Action Physical Therapy and Rehabilitation

PATIENT MEDICAL HISTORY

PATIENT INFORMATION		
PATIENT'S FULL NAME (LAST, FIRST, MI)	HEIGHT	WEIGHT

PHYSICIAN	
REFERRING PHYSICIAN	PCP/ FAMILY PHYSICIAN

REASON FOR THERAPY
HOW WERE YOU INJURED
WHAT ARE WE TREATING YOU FOR

DATE OF INJURY/ ONSET	DATE OF SURGERY	DIAGNOSIS
DIAGNOSTIC TEST: (X-RAYS, MRI, ETC.)		

MEDICATIONS
ANT-INFAMMATORIES
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	___Joint Replacement	___Anemia	___Pins/Metal Implants
___Smoke/Tobacco Use	___Vision/Hearing Problems	___Fibromyalgia	___Pacemaker
___Dizziness or Fainting	___HIV/AIDS	___Cancer (Chemotherapy/ Radiation)	___Pregnant
___Tuberculosis	___Respiratory Problems/ Asthma	___Hepatitis A B C	___Hypoglycemic
___MVP (mitral valve prolapse)	___Hernia	___Incontinence	___Neuropathy
___Autoimmune Disease	___Heart Disease	___Vertigo	___High Cholesterol
___Hyper/Hypo Thyroid	___History of Alcohol/Drug Abuse	___Shortness of Breath/ Chest Pain	___Stroke
___Recent Broken Bones	___Heart Attack/ Heart Surgery	___TBI (traumatic brain surgery	
___Other: _____			

USE THE DIAGRAM TO MARK AREAS WHERE SYMPTOMS EXIST

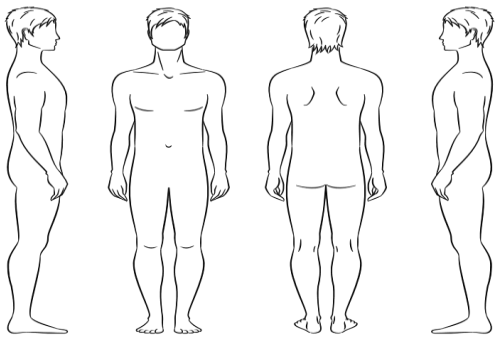
DESCRIBE NATURE OF PAIN: (CIRCLE ALL THAT APPLY)

SHARP ACHING CONSTANT DULL PERIODIC THROBBING

OCCASIONAL OTHER: _____

PAIN LEVEL: NO PAIN WORST PAIN

0 1 2 3 4 5 6 7 8 9 10



Patient/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Action Physical Therapy and Rehabilitation

NEW PATIENT INTAKE FORM

PATIENT INFORMATION			
PATIENT'S FULL NAME (LAST, FIRST, MI)			
ADDRESS	CITY	STATE	ZIP
BIRTH SEX ( ) Male ( ) Female	SSN	DOB	
HOME PHONE	CELL PHONE	WORK PHONE	
EMAIL	EMERGENCY CONTACT NAME RELATION	PHONE	
REFERRING PHYSICIAN	ADDRESS	PHONE	

WORK COMP/ MVA INFORMATION			
TYPE OF INJURY ON THE JOB MOTOR VEHICLE OTHER	DATE OF INJURY	ADJUSTOR	PHONE
AT FAULT INSURANCE (MVA)	ADDRESS		PHONE
CLAIM #	EMPLOYER (WORK COMP)	ATTORNEY	PHONE

PRIMARY INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY		PHONE NUMBER	
SUBSCRIBERS NAME	SUBSCRIBERS DOB (MM/DD/YYYY) RELATION		
ID#	GROUP ID#	EMPLOYER / PHONE	
INSURANCE ADDRESS			

SECONDARY INSURANCE INFORMATION			
SECONDARY INSURANCE COMPANY		PHONE NUMBER	
SUBSCRIBERS NAME	SUBSCRIBERS DOB (MM/DD/YYYY) RELATION		
ID#	GROUP ID#	EMPLOYER / PHONE	
INSURANCE ADDRESS			

GUARANTOR INFORMATION			
GUARANTOR NAME	PHONE		DOB
ADDRESS	CITY	STATE	ZIP

I acknowledge that all the information that I have supplied on these forms is true, accurate, current, and complete.

_____ _____ _____

Signature Printed Name Date

ACKNOWLEDGEMENT/AUTHORIZATION PAGE

CONSENT TO TREATMENT

I consent to and authorize Action Physical Therapy & Rehabilitation to administrator rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

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 handled.

EXPLANATION OF INSURANCE COVERAGE

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. 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.

ASSIGNMENT & RELEASE OF BENEFITS

I hereby appoint Action Physical Therapy & Rehabilitation as my authorized representative, and assign to it my right, to file for, receive and recover all monies payable for the care which it rendered to me from any third-party claims payment source, including my health insurer, Medicare, Medicaid, or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize APT to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to APT and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to APT not later than ten (10) days after my receipt.

FINANCIAL RESPONSIBILITY

Payment is due at the time of treatment. I agree to pay Action Physical Therapy & Rehabilitation all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

WORKERS COMPENSATION PATIENTS

We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

PHOTOGRAPHY/ VIDEOGRAPHY AGREEMENT

I understand that in order to protect the confidentiality of our patients, there can be no filming, going "live" via social media or taking pictures of my treatment, or that of other patients, without prior authorization from the Clinic Director.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY

I understand that authorized personnel (including my physical therapist) from Action Physical Therapy & Rehabilitation may communicate with me regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational/informative content as it relates to my condition. I understand that my protected health information (PHI) will not be communicated electronically.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE.

Signature: _____ Date: _____

How Did you hear about Action Physical Therapy?

_____

PATIENT QUESTIONAIRE/ NO SHOW POLICY

TREATMENT VISITS

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

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

HOME HEALTH

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

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

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: _____

TO OUR PATIENTS REGARDING
CANCELLATIONS AND NO-SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

1. **We require 24-hour notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)**
2. **There is a $25 charge for a cancellation without 24-hour notice. This charge will not be covered by insurance but will have to be paid by you personally before your next treatment.**
3. **For Worker's Compensation and Personal Injury patients' documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.**
4. **You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.**
5. **Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you are feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for golfing. Neither of these conditions are legitimate reasons not to come a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.**
6. **When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.**
7. **If you are so late for your appointment that it would throw the entire schedule off and inconvenience other patients, you may miss out on your treatment and be charged the fee for a missed appointment.**

Patient Signature: _____ Date: _____

APT Employee _____ 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

PAYMENT ARRANGEMENT

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____

Print your name here and sign below

X_____ Date: _____

Rectangle HEALTH
Innovation That Drives Patient Payments