PATIENT INTAKE FORM

PLEASE FILL OUT COMPLETELY AND CLEARLY

Date: **Patient's Legal Name:**

Nickname: **[ ] Male [ ] Female DOB:** **SSN:**

Mailing Address: **City/State/Zip:**

Main Phone: **Cell:** **Email Address:**

Primary Insurance: Secondary Insurance:

Primary Insured Name: Relationship to patient:

Primary Insured DOB: Primary Insured SSN:

Primary Insured Mailing Address *(if different from the above)*:

W O R K C O M P & M V A

Date of Injury:________________________ **Claim #:**____

Insurance Company:_____________________________________ **Phone #:**____________________

Address:____ **State:**______ **Zip:**_____________

Adjuster/Case Manager:____

Is an attorney involved? [ ] Yes [ ] No - Attorney Name/Phone#:____________________________________

Employer: Occupation:

Address: Phone#:

Medicaid Patients: *Who is your Passport Provider:* *Date of last visit:*

Have you had physical therapy in the *past year*? [ ] Yes [ ] No
If yes, when was it?____________________

Was it at our clinic [ ] Yes [ ] No
Was it for the *same injury*? [ ] Yes [ ] No

Referring Physician: Phone:

Emergency Contact: Phone: Relationship:

Please sign below to acknowledge that the above information is accurate, that you have received the **HIPAA Notice of Privacy Practices** handout, and to authorize our clinic to treat for physical therapy.

Signature of Patient: Date:

Information below is *required for treatment of a minor or a patient who does not have their own power of attorney.*

Name of Parent or Legal Guardian: Signature:

[ ] I would like to receive appointment reminders via email.

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PHYSICAL THERAPY

PATIENT HEALTH SUMMARY

Name:__________________________ Age:_______ M F DOB:____________________

Occupation/Student (grade):____________________ Hand Dominance: R / L *(circle one)*

Reason you are being seen today:____________________________________

Have you had any diagnostic testing for your current condition? If so, what tests:____________________

What leisure/physical activities do you enjoy?____________________________________

What activities/movements can you no longer do due to your injury?____________________________

Date of injury or when your symptoms began:____________________

How were you injured?____________________________________

Describe your current symptoms:____________________________________

What makes your symptoms worse?____________________________________

What makes you feel better?____________________________________

How long can you stand?__________________ sit?__________________ walk?__________________

Do you have a previous history of the condition for which you are being seen today? Yes_____ No_____

What are your goals for therapy?____________________________________

Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes_____ No_____

Medication/Injection and condition taken/given for: ____________________________________

Please check all that apply to you:

___ Cancer	___ Emphysema	___ Infectious Disease	___ Prostate Condition
___ Heart Condition	___ Hepatitis/kidney problems	___ Diabetes	___ Bowel/bladder
___ High BP/hypertension	___ Tuberculosis	___ Glaucoma	___ Emotional Problems
___ Pacemaker	___ Phlebitis/Circulatory Problems	___ Thyroid Problems	___ Migraines/headaches
___ Asthma	___ Stroke	___ Arthritis	___ Dizzy Spells
___ Lung Disease	___ Anemia	___ Multiple Sclerosis	___ Seizure
		___ Neurological Disorder	___ Tobacco use

Are you currently pregnant? Yes_____ No_____

Is there anything else you feel we should be aware of? (fractures, surgeries, other medical conditions)

____

Circle the number that best describes your status:

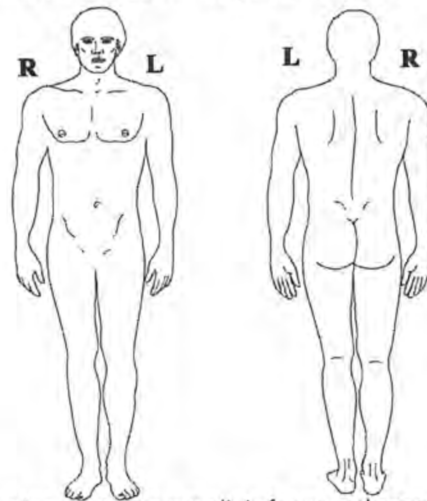
PAIN 0 1 2 3 4 5 6 7 8 9 10
Best ______________________________ Worst

FUNCTION 0 1 2 3 4 5 6 7 8 9 10
Best ______________________________ Worst

SLEEP 0 1 2 3 4 5 6 7 8 9 10
Best ______________________________ Worst

WORK 0 1 2 3 4 5 6 7 8 9 10
Best ______________________________ Worst

Please shade in the areas where you are experiencing pain:



Please notify your therapist if there are any changes in your condition. Thank you for coming to our clinic for your therapy needs.

Patient Signature ______________________________ Date ______________

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PHYSICAL THERAPY

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your wellbeing and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

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.

We expect you to keep all your appointments. We write down the time of your visits on an appointment card or calendar for you so you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to reschedule an appointment we require 24-hour notice. In such case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24-hour notice or no-show to a scheduled appointment, we reserve the right to charge you a $35 no-show fee.

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.

All the staff at On The Mend ☺

I have read and understand this policy.

Patient Name: ____________________ **Signature**: ____________________

Date: ____________________

Information below is *required for treatment of a minor or a patient who does not have their own power of attorney.*

Name of Parent or Legal Guardian: ____________________ **Signature**: ____________________

Date: ____________________

PATIENT FINANCIAL POLICIES

TO OUR VALUED PATIENTS:
We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to do this, we need your assistance and understanding of our payment policy. Also note, our company complies with all HIPAA Privacy Practices. By signing this form, you acknowledge that you have been offered and/or have received a list of these practices.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. You will be responsible for paying for your visits until your deductible is met. Once your deductible is met, you will be responsible for your co-pay or co-insurance.
2. Our fees are considered to fall within the acceptable range by most companies, and are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees.
3. Not all services are covered in all contracts. Some insurance companies select certain services they will not cover. *These particular services, if any, are your responsibility.* We will make our best attempts to inform you as soon as possible if/when we encounter services your insurance company does not cover. If your insurance company does not cover supplies, you will be responsible for payment of such, should you choose to receive them.
4. The estimate provided at time of service is not an exact calculation of your actual costs and does not reflect all of the terms, conditions, limitations, and exclusions that may apply to your coverage. Your actual costs will vary depending upon the specifics of your benefit plan and the particular services and supplies you receive.
5. If this injury is work related and a Workers Compensation claim has been initiated then we require, on your initial visit, that you provide us with a claim # to ensure payment of the account.
6. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is OTM's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.
7. Our office requires **a 24-hour notice for cancellation of appointments;** you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a $35.00 charge for a missed appointment without notification to the office.
8. Payment is due at time of service unless other arrangements are made. Any account that goes beyond our 6 month maximum allowance time for payment in full will be assessed a 2% finance charge per month (minimum $.50/mth) against any unpaid balance.
9. We reserve the right to terminate services if payments are not made in a timely fashion.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Should you have encounter problems making payments on time, we encourage you to contact us promptly for assistance in setting up a payment plan. If we do not receive payment from you according to agreement and/or the arranged payment plan notice we sent to you, you agree to be responsible for any expenses incurred in collecting patient's account, including all fees, court costs, attorney fees and all other collection related expenses. By signing below, patient/responsible party acknowledges that he/she has read, understands and hereby accepts the above obligations and agreements.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read the above policies and agree.

Patient Name: ______________________ **Signature:** ______________________ **Date:** ____________

Information below is ***required for treatment of a minor or a patient who does not have their own power of attorney.***

*******PERSON SIGNING BELOW MUST FILL OUT ATTACHED GUARANTOR INFORMATION**********

Name of Parent or Legal Guardian: ______________________ **Signature:** ______________________

Date: ______________________

GUARANTOR INFORMATION

IF YOU ARE SIGNING OUR FINANCIAL POLICY OR INTAKE FORM AS THE PERSON OR LEGAL GUARDIAN OF THE PATIENT LISTED ON THIS FORM, WE MUST HAVE THE FOLLOWING INFORMATION:

Name of Parent or Legal Guardian: ____________________

Male Female DOB:____________________ SSN:____________________

Mailing Address: ____________________ City/State: ____________________ Zip: __________

Phone: Home: ____________________ Work: ____________________ Cell: ____________________

Email Address: ____________________

Place of Employment: ____________________ Occupation: ____________________

Employment Address: ____________________ City/State: ____________________ Zip: __________

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PHYSICAL THERAPY

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information.

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522)
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your health record [ePHI] (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- Request restriction of use and disclosure of PHI when you pay cash in-full for the healthcare item or service

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

If you have questions and would like additional information, you may contact our Privacy Officer at (406) 756-2555. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

***We will use your health information for regular health operations.* For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality & effectiveness of the healthcare and service we provide.**

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by accounting, collection agencies, computer maintenance services, and vendors (hardware, software). When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. ***We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.***

Family communication. **After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.**

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

LOCATION SPECIFIC: The following are areas in our current location that pose a potential breach of confidentiality:

1) We have an open waiting area.
2) We have an open gym.
3) Our window blinds are left open to the mountains. Blinds can be pulled upon request.
4) Our treatment rooms are not soundproof, but every effort will be made to protect your privacy.
5) Each patient chart is kept on an e-file on a laptop or iPad.