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 _____

Phon:e 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 ***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 with the expectation of circumstances beyond your control we will be forced to charge a Missed Visit fee of $*50.00.* 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.

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 _____

LIEN, ASSIGNMENT AND AUTHORIZATION

The rights and powers identified in this Lien, Assignment and Authorization (the "Agreement") are hereby granted, as of the date indicated below, by _____ ("Patient") to Physical Therapy Professionals, Inc., any physician/contractor of Physical Therapy Professionals, Inc., (referred to jointly and individually as "Medical Providers").

WHEREAS, Patient desires to receive health care services from Medical Providers for treatment of injuries sustained as a result of an incident that occurred on or about _____ (the "Incident"); and

WHEREAS, Patient may not be able to provide immediate personal payment, insurance coverage or other form of payment to Medical Providers for the health care services.

THEREFOR, Medical Providers agree to provide health care services to Patient, and Patient agrees to accept the health care services from Medical Providers pursuant to the following terms:

I. LIEN:

A. Patient agrees to have a lien placed on any funds received or awarded pursuant to a settlement, judgment or other payment from any legally responsible party or insurance company (a "Lien") arising from Patient's legal claim for damages related to the Incident, including, but not limited to, a bodily injury liability claim, an uninsured or underinsured motorist claim, workers' compensation claim, or any other insurance or other claim for damages. This Lien is granted to each of the Medical Providers who provide health care services to Patient for injuries sustained as a result of the Incident.

B. **Patient agrees and instructs any insurance company or other responsible party making payment, that any check or draft payable to Patient related to the Incident will be made payable jointly to Patient and to each of the Medical Providers who provide health care services to the Patient for injuries sustained as a result of the Incident.**

C. Patient understands that Patient is directly and fully responsible to Medical Providers for treatment rendered pursuant to this Agreement, and that this Agreement is made solely for additional protection and consideration of the Medical Providers. Patient further understands that such payment is not contingent on any settlement, claim, judgment or verdict, which Patient may eventually recover. In the event of non-payment or reduced payment by any insurance company, health care benefit plan or any other party liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by the Medical Providers, Patient agrees to be responsible for any such outstanding balance. Interest at a rate of 9% per year, compounded annually, will apply to all outstanding balances.

D. Patient authorizes and directs any attorney representing Patient to honor this Lien and make payment in accordance with this Lien directly to one or more of the Medical Providers from the attorney's COLTAF trust fund account. In the event that there is a dispute on payment of all or a part of bills covered by this Agreement, Patient agrees to instruct Patient's attorney to hold the full amount of one or more of the Medical Providers' bills in the attorney's COLTAF trust fund until an agreement is reached on payment or a court decides the matter.

E. Patient agrees that in the event Patient or Patient's attorney receives any check or draft from an insurance company, paying any bills of one or more of the Medical Providers, Patient or Patient's attorney agrees to act as a fiduciary agent for the Medical Providers, and will immediately deliver the check or draft to these entities to be applied to Patient's debt for services rendered.

II. ASSIGNMENT:

A. Patient assigns to each of the Medical Providers any and all benefits and payments from the Patient's medical insurance company, Med-Pay insurer, workers' compensation insurer, and/or any other health benefit plan for services provided by Medical Providers related to the Incident. Patient also assigns to each of the Medical Providers all contractual rights and legal causes of action Patient has against Patient's medical insurance company, Med-Pay insurer or any other health benefit plan that fails to properly pay the Patient's bills from a Medical Provider related to health care services provided for injuries sustained in the Incident.

III. AUTHORIZATION:

A. Patient authorizes and directs Patient's attorney to disclose any settlement or collected judgment amounts, distribution sheet and final accounting by Patient's attorney on the Patient's legal case related to the Incident to one or all of the Medical Providers. Patient waives any attorney/client privilege as it relates to any terms, distribution and final accounting of any funds collected and monies paid from a settlement or payment on a judgment related to the Incident.

B. Patient authorizes and directs any third party insurance company to disclose the settlement amounts, dates of settlement and terms to one or all of the Medical Providers.

C. Patient authorizes each Medical Provider to receive a complete copy of Patient's insurance policy, including any declaration pages, endorsements, conditions, limitations, benefits, exclusions and policy limits.

IV. GENERAL:

A. Patient fully understands and agrees that this Agreement is irrevocable.

B. Patient agrees to complete the information requested in Exhibit A to this Agreement, and such Exhibit A is incorporated into this Agreement by reference.

C. In the event of a breach of this Agreement, the prevailing party is entitled to its reasonable attorney fees and costs incurred to enforce this Agreement.

D. Patient agrees that, as an additional inducement to each Medical Provider's decision to provide or fund health care on a lien basis, that (1) Patient has no intention to file any bankruptcy proceedings either now or in the future in which Patient will seek to discharge any portion of the bills that Patient owes to a Medical Provider; (2) in the event that Patient does file a bankruptcy petition in the future, that any effort by Patient to discharge a Medical Provider's bills would be in bad faith and would be a fraud on such Medical Provider, and (3) in the event that Patient files a bankruptcy petition in the future seeking a discharge of any bills of a Medical Provider, that such Medical Provider shall be entitled to a priority and secured lien on shall still be entitled to a priority and secured lien on any bodily injury, uninsured, underinsured or other settlement for personal injuries that Patient obtains as a result of submitting Medical Providers' bills and treatment records. Patient agrees that the Medical Providers are providing health care on a lien basis and each Medical Provider is relying on Patient's representations that Patient will pay the bills out of the proceeds of any insurance settlement, judgment or other payment from any legally responsible party or insurance company related to the Incident.

Patient Signature: _____ _____
Date

Medical Provider: _____ _____
Date

By: _____ Title:_____

2149 S. Holly Street • Suite 200 • Denver, CO 80222
(303) 338.1500 fax (303) 338.1508

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: _____

PHYSICAL THERAPY PROFESSIONALS
8850 W. 58th Avenue, Suite 200, Arvada, CO 80002
2175 S. Jasmine Street, Suite 117, Denver, CO 80222
866.343.5264 fax 866.543.7981

Patient Name: _____

ACCIDENT QUESTIONNAIRE

☐Auto Accident? If so, what date did it occur on?
☐Work Accident? If so, what date did it occur on?

AUTO INSURANCE INFORMATION OF CAR YOU WERE IN AT TIME OF ACCIDENT
(Please Provide Us with a Copy of the Card)
Information of the car that you were driving or riding In:

Owner of the Vehicle	Type of Vehicle
Insurance Company	Policy #
Claim #	Adjuster's Name
Insurance Company Address & Phone	
Med Pay Limit $	Uninsured Motorist Limits $

IF YOU WERE A PASSENGER IN THE VEHICLE AND YOU OR A RELATIVE LIVING WITH YOU HAD AUTO INSURANCE PLEASE COMPLETE THIS SECTION
(Please provide us with a copy of each insurance card)

Insurance Company	Policy #
Agent's Name	Agent's Phone #
Med Pay Limit $	Uninsured Motorist Limits $

INSURANCE INFORMATION OF DRIVER AT FAULT

Name of Person at Fault	Phone #
Address of Person at Fault	
Insurance CO of Person at Fault	Phone #
Policy #	

MEDICAL INSURANCE (Please Provide Us with a Copy of the Card)

Insurance Company	Policy #
Group #	Phone #
Type of Policy (check one) ☐PPO ☐HMO ☐Major Medical	

FOR WORK RELATED INJURIES (if you were working at the time of injury) ☐NA

Work Comp Ins Company	Claim #
Adjuster's Name	Phone #
Employer's Name	Phone #

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 866.343.5264.