Action Physical Therapy and Rehabilitation

MEDICAL HISTORY

Patient Name: _____ Date:_____

Referring Physician: _____ Family Physician:_____

How were you injured?_____

What are we treating you for?_____ Pain level: 1 2 3 4 5 6 7 8 9 10

Date of Injury/Onset:_____ Date of Surgery: _____

Diagnostic Test: (X-rays, MRI, etc.)_____

MEDICATIONS

Anti-inflammatories: _____

Pain Medication: _____

Muscle Relaxers: _____

Other Medications and why: _____

_____

Medical Conditions

___High Blood Pressure	___Blood Clot	___Decreased Balance/Falls
___Diabetes	___Seizures/Epilepsy	___Arthritis
___Coronary Heart Disease	___Infectious Disease	___Osteoporosis
___Heart Attack or Heart Surgery	___Anemia	___Pins/Metal Implants
___Shortness of Breath/Chest Pain	___Vision/Hearing Problems	___Joint Replacement
___Pacemaker	___Dizziness or Fainting	___HIV/AIDS
___Cancer (Chemotherapy/Radiation)	___Pregnant	___Tuberculosis
___Respiratory Problems/ Asthma	___Smoke/Tobacco Use	___Hepatitis A B C
___Stroke	___Hernia	___Incontinence
___Recent Broken Bones	___MVP (mitral valve prolapse)	___Heart Disease
___Vertigo	___ TBI (traumatic brain injury)	___High Cholesterol
___History of Alcohol/Drug Abuse	___Neuropathy	___Hyper/Hypo Thyroid
___Hypoglycemic	___Autoimmune Disease	___Fibromyalgia

Patient/Guardian Signature:_____ **Date:**_____

Therapist Signature: _____ **Date:**_____

GENERAL INFORMATION

Patient Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Age:_____ Social Security #:_____

Sex: Male_____ Female_____ Marital Status: Single_____ Married_____ Divorced_____ Other_____

Employer Name:_____ Employer Phone:_____

Emergency Contact Name:_____ Emergency Phone:_____

Have you had any physical therapy or chiropractic services this year? Yes_____ No____ How many:_____

Are you currently receiving Home Health services for any reason? Yes_____ No_____ Start date:_____

****If you answered <u>NO</u> and Home Health services are being actively provided, <u>the PATIENT will be responsible for charges</u>. A patient is considered Home Health active if any person or persons, who are not immediate family, come to the patients home and engage the patient with any assistance including but not limited to feeding, bathing, ambulating, clothing and cleaning or any up keep of the home. If any activities like this are taking place then you <u>MUST</u> mark <u>YES</u> to the above question.****

PERSON RESPONSIBLE FOR BILL (Parent or guardian if patient is a minor)

Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

CONSENT FOR RELEASE IF INFORMATION AND ASSIGNMENT OF BENEFITS

I certify this information is true and correct to the best of my knowledge. I authorize Action Physical Therapy & Rehabilitation to release information concerning my treatment necessary to process insurance claims and/or to discuss my treatment with other practitioners. I authorize benefits payable to Action Physical Therapy & Rehabilitation for my physical therapy treatments. I am fully aware that I am ultimately responsible for my deductible, co-pay/co-insurance and any other non-covered services.

Signature :_____ Date:_____

How Did you hear about Action Physical Therapy:_____

ACKNOWLEDGEMENT/AUTHORIZATION PAGE
NO SHOW POLICY

I _____have read the Cancellation and No-Show policy for Action Physical Therapy. I do understand the $25 charge is to be paid by me and not the insurance company. I am aware the $25 charge will need to be paid before my next treatment. Please co-operate with us in this regard. We're looking forward to working with you.

Patient Signature: _____ Date:_____

APT Employee _____ Date:_____

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

By signing this form I acknowledge that Action Physical Therapy & Rehabilitation has given me a copy of its Privacy Notice, which explains how my health information will be handed.

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover physical therapy, but Action Physical Therapy & Rehabilitation makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for physical therapy. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in the office. We will do our best to verify your insurance coverage and will bill your insurance company in a timely manner.

PAYMENT ARRANGEMENTS

Deductible, copay/coinsurance is due at time of services. If you are not able to pay at the time of the service, please see the billing office after your first visit to set up pay arrangements. The contract pay plan will require you have a credit/bank card on file for Action Physical Therapy & Rehabilitation to make the agreed amount of payment on the agreed pay date.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

With permission Action Physical Therapy & Rehabilitation may release your health information to a family member or another person involved in your care. For example Action Physical Therapy & Rehabilitation may tell a family member your next scheduled appointment. Although you are not authorizing Action Physical Therapy & Rehabilitation to release extensive information about your medical history. If you wish to release such information then a separate authorization form must be filled out.

Name:_____ Relationship:_____ DOB:_____

Name:_____ Relationship:_____ DOB:_____

Name:_____ Relationship:_____ DOB:_____

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE.

Signature:_____ Date:_____

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, significantly new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- Treatment means proving, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with the respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of the protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of 4/3/06 and we are required to abide by the terms of the notice of privacy practices currently in effect. We reserve the right to change the terms of the notice of privacy practices currently in effect. We reserve the right to change the terms of our notice of privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post the revised notice and you may request a written copy of it from us. You have the right to file a written complaint with our office or the department of health and human services, office of civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact: The US Department of Health and Human Services 200 Independence Ave., S.W. Washington, D.C. 20201 Phone (202) 619-0257 or toll free 1-800-696-6775 for more information about HIPPA or to file a complaint.

Action Physical Therapy and Rehabilitation

Claim Filing

Method you wish to file this claim: ( ) Health Ins. ( ) Workers Comp ( ) Self Pay ( ) Auto Accident

Complete the area below that applies:

HEALTH INSURANCE

Primary Ins. Name:_____ Primary Ins. ID/Member #:_____

Secondary Ins. Name:_____ Secondary Ins. ID/Member #:_____

Policy Holder name:_____ Date of Birth:_____

WORKERS COMP.

Adjuster Name:_____ Adjuster Contact Number:_____

Insurance:_____ Claim #:_____

Employer:_____ Date of Injury:_____

SELF PAY

Pick payment schedule:

Weekly_____ Bi-Weekly_____ Monthly_____ agree to **AMOUNT** $_____

A payment plan **Requires a Minimum of $ 25.00 for each payment **

AUTO ACCIDENT

Attorney Name:_____ Attorney Phone:_____

Attorney Address:_____

At Fault Insurance:_____ Claim #:_____

Insurance Address:_____

Insurance Phone:_____ Date of Injury:_____

Adjuster Name:_____ Adjuster Contact Number:_____

Do you have Medpay? Yes_____ No_____