WELCOME!

Thank you for selecting Physical Therapy Professionals. Please fill out all fields in these documents.

Patient Information

Name: Last_____ First _____ MI ____

Current address_____

City _____ State _____ Zip _____

Phone: Home_____ Work _____ Cell_____ _____

E-mail address: _____

SS#_____-_____-_____ □ Male□ Female □ Student □ Single □ Married □ Divorced □ Widowed □ Separated

Date of Birth: Month _____ Day _____ Year_____ Drivers License# _____State____

Employer_____ Occupation_____

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

and

Assignment of Benefits: I hereby assign payment directly to **Physical Therapy Professionals, Inc,** who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

and

Consent for treatment: I authorize the above-named company and its clinical staff to perform the treatment/procedure(s) which will be discussed with me today and as described in the Plan of Care (included with my Evaluation). I will be/have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences. The treatment/procedure(s) will be/were explained to me in detail and all of my questions will be/have been fully answered. Understanding this, I authorize the above-named company and its staff to perform such examinations, treatments, modalities, tests and exercise prescriptions as, in his or her opinion are necessary or advisable for me (_____).

Name of Patient if minor

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Signed_____ Date_____

Unaccompanied Minors (patients 17 years old or younger) ***Initial Box***

The parents (or guardians) are responsible for full payment at the initial visit. Subsequent charges may be billed to the insurance company, but co-payments, deductibles, and non-covered amounts must accompany the minor at each visit. ☐

Notice of cancelation policy: Should you fail to cancel your appointment 24 hours before your appointment You are responsible for making changes to your schedule by contacting this office. A No Show or Cancellation without 24 working hours notice will result in a Missed Visit fee of $*50.00* for which you are personally responsible. This is not a covered benefit of most insurance companies so therefore you will be responsible for the payment of this charge should you fail to cancel within the allowed timeframe. Alternatively if you abandon your visits via a late cancellation or no show we reserve the right to discontinue your care..

I have read and understand the above stated Notice of Cancellation Policy. I also understand my insurance will not cover a missed visit charge and I will be responsible for payment.

Signed_____

Acknowledgement of Receipt of Notice of Privacy Practices: Physical Therapy Professionals, Inc., reserves the right to modify the Privacy Practices outlined in the Notice.

Authorized forms of Contact - Please check any of the approved forms of contact with you or your child where:

- We may leave a message on your answering machine with appointment dates and times.
- We may leave a message on your answering machine which may contain information relating to your treatment with our office.
  - ☐ Home telephone
  - ☐ Work telephone
  - ☐ Cell phone

I have read and/or received a copy of the "Notice of Privacy Practices" for Physical Therapy Professionals, Inc.

Signed_____

[FOR MINORS: Signature of Patient Representative _____]

PATIENT HISTORY

Name:_____ Age:_____ Height:_____ Weight:_____ Handedness: ☐R ☐L

Date problem started:_____

Have you been treated for this problem? ☐Y ☐N
If YES, please check all that apply and indicate dates and % improvement as appropriate:

	(✓)	Date(s)	Details
Surgery			
Physical Therapy			
Chiropractic			
Massage			
☐Cortisone injection ☐Epidural injection			
Medication(s)			

Since the onset of this episode, are you symptoms getting: *(Check one)*
❑ better ❑ worse ❑ not changing

How many times have you had similar symptoms to your current problem in the past? *(Count episodes that lasted at least one day, but eventually went away completely.) (Check one)*
❑ none previously ❑ 1-5 episodes ❑ more than 5 episodes

Nature of pain *(Check all that apply)*
❑ constant
❑ intermittent
❑ constant dull aching
❑ dull aching
❑ throbbing
❑ intermittently more intense /sharp
❑ fluctuating intensity
❑ intermittent
❑ occasional
❑ throbbing
❑ burning
❑ sharp/stabbing
❑ tingling & numbness
❑ tingling/numbness into arm
❑ tingling/numbness into leg
❑ other:_____

Do you have pain/stiffness upon getting out of bed in the morning?
❑ yes ❑ no

As the day progresses, do your symptoms *(Check one)*
❑ increase? ❑ decrease? ❑ not change?

What aggravates your symptoms? *(Check all that apply – label the three worst as 1, 2, 3)*
❑ almost any position/movement
❑ sitting
❑ prolonged sitting
❑ driving
❑ going to / from sitting
❑ standing
❑ prolonged standing
❑ squatting
❑ lying down
❑ sleeping
❑ walking
❑ prolonged walking
❑ going up / down stairs
❑ sustained bending
❑ looking up overhead
❑ reaching overhead
❑ reaching out from body
❑ reaching behind back
❑ reaching across body
❑ repetitive activities such as:
❑ recreation
❑ household activities
❑ coughing / sneezing
❑ taking a deep breath
Oral activities such as:
❑ talking ❑ yawning ❑ chewing
❑ other: _____
❑ swallowing
❑ stress
❑ other: _____

What relieves your symptoms? *(Check all that apply)*
❑ nothing
❑ medication
❑ sitting
❑ rising from sitting
❑ standing
❑ lying down
❑ stretching
❑ exercise
❑ recreation/sports
❑ rest
❑ walking
❑ topical patch / cream
❑ heat
❑ cold
❑ whirlpool
❑ massage
❑ elevating limb
❑ other: _____

HIPAA Notice of Privacy Practices
Physical Therapy Professionals, Inc.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physical therapist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage you health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a additional therapy treatments may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physical therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing, marketing or fund raising activities, and conducting or arranging for other business activities. For Example, we may disclose your protected health information to physical therapy students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physical therapist. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing except to the extent that your physical therapist or the physical therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restriction to apply.

Your physical therapist is not required to agree to a restriction that you may request. If the physical therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have their right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physical therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPAA Compliance Office in person or by phone at 720.222.9669.