Patient Intake

PATIENT INFORMATION

Patient Name: _____ Social Security Number: _____ - _____ - _____

Date of Birth:_____ Gender: M F Marital Status: M D S W O

Address:_____ City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone: _____

Work Phone: _____ Ext: _____ Email :_____

Best way to contact you: _____ How did you hear about us? _____

Is this a work comp injury: _____ Is this a motor vehicle accident? _____

Can we leave messages at any of the above listed numbers?

Home: Yes No Work: Yes No Cell: Yes No

EMERGENCY CONTACT/PATIENT REPRESENTATIVE INFORMATION

Contact Name:_____Relationship:_____

Home Phone:_____Cell Phone:_____

Mark each purpose for which you are authorizing your protected health information to be used and/or disclosed to your emergency/representative contact:

Discussion of financial account _____

Discussion of medical status _____

Discussion of scheduling appointments _____

Other _____

Signature: _____ Date:_____

Legal Guardian:_____ Date:_____

MEDICAL HISTORY

Please circle each condition that you have been told you have (or had).

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease	
Allergies	Asthma	Lung Disease	Hepatitis (type)_____	

Please list other medical issues not listed above:

_____

_____

Please list all relevant surgeries and dates:

_____

_____

Are you on blood thinners? YES NO
Are you allergic to latex? YES NO
Do you have a pacemaker? YES NO
Are you pregnant? YES NO

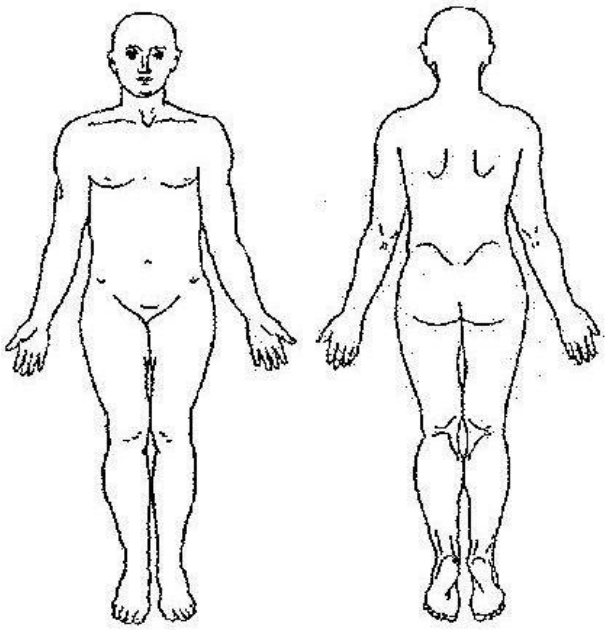
<u>Medications:</u> Please list current medications or provide us with a copy.

	Name	Dosage	Frequency	Administration
1.	_____	_____	_____	Oral, Patch, Topical, Other
2.	_____	_____	_____	Oral, Patch, Topical, Other
3.	_____	_____	_____	Oral, Patch, Topical, Other
4.	_____	_____	_____	Oral, Patch, Topical, Other
5.	_____	_____	_____	Oral, Patch, Topical, Other
6.	_____	_____	_____	Oral, Patch, Topical, Other
7.	_____	_____	_____	Oral, Patch, Topical, Other

CURRENT INJURY

Body Diagram

Please mark on the diagram to indicate where you feel your symptoms. Use the key below to indicate the different types of symptoms.



Deep Ache= zzzz
Stabbing= ////
Numbness or tingling=0000
Burning= XXXX

On the scales below, please circle the number which best represents the severity of your pain:

Now

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable (ER)**

Best in the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable (ER)**

Worst in the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable (ER)**

When did your problem start? _____

How did your problem start? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

What do you feel is your overall functional level from 0-100%: _____

What is your overall goal for therapy? _____

Thank you for choosing Velocity Physical Therapy. We are committed to providing you with the best professional care. Your clear understanding of our policies is important to our relationship.

Consent to treatment
I hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Acknowledgment of Privacy Practices
I have read and understand the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

No Insurance/ Cash Pay
Velocity Physical Therapy offers a cash rate to those who do not have insurance coverage or those who have maximized their insurance benefits. You may make a cash payment if you do not wish to involve your insurance.

Returned Checks / Unpaid Balances
The returned check fee is $25.00. Account balances over 90 days without payment or payment agreement will accrue a 1.5% (18% annually) finance charge each billing cycle. Balances unpaid after 90 days will be turned over to a collection agency. If this is necessary, you agree to pay interest, collection fees and/or attorney fees.

Supplies
Some physical therapy supplies are not covered by insurance. If these small supplies would be of benefit to you, your therapist will give you the opportunity to opt out before incurring a charge.

Cancellation Policy
Cancellations should be made at least 24 hours prior to your appointment. If you miss an appointment without giving notice you will be charged $35. This fee is not covered by insurance.

Medical Insurance Coverage
Velocity Physical Therapy, LLC participates in most health plans, but not all. Upon your initial visit we will attempt to verify your current insurance coverage. Verification of physical therapy benefits is **NOT** a guarantee of payments. It is your responsibility to know your physical therapy benefits. All coverage is based on insurance coverage at the time of service.

Co-payments and Deductibles
As part of our contractual agreement with your insurance company we must collect co-payments and/or deductibles directly from you.

I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and myself. I understand that Velocity Physical Therapy, LLC will prepare insurance forms and bill my insurance company only as a courtesy. I understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

Patient Signature:_____ Date:_____

Legal Guardian:_____ Date:_____

Velocity Physical Therapy
3201 Teasley Lane, Suite 201
Denton, TX 76210

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Velocity Physical Therapy
3201 Teasley Lane, Suite 201
Denton, TX 76210