____

Medicare Notice

Effective January 1, 2023 Medicare has changed the coverage of Physical Therapy/Occupational Therapy services delivered in an outpatient setting. The Part B deductible is now $226 per calendar year. Medicare covers only certain procedures and therefore may not cover all of your healthcare costs.

- **Medicare pays 80% of the allowed amount and the beneficiary pays 20% up to $2,230.00, at which point your Physical Therapist/Occupational Therapist must justify medical necessity. Therapy services beyond $3,000 per calendar year are subject to medical review.**

- **Medicare will not pay for both home health care and outpatient therapy simultaneously.**

_____ I certify that I currently do not have home health care/have been discharged from any previous home health care treatments.

This form acknowledges that you are aware of the fact that you may be held financially responsible should Medicare not pay for your Physical/Occupational Therapy expenses. At some point in your treatment, you may be required to sign an ABN form. As you progress in your treatment, you, your therapist and your physician must prove medical necessity to Medicare in order to continue treatment.

_____ _____

Signature of Beneficiary **Date**

Endurance Rehabilitation

Patient History

Patient Name: _____ Preferred Name:_____

Today's Date: _____Age: _____ Height: _____ Weight: _____

E-Mail Address: _____

How would you prefer our front office reach out to you? TEXT CALL

How would you prefer your therapist to contact you? EMAIL PHONE

How would you like appointment reminders? TEXT EMAIL NONE

If you'd like text reminder, please provide your cell phone provider: _____

All home exercise programs will be emailed

If you would like to authorize us to speak to someone about your care here please provide their info below:

Name: _____DOB:_____ Phone Number: _____

How did you hear about Endurance Rehab?

- ☐ Internet
- ☐ Physician: _____
- ☐ Sport Club: _____
- ☐ Insurance
- ☐ Friend: _____
- ☐ Other: _____
- ☐ Radio
- ☐ Store: _____

Did a physician refer you for this injury? YES NO If yes, who?: _____

If yes, when is your next follow-up appointment? _____

Please check any conditions/symptoms listed below that you have had in the past or are currently experiencing:

- ☐ Thyroid problems
- ☐ Hernia
- ☐ Cancer
- ☐ Headaches
- ☐ Migraines
- ☐ Neck stiffness
- ☐ Muscle spasms
- ☐ Muscle cramps
- ☐ Painful joints
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Multiple sclerosis
- ☐ Chills
- ☐ Weakness
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fainting
- ☐ Seizures/Epilepsy
- ☐ Facial pain/numbness
- ☐ Vision deficits
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Jaw pain
- ☐ Heat/cold intolerance
- ☐ Poor wound healing
- ☐ Diabetes
- ☐ Circulation problems
- ☐ Kidney problems
- ☐ UTI
- ☐ Asthma
- ☐ Emphysema
- ☐ Pain when breathing
- ☐ Shortness of breath
- ☐ Angina
- ☐ Heart attack
- ☐ High Blood pressure
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Abnormal Heartbeat
- ☐ Stroke
- ☐ Anemia
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of sleep
- ☐ Allergies

For any of the above conditions/symptoms that you marked, please explain:

_____

_____

Please list any medications you are taking:

_____

_____

_____

Please list any surgeries you have had (including dates):

_____

_____

_____

_____

_____

_____

Are you allergic to latex? YES NO
Are you taking a blood thinner? YES NO
Do you smoke? YES NO

FEMALES
Could you be or are you pregnant? YES NO

Please BRIEFLY describe why we are seeing you: _____

_____

I attest that the information provided above is true:

Printed Name: _____

Patient or Parent/Guardian Signature: _____ Date: _____

Patient Rights & Responsibilities
Consent for Treatment Medical Release

I, _____, hereby authorize Endurance Rehabilitation and/or its licensed medical professionals and such assistants to render any and all medical care deemed necessary and any additional care and supplies that are recommended.

Assignment of Benefits
I authorize Endurance Rehabilitation to process claims related to my personal health or other insurance for covered services rendered to me. I also assign and authorize payment from said insurance carrier to be paid directly to Endurance Rehabilitation rendered on my behalf.

Financial Obligation
Endurance Rehabilitation requires that all co-pays, co-insurances and deductibles be paid at the time of service. Failure to maintain a current patient account may result in the placement of your account with an outside agency for Collection.

Medical Record Release
This will authorize Endurance Rehabilitation to release any general, medical, as well as Psychiatric/Psychological, drug/alcohol, and HIV testing information from my health records, per patient's request.

Third Party Liability
Endurance Rehabilitation does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement, judgment, or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered.

Circumstantial Risk
I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

Cancellation/No Show Policy
When canceling your appointment due to scheduling conflicts we ask that you please do so by 4:00 the day prior. In high traffic times we keep a waiting list of patients that would like to have your spot if it is available. If you are unable to cancel your appointment by 4:00 pm the prior day, or if you are unable to make your appointment and do call us, you will be charged a $25 fee.

I have reviewed and understand the Patient History, Patient Rights & Responsibilities, Consent For Treatment, Financial Responsibility, Medical Release, Cancellation/No Show Policy, and HIPAA Privacy Notice. A copy of the aforementioned paperwork will be provided upon request.

Print Patient's Name: _____

_____ _____

Patient or Parent/Guardian Signature **Date**

SERVICES we provide that are NOT typically covered by insurance:

To be cost transparent, we are providing a list of services that are typically NOT covered by insurance. If you have any questions or concerns regarding coverage, please do not hesitate to ask our front office or Practice Manager.

Dry Needling with therapy = $25
Dry Needling without therapy session = $65
Taping Session = $10
Wellness WITH boots= $85
Wellness WITHOUT Boots= $65
Recovery boots ONLY = punch card $90 for 10 or $10 /session
Iontophoresis = $20
Traction ONLY = $25

Supplies (that may be part of treatment session)

Electrical Stim Pads = $5 (MOST COMMON)
Tape Roll (after one prior trial of taping) = $20

We also have various supplies available for purchase (see posting at desk)

Please initial here that you understand that you will be charged for any of the above referenced services or supplies only if you need or request them!

PATIENT INITIALS HERE: _____

Print Name _____ Date _____

BRIEF PAIN INVENTORY

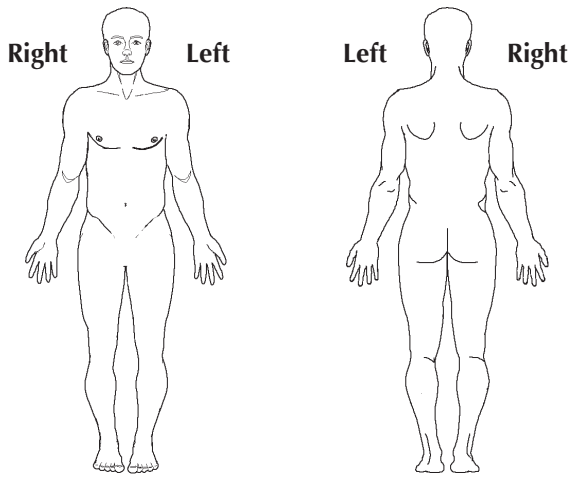
Date_____/_____/_____ Time:_____

Name:_____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10	20	30	40	50	60	70	80	90	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Brief Pain Inventory (Short Form). Source: Pain Research Group, Department of Neuro-Oncology, The University of Texas MD Anderson Cancer Center. Used with permission. Adapted to single page format.

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

Do you have any other symptoms? Circle any that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____

_____

_____

Provided as an educational service by ENDO PHARMACEUTICALS

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