Patient Intake Form

Who referred you to us?:_____

Was this the first time you heard of us? Yes / No. If no, where?_____

Patient Information:

Patient Name:_____ DOB_____

Cell Phone:_____ Home Phone:_____ Other Phone:_____

Address:_____City_____Zip_____

Email address: _____Best time and way to reach you_____

Insurance Information:

Insurance name:_____

Policy Holder's Name_____ Policy Holder's DOB:_____

Emergency Contact:

Name: _____Relationship: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Referring Physician:

Name: _____Location: _____

Primary Care Physician:

Name: _____Location: _____

Accident Information:

Is this injury due to an accident: _____Type of injury: Home Work Auto Other
Date of injury: _____ Have you made a report of your accident?: YES / NO

Attorney name: _____Phone: _____

Patient Condition Form

Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting worse? _____

Rate severity of pain on a scale of 1 (least pain) - 10 (severe pain): _____

Type of pain: • Sharp • Dull • Throbbing • Numbness • Cramps • Aching • Tingling • Shooting • Burning •Stiffness • Swelling • Other_____

How often do you have this pain?: _____

Is it constant or intermittent? _____

Does it interfere with your: • Work • Sleep • Daily Routine • Recreational activities

Activities or movements that are painful to perform: • Sitting • Standing • Walking • Bending • Lying down

Prior to the condition or injury, please rate your functional status with self-care and home management activities: • Excellent • Good • Fair • Poor

Please rate your current functional status with self-care and home management activities: • Excellent • Good • Fair • Poor

Have you experienced any of the following?: •

Changes in bowel/bladder • Non-healing sores/wounds • Fatigue

• Unexplained weight loss • Referred or radiating pain • Fever/sweats

• Pain worse at rest vs activity • Unexplained lower or upper extremity weakness

Are you currently pregnant? _____IF yes, what is your due date? _____

<u>Family/Social History:</u>

Do you live alone? _____If no, with whom do you live?_____

What type of home • 1 story • 2 story • Apartment • Tri-level • Other: _____

Are there stairs in the home or to get into home? _____If yes, how many? _____

Are you currently working? _____ What is your occupation? _____

Do you smoke? _____ Do you drink alcohol? _____If yes, drinks/week_____

Do you exercise? _____ If yes, how many times per week? _____

Health History Form

Have you received any of the following treatment(s) for your condition/injury?:

• Medication • Surgery • Physical Therapy • Chiropractic • Other: _____

If yes to above, please describe: _____

Name and locations of other doctors who have treated you for your condition:

_____

Have you had any diagnostic testing: • X-ray •MRI • CT Scan • Bone Scan • Other _____
If you have had testing, please provide dates: _____

Have you been diagnosed with any of the following conditions?

	Yes	No		Yes	No
Osteoporosis			Have a Pacemaker		
Cancer			Hearing or Visual Impairment		
Diabetes			Thyroid Problem		
Arthritis			Kidney Disease		
High Blood Pressure			Vertigo		
Circulatory Problems			History of Falls		
Depression			High Cholesterol		
Seizures			Contagious Disease		
Heart Problems			Stroke		

Please list any other injuries or diagnoses not listed above: _____

Please list all past injuries and/or surgeries you have had with dates: _____

_____

Are you currently taking over-the-counter medication, vitamins or supplements? _____ If yes, please list: _____

Are you currently taking prescribed medication? _____ If yes, please list:

_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Tailor-Made Physical Therapy to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

TREATMENT COMMITMENT

Tailor-Made Physical Therapy cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at Tailor-Made Physical Therapy:

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment.

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

In an instance of cancellation, without 24 hours-notice, we reserve the right to charge you a $25.00 fee. In an instance of a no-show you will be charged a $50.00 fee. After the second no-show or third canceled appointment all future appointments will be removed from the schedule and you will be added to our "same day appointment only" list.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

By signing, Patient agrees & understands all items outlined above

_____ _____ _____/_____/____

Patient's Signature/Legal Representative Relationship Date

_____ _____

Practice Representative Date

Financial Policy

We are committed to providing you with the best in Therapy care. In order to do this without compromising our patients, this policy has been implemented for each patient. If you have medical insurance, we are happy to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

▪ Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard and Discover. We will be accommodating to you in the process of seeking reimbursement from your Insurance carrier. In special instances, we may accept assignment of insurance benefits.

▪ Deductibles and Copayments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

▪ Please be further advised that Returned checks and balances older than 30 days from your Treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month.

▪ If you participate with our in-network, we will bill your insurance company and accept assignment of benefits. You will be responsible for any copays or deductibles at each visit. We will verify your coverage and determine your out-of-pocket cost prior to treatment starting. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Please be aware of the following:

1. Your insurance is a contract between you, your employer and the insurance company.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.

3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.

4. We will not COMPROMISE patient care based on an insurance company's “FEE SCHEDULE”.

5. Verification of your insurance benefits is not a guarantee that payment will be made.

In cases involving Auto Claims and Workers Compensation, we will ONLY accept payment directly from the patient or from their insurance company and will arrange to accept payments from attorneys on a case by case basis. If a patient has instructed their insurance company to send payment to their attorney, the patient will be billed and held solely responsible and accountable for their bill. We will accept settlements on auto accounts only after prior approval and a letter of protection is on file. We must emphasize that as a Medical provider, our relationship is with you, not your insurance company.

While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, **PLEASE don't hesitate to ask us. WE ARE HERE TO HELP YOU!**

_____ _____ _____/_____/____

Patient's Signature/Legal Representative Relationship Date

_____ _____

Practice Representative Date

Assignment of Medical Benefits, Payment Responsibility and Authorization for Treatment

PATIENT: _____

1. THE UNDERSIGNED, hereby authorize Tailor-Made Physical Therapy and its affiliates ("Provider") to render to Patient physical therapy, or other related services (collectively, "Therapy Services") that Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Therapy Services.

2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.

3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient's Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.

5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by the Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of the Patient.

6. THE UNDERSIGNED, authorizes Tailor-Made Physical Therapy to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.

7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider's invoice that is not paid, except in the event of

Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or

similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.

8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.

9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.

10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest to Provider.

11. THE UNDERSIGNED understands that they have a choice or rehabilitation service providers.

_____ _____ _____/_____/_____

Patient's Signature/Legal Representative Relationship Date

_____ _____

Practice Representative Date

TAILOR MADE PHYSICAL THERAPY

patientprivacyrights

Health Privacy Rights

Health Privacy "Rights" Under HIPAA

- Receive **notice** of how providers **use and share** your information with over 4 million "covered entities", **without asking you** ("Privacy Notice" or "Notice of Privacy Policies").
- The right to a copy of your health records. The provider may charge a "reasonable fee" for such copies.
- You can **request changes** to your health records. The provider does NOT have to make the changes requested. Your changes must be added to your records and the provider has to state reasons s/he disagrees with changes.
- You can **request an accounting of disclosures** of your health information. Most disclosures do not require consent and have no audit trails. Audit trails are required only for disclosures for "non-routine" uses.
- Health establishments and "covered entities" are required to **secure information** to the best of their ability, and a **privacy official** must be designated by each "covered entity."
- The ADA prohibits an employer from asking about health information or requiring a physical prior to an offer if they have more than 15 employees. After the offer is made, the employer may require a medical exam if it is required by all employees with similar positions. Employers may also ask employees to authorize disclosure of their medical records. **But, if the employer is self-insured they can access their employees' medical information without consent.**

Job discrimination is the most common complaint sent in to Patient Privacy Rights.

These rights are based on thousands of years of medical ethics, our own Constitution and state laws. None of these rights are provided by HIPAA.

Health Privacy Rights You Should Have

- Right to **control** who can see, use, share and sell your health information.
- Right to **feel safe talking truthfully** to your doctors.
- Right to privacy and control of health information unless otherwise stated or required by law.
- Right to be **notified of any breach** or possible breach of information.
- Right to **audit trails** of every disclosure of health information. Health IT makes it easier than ever to know exactly who has your information.
- Right to EHR and PHR systems that have the highest standards for **security (keep hackers out).**
- Right to participate in **research** and have researchers access your records ONLY if you give informed consent
- Right to **segment sensitive information** such as mental health, addiction or STDs, in your health record.
- Right to obtain **prescriptions** with privacy; no one should be able to use or sell your prescriptions without your consent.
- Right to obtain **employment, insurance, credit, admission to schools**, etc. without being compelled to share health information unless required by statute.

Patient Privacy Rights is working to ensure **these rights** are guaranteed by Congress.