"We treat you like family"

LOW COUNTRY
Physical Therapy

Voted "Best Physical Therapy Center" by the Myrtle Beach Herald

Welcome to Low Country Physical Therapy,

Your appointment is scheduled on _____ ____/ ___/ ___ at ____:____AM/PM.

It is the mission of Low Country Physical Therapy and its staff to provide therapeutic and restorative services to patients for the rehabilitation of injured, disabled, or sick; to assist each patient in reaching his/her maximum performance so he/she may resume his/her rightful place in the society while learning to live within the limits of his/her capabilities. Low Country Physical Therapy shall provide state-of-the-art health care that strives to significantly improve the well being of each patient, while recognizing their capacity of being responsible for their own health.

All patient co-pays and balances are due prior to treatment. We accept the following forms of payment: cash, check, Visa, MasterCard, Discover, and American Express.

Enclosed you will find your new patient paperwork you will need to complete in blue or black ink only, and bring with you the day of your appointment. Make sure you also bring the following items:

1. **Driver's license**
2. **Insurance card(s)**
3. **A current list of medications including anything that is over the counter with the milligrams, how many times a day you take each one, how each one is taken, and the reason you are taking each medication**.

If your physician has given you the script for your therapy, it is necessary for you to bring this with you as well, as some insurance companies will not allow us to treat you without it.

You should wear something comfortable so the therapist will be able to access the individual body part(s) necessary for your treatment. We have included a map with directions on the back of this page. If you have any questions please call us at (843)651-6565 or (843)314-3980.

We look forward to treating you and helping you reach the goals set forth by you, your physician, and your therapist.

Thank you,
Low Country Physical Therapy

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Two Convenient Locations!

Garden City Office
2586 Hwy. 17 Business
Garden City Beach, SC 29576
p: 843.651.6565
f: 843.651.6575

Directions:
Located on west side of Business17 between Glenns Bay Rd. in Surfside Beach and the Garden City Connector, opposite St. Michael's Catholic Church.

Litchfield Office
267 Willowbrook Blvd. Suite D
Pawleys Island, SC 29585
p: 843.314.3980
f: 843.314.3979

Directions:
Continue south on Business17 or Ocean Blvd. Turn right onto Willbrook Blvd. Office is on the left, the 3rd entrance into Mingo Plaza next to Quigley's Pint & Plate.

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Patient Information:

Verified DL: ☐ Yes ☐ No

Last Name: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: E-mail Address:

Date of Birth: SSN: Sex: ☐ Male ☐ Female Marital Status:

I would like to receive appointment reminders by: ☐ Text Message ☐ E-mail

**By giving my e-mail address or cell phone number, I agree to receive appointment reminders and any business updates from LCPT*

Employer Information:

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

How did you hear about LCPT? What Source? ☐ Past Patient ☐ Referral from MD ☐ Insurance Co. ☐ Facebook

☐ Google ☐ Instagram ☐ Website ☐ Referred by friend ☐ Other: _____

Emergency Contact Information:

Contact Name:_____ Phone Number: Cell: _____Home:_____

Relationship to Patient:_____

Emergency contact is permitted to discuss the medical conditions of the patient: ☐ Yes ☐ No

Physician Information:

Name of Referring Physician:_____ Family Doctor_____

Additional Questions: ☐ Auto Related Date of Accident: _____/_____/_____ State it happened: _____

☐ Work Related Date of Injury: _____/_____/_____ State it happened: _____

COMMERCIAL AND MEDICAID INSURANCES ONLY:

Have you received PT, OT, Speech Therapy, Chiropractic and/or any type of Massage Therapy services this year and or last year? ☐ Yes ☐ No

If yes, name of facility_____

If yes, when? and how many visits? _____

MEDICARE ONLY - Additional Questions

If Medicare, are you currently receiving Home Health Services? ☐ Yes ☐ No

If yes, name of Agency _____

If yes, what type of Home Health Services are you receiving? _____

Last date of service: _____/_____/_____

Are you currently residing in a skilled Nursing Facility? ☐ Yes ☐ No

If yes, facility name: _____

If Medicare, have you received PT, OT, or Speech Therapy, Chiropractic and/or any type of Massage Therapy services since the first of the year? ☐ Yes ☐ No If yes, circle all that apply: PT OT Speech Chiropractic Massage Therapy

Where did you receive therapy services?_____How many visits did you have? _____

If yes, do you know if you have exceeded your Medicare Therapy Threshold Amount? ☐ Yes ☐ No

(Please continue on reverse side)

Primary Insurance: _____

_____

Secondary Insurance: _____

_____

I have read and understand Low Country Physical Therapy's privacy notice. I further understand that I may obtain a copy of the HIPAA privacy notice for LCPT upon my request. ☐ Yes ☐ No

I consent to Low Country Physical Therapy for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Low Country Physical Therapy to exchange with and or release requested information on my medical care to my insurance carrier(s) and to:

☐ Workers Compensation ☐ Patient/Guardian ☐ Attorney

COVID-19 Liability Release Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Low Country Physical Therapy has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19. I further acknowledge that Low Country Physical Therapy can not guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, and other Low Country Physical Therapy clients and their families. I voluntarily seek services provided by Low Country Physical Therapy and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non contagious by state or local public health authorities.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Low Country Physical Therapy harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the facility, or that may otherwise arise in any way in connection with any services received from Low Country Physical Therapy.

Patient Signature: _____ Date: _____/_____/_____

_____ Date: _____/_____/_____

Responsible Party's Signature (if patient is a minor)

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Date: _____/_____/_____

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Patient Name: _____ **Referring Physician:** _____

What is your main complaint or reason for coming to therapy? _____

_____

_____

When did this condition begin? Date: ___/____/_____ _____

_____

Have you had any tests or surgery for this condition? ❑ Yes ❑ No

❑ X-Ray ❑ MRI ❑ Surgery ❑ Other

What Doctor ordered the tests/did your surgery? _____ **Date:**___/____/_____

What are you having difficulty doing because of this condition? _____

_____

_____

What relieves your symptoms? ❑ Medication ❑ Heat ❑ Ice ❑ Other: _____

_____

What aggravates your symptoms? _____

_____

Numeric Pain Rating

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No Pain Moderate Pain Worst Pain

For BCBS Plans/Office Use Only:

Estim Code: ☐ 97014 ☐ G0283

(Please continue on reverse side)

Past Medical History:

Allergies	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Metal Implants	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Dizzy Spells	❑ Yes	❑ No	MRSA	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Emphysema/Bronchitis	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Muscular Disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No
Autoimmune Disorder	❑ Yes	❑ No	Gallbladder Problems	❑ Yes	❑ No	Parkinsons	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Cardiac Conditions	❑ Yes	❑ No	Hearing Impairment	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Cardiac Pacemaker	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Smoking	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Speech Problems	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No	High/Low Blood Pressure	❑ Yes	❑ No	Strokes	❑ Yes	❑ No
COVID-19	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Currently Pregnant	❑ Yes	❑ No	Incontinence	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No	Vision Problems	❑ Yes	❑ No

Past Surgical History:

Height: _____ Weight: _____

1. _____

2. _____

3. _____

Current Medication List: ❑ **Scanned in chart**

Drug Name Dosage Route (Orally, Injection, Other)

1. _____

2. _____

3. _____

4. _____

5. _____

Fall History:

Any falls in the last 12 months? Yes _____ No _____

If yes, how many? _____ Any injury from the fall? Yes _____ No _____

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Attention: _____ Fax: (_____) _____ - _____

PROTECTED HEALTH INFORMATION RELEASE

Full name:_____ Date of Birth:_____ SS#_____

This will authorize _____ Fax#: (_____) _____ - _____

to disclose my protected health information, as described below to

Low Country Physical Therapy (Garden City)
2586 Hwy 17 Business South
Garden City, SC 29576
Tel: (843)651-6565 Fax: (843)651-6575

_____ Complete Medical Record

_____ Specific Information Only (list)

_____

Low Country Physical Therapy (Pawleys Island)
267 Willbrook Blvd. Suite D
Pawleys Island, SC 29585
Tel: (843)314-3980 Fax: (843) 314-3979

_____ other (describe)

_____

_____

Dates of care included: From _____ to _____

I understand that I may inspect or copy the protected health information described by this authorization. I understand that this authorization may be revoked in writing by me and delivered to the Privacy Contact of your organization at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality. ·

Date: _____

Patient Signature or Authorized Representative:_____

Relationship to Patient:_____

EXPIRATION DATE: This authorization will expire on (date or event)_____/_____/_____(If no date or event is stated, expiration is six (6) months from the date signed).