Internet–Based Home Exercise Program

Studies show that following a home exercise program shortens recovery time. Our office uses WebExercises® to help you at home. You can easily access WebExercises® with your regular email and you will not receive unsolicited email from us or WebExercises®. Regular email is not protected by a security process called encryption so please understand there is some level of risk that information in any regular email can be read by someone besides you.
In order to get access to WebExercises® through your regular email, please check box 1 and provide your email address. If you only want to receive exercise handouts check box 2. Please sign and date this form.

1. ☐ Yes. I prefer to participate in the WebExercises® online program using my regular email. Please use the following email address:

   ____

   I will let you know right away if my email address changes.

2. ☐ I prefer to receive exercise handouts only.

Name: ____

Signed: ________________________________ Date ____________

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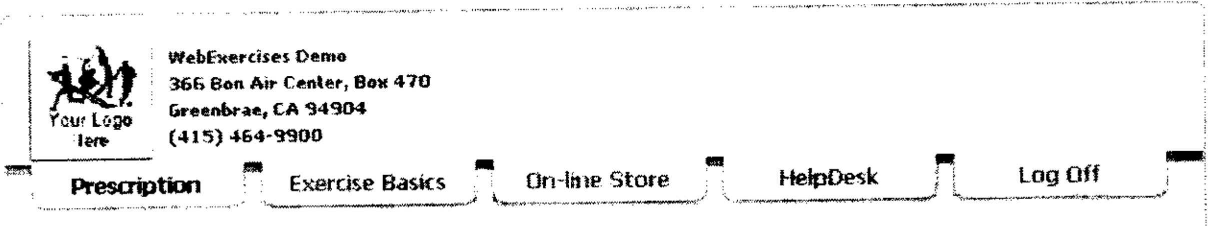
Dear Patients,

Our office utilizes WebExercises® online rehabilitation system to assist in your home care. Studies show recovery times are shorter when participating in a home exercise program. WebExercises® provides web-based online instruction and streaming video demonstration of your personalized exercise prescription. No special software or downloads are required. The information below will familiarize you with this online system.

You will receive an email from patientcare@webexercises.com containing: your username, password and a website link to access your exercise prescription. Please write your password down and keep it in a safe place. If you lose or forget your password your healthcare provider can re-email it to you.



After opening your email and logging in, the **Prescription** page will display your current exercise prescription. Select the **Exercise Basics** tab to learn useful exercise information and tips. If your exercises require equipment, it may be ordered directly through our **On-line Store**. Please refer to the **HelpDesk** tab if you need to download QuickTime player to watch your exercises in streaming video.

Rx Detail: 10117 for Allegro, April

Rx Date 12/27/2006 **Comments** Rotator Cuff Strengthening Exercises

Duration 2 week(s)

End Date 01/10/2007

Code	Exercise Name	Sets	Reps	Hold	Rest	Freq		
1 SH302	Rotator Cuff External Rotation	3	10	0	30	3x/week		View Print
		Comments:						
2 SH304	Rotator Cuff Internal Rotation	3	10	0	30	3x/week		View Print
		Comments:						
3 SH306	Scaption with Resistance Band	3	10	0	30	3x/week		View Print
		Comments:						
4 SH314	Abduction and Flexion	3	10	0	30	3x/week		View Print
		Comments:						

Print Summary | Print All

Your prescription contains important information and special instructions. The **Sets, Repetitions, Hold, Rest,** and **Frequency** for each exercise are provided. Select the **View** button to display a full page version of each exercise that includes **Rehabilitation Level, Muscles** involved, **Benefits** and a **Streaming Video** option. Select the **Print** button to take a copy with you on the road or when you are at the gym. The printed version also includes a calendar to keep you on track. The **Print Summary** displays a one-page overview of your prescription. If you have question regarding your exercise prescription, please contact your healthcare provider by telephone.

DELTA/FILLMORE PHYSICAL THERAPY & SPORTS MEDICINE

95 S White Sage Ave, Suite C
Delta, UT 84624
(435)864-2551

674 S Highway 99
Fillmore, UT 84631
(435)743-6100

Date________________

Patient____ Date of Birth ____/____/____

Social Security Number_____-_____-_______ Sex: M F

Mailing Address______________________________ City______________ State ________ Zip Code____________

Street Address______________________________ City______________ State________ Zip Code____________

Home Phone ________________________ Cell Phone ______________________

Email Address____

Preferred Contact: ☐ Home ☐ Cell ☐ Email ☐ Mail

Emergency Contact ______________________________ **Phone Number** ______________________

How were you referred to us: ☐ Walk In ☐ Doctor Referral ☐ Ad ☐ Mail ☐ Internet ☐ Friend______________________ ☐ Other______________________

In accordance with the Health Insurance Protability and Accountability Act of 1996 (HIPPA), we ask that you provide the name and date of birth of family members we may discuss your treatment, condition(s), and/or billing information with:

____

____

RESPONSIBLE PARTY INFORMATION ☐ Self ☐ Relationship to Patient:______________________

Name____

Mailing Address______________________________ City______________ State_______ Zip Code____________

Social Security Number _____-_____-_______ Phone Number__________________

Occupation/Employer of Responsible Party____

Business Address______________________________ Business Phone Number______________

INSURANCE INFORMATION ☐Medical ☐Workers Comp ☐Auto **Injury Date**______________

PRIMARY INSURANCE

Insurance Name________________________

Policy Holder__________________________

Policy Holder Birthday_____/_____/_____

Policy Number__________________________

Insurance Phone Number__________________

SECONDARY INSURANCE

Insurance Name________________________

Policy Holder__________________________

Policy Holder Birthday_____/_____/_____

Policy Number__________________________

Insurance Phone Number__________________

Consent of Treatment: On behalf of the patient, consent is hereby given to the facility, its contractors, medical staff, and employees to provide health care services to the patient and to administer physician orders for the benefit of the patient for this visit and any subsequent visits, and it is understood that this consent may be revoked in writing at any time. It is understood that there is a risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such service. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty cases, to obtain seperate consent for some of the services they perform.

Release of Information: The law requires health care providers to make and keep records of your treatment. These records are safeguarded by the facility. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, subject to applicable law. By receiving services at this facility, you agree to the release of medical record information for the uses specified above. You also agree to the release of claims related information to insurance companies or other third parties to assist in paying your health care costs.

Our clinic will occasionally use photographic documentation to track progress and status. This documentation will be placed in your electronic file and used for billing and may be released to your physician if requested. By signing below, you acknowledge and consent to this type of documentation.

Assignment of Benefits: The patient and the undersigned, if other than the patient, do hereby authorize carrier(s) to pay directly to Delta/Fillmore Physical Therapy and Sports Medicine Clinic, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions.

Terms: A finance charge of $10.00 will be added to the unpaid balance monthly if your account should age past 75 days without any payments or arrangements made with Office Manager. Should collection become necessary, the responsible party agrees to pay an additional 50% collection fee, and legal fees of collection, with or without suit, including attorney fees and court costs.

Our clinic offers a **bi-monthly newsletter** to help keep our patients up to date with events happening at our clinic. It is also to help keep you informed about the lastest research and happenings in the field of Physical Therapy. When you enter your email above we will sign you up for this free service.

______________________________ ______________________

Signature of Insured/Guardian **Date**

Health History/Review of Systems

Date________________
Patient Name______________________________________ **Sex: M / F**

Date of Birth _____/_____/_______
Height:__________ **Weight:**________

Patient Health History

	Yes	No
Asthma	( )	( )
Stroke	( )	( )
Heart Trouble	( )	( )
High Blood Pressure	( )	( )
Diabetes	( )	( )
Arthritis	( )	( )
Gout	( )	( )
Seizures	( )	( )
Mental Illness	( )	( )
Kidney Trouble/Stones	( )	( )
Cancer	( )	( )
Bleeding Disorders	( )	( )
Alcoholism	( )	( )
Serious Injury	( )	( )
Lung Disease	( )	( )
Tuberculosis	( )	( )
Phlebitis	( )	( )
Anemia	( )	( )
Stomach Ulcers	( )	( )
Liver Trouble	( )	( )
Thyroid Trouble	( )	( )
Other Illnesses	( )	( )

Explain all Yes answers:

____
____
____
____
____
____

Surgical Procedures (include dates)

____
____
____
____
____

Current Medications/Dosages (Including Over the Counter)

____
____
____
____
____

Allergies **None ( )**

____
____
____
____
____

Family History

	Yes	No
Stroke	( )	( )
Heart Trouble	( )	( )
High Blood Pressure	( )	( )
Diabetes	( )	( )
Arthritis	( )	( )
Gout	( )	( )
Seizures	( )	( )
Mental Illness	( )	( )
Kidney Trouble/Stones	( )	( )
Cancer	( )	( )
Bleeding Disorders	( )	( )
Alcoholism	( )	( )
Other	( )	( )

Explain all Yes answers:

____
____
____
____
____
____

Cause of Death of Parents, Brothers, Sisters:

____
____
____
____
____

Social History

Most Recent Occupation

____
____

Number of Pregnancies ________
Number of Children Living______

Presently Living Alone: YES NO

Smoke_______Packs per Day

Alcohol: Never ( ) Occasional ( )
Moderate to Heavy ( )

Drug Overuse: None ( )
Presently ( ) Past Problem ( )

Review of Systems

Have you recently had or do you now have:

	Yes	No
Reading Glasses	( )	( )
Change of Vision	( )	( )
Loss of Hearing	( )	( )
Ear Pain	( )	( )
Hoarseness	( )	( )
Nose Bleeds	( )	( )
Difficulty Walking	( )	( )
Morning Cough	( )	( )
Shortness of Breath	( )	( )
Chills or Fever	( )	( )
Heart or Chest Pain	( )	( )
Abnormal Heartbeat	( )	( )
Badly Swollen Ankles	( )	( )
Calf Cramps w/ Walking	( )	( )
Poor Appetite	( )	( )
Toothache	( )	( )
Gum Trouble	( )	( )
Nausea or Vomiting	( )	( )
Stomach Pain	( )	( )
Ulcers	( )	( )
Frequent Belching	( )	( )
Frequent Loose Bowel Mvmt	( )	( )
Blood in Bowel Mvmt	( )	( )
Frequent Constipation	( )	( )
Hemorrhoids	( )	( )
Frequent Urination	( )	( )
Burning with Urination	( )	( )
Difficulty Starting Urination	( )	( )
Difficulty Stopping Urination	( )	( )
Get up Every Night to Urinate	( )	( )
Frequent Rash	( )	( )
Hot or Cold Spells	( )	( )
Recent Weight Change	( )	( )
Nervous Exhaustion	( )	( )
Insomnia	( )	( )
Depression	( )	( )
Nervous Tension	( )	( )
WOMEN ONLY!!	( )	( )
Irregular Periods	( )	( )
Vaginal Discharge	( )	( )
Frequent Spotting	( )	( )

Do you have a pacemaker?	YES	NO
Are you taking any Nitro for any heart condition?	YES	NO
If yes, do you have it with you?	YES	NO
If you have allergies, do you have a prescribed EpiPen?	YES	NO
If yes, do you have it with you?	YES	NO

Patient Specific Functional Scale (PSFS)

Patient Name: ____________________ **Date of Birth:** ____________

Below, please write at least 3 and up to 5 activities that you are unable to do or have difficulty doing due to your current problem. Then, next each activity, write a number that corresponds to your ability to do the activity during the past week.

Scoring: 0 1 2 3 4 5 6 7 8 9 10

Unable to perform (0) — No Difficulty (10)

	Date:				
Activity 1:					
Activity 2:					
Activity 3:					
Activity 4:					
Activity 5:					
Total					

For Therapist Use Only:

SCORE: Sum of individual's numbers, divided by total number of activities.

Patient Specific Function Scale	% Patient Does	Impairment Rating
10	100%	0% impaired
9	90%	1-19% impaired
7-8	70-80%	20-39% impaired
5-6	50-60%	40-59% impaired
3-4	30-40%	60-79% impaired
1-2	10-20%	80-99% impaired
0	0%	100% impaired