

MUNGER

PHYSICAL THERAPY

We would like to personally thank you for choosing us to serve you for your physical therapy needs. Our team takes pride in offering a professional and friendly environment for you to rehabilitate. Our goal is to create a safe and comfortable environment for all to heal using the most up-to-date and advanced treatment techniques to provide a quick recovery.

If you have any questions regarding physical therapy one of our licensed therapist would be happy to speak with you. Please call the front desk to arrange this. Any questions regarding billing can be addressed to Judy at the Fort Gratiot location. Any other business inquiries can be addressed to the business manager, *Julie Munger*.

Before your first visit there are a few things we would like you to be aware of:

- If you are coming to be evaluated for the neck or shoulder, please consider a tank top or sports bra so we have access to your shoulder and neck.
- If you are coming to be evaluated for you low back, hips, knees, or feet please bring loose fitting shorts (If you do not have them, we can provide them for you).
- The first visit will last about an hour and will include a thorough examination, a functional report survey, and in many cases exercises to be done at home.
- A physical therapy program may last 4-6 weeks based on your need, so bring your calendar to set up appointments.
- Remember your prescription for your physical therapy if you have one, an updated health history form, current medication list, your insurance card and a current ID.
- Please arrive 15 minutes early.

We look forward to working with you to achieve your goals

Jim Achatz PT, MPT, Cred. MDT, CMP, CIDN

Clinton Township
44925 Morley Drive
Clinton Township, MI 48036
(586) 846-4320

Markus Munger PT, Cred. MDT

Fort Gratiot
4351 24th Ave. Suite 5
Fort Gratiot, MI 4805
(810) 385-7405

PLEASE FILL OUT COMPLETELY

New Patient Information			
Full Legal Name:			
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell:	
SS#:	E-Mail Address:		
Date of Birth:	Age:	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Marital Status:	<input type="checkbox"/> S	<input type="checkbox"/> M	<input type="checkbox"/> D <input type="checkbox"/> W
How did you hear about us?			
Have you had therapy before in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No: If yes, describe:			
Have you received Home Care in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No: If yes, what was your date of discharge?			
Emergency Contact:		Phone:	
Reason for Therapy:	Surgery Date:	Date of Onset:	
Physicians Name:		Last Seen:	
Responsible Party:		Relationship:	
Address:	City:	Phone:	
Employer:	Occupation:		
Primary Insurance:	Insured Name:	D.O.B:	
Group #:	ID#:	Insured Employer:	
Relationship to Insured:	Sex:	<input type="checkbox"/> M	<input type="checkbox"/> F
Secondary Insurance:	Insured Name:	D.O.B:	
Group #:	ID#:	Insured Employer:	
Relationship to Insured:	Sex:	<input type="checkbox"/> M	<input type="checkbox"/> F

New Patient Information

Patient Name: _____

Date of Birth: _____

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> Visual Impairments <input type="checkbox"/> Heart Condition <ul style="list-style-type: none"> <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Atherosclerotic Disease CAD <input type="checkbox"/> Angioplasty <input type="checkbox"/> Valvular Disease <input type="checkbox"/> Stents <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Coronary Artery Bypass <input type="checkbox"/> Graft <ul style="list-style-type: none"> <input type="checkbox"/> Angina <input type="checkbox"/> Pacemaker <input type="checkbox"/> Stroke <input type="checkbox"/> Peripheral Artery Disease | <ul style="list-style-type: none"> <input type="checkbox"/> High Blood Pressure <ul style="list-style-type: none"> <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Diabetes <ul style="list-style-type: none"> <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Fractures <input type="checkbox"/> Headaches <input type="checkbox"/> Hepatitis/HIV/AIDS <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Prior Surgeries <input type="checkbox"/> Recent Pneumonia <input type="checkbox"/> Neurological diseases | <ul style="list-style-type: none"> <input type="checkbox"/> Back pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Anxiety or Panic Attacks <input type="checkbox"/> Kidney problems <input type="checkbox"/> Incontinence <input type="checkbox"/> Respiratory Problems <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <ul style="list-style-type: none"> <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled <input type="checkbox"/> COPD <ul style="list-style-type: none"> <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Seizures <ul style="list-style-type: none"> <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Allergies |
|--|--|--|

If checked any above, explain: _____

What specific activities are you having difficulty with? _____

What are your personal goals you hope to achieve from therapy? _____

Have you had prior Physical/Occupational Therapy for this condition? YES NO

What was done, what were the results?

Authorization/Consent

Patient Name: _____

Date of Birth: _____

Please Initial Each as Applicable:

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Munger Physical Therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature.

INIT: _____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

INIT: _____

LIABILITY: I know and agree that Munger Physical Therapy is not responsible for loss or damage to personal valuables.

INIT: _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Munger Physical Therapy, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

INIT: _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Munger Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice and Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

INIT: _____

CANCELLATION NOTICE: Failure to give a 24-hour notice for a cancelled appointment will result in a no show fee.

INIT: _____

NOTICE OF PRIVACY: Is Accessible for viewing.

INIT: _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____

Date: _____

Witness Signature _____

Date: _____

