PhysioWorks
Physical Therapy

Name:_____
(Last) (First) (Middle)
Date of Birth:_____

Age:_____ ☐ Male ☐ Female

Social Security #:_____

Marital Status:_____ Name of Spouse/Significant other:_____

Address:_____
(Street) (City) (State) (Zip Code)

Telephone:_____

Cell Phone:_____

Email Address:_____

Northern Address (if applicable):_____

Telephone:_____

Occupation:_____ Employer:_____

Address:_____ Work Telephone: _____

Referring Physician:_____ Family Physician: _____

Diagnosis / Condition you are being seen for today:_____

Date of Injury: _____
Date of Surgery: _____

How did injury occur? _____

Is your injury part of a Workman's Compensation claims? ☐ Yes ☐ No
Is your injury motor vehicle related? ☐ Yes ☐ No

Have you had ***any*** home health services in the last 60 days? ☐ Yes ☐ No
Have you received ***any*** previous therapy this year? ☐ Yes ☐ No

Medications (*If you have a list, we wil be happy to scan/photocopy it for you)*

_____
_____
_____
_____
_____
_____

Past Medical History (*List any medical conditions, including surgeries, that are pertinent)*

☐ Cardiac
☐ Pacemaker/defibrillator
☐ High blood pressure
☐ Stroke
☐ Diabetes
☐ Joint replacement
☐ Cancer
☐ Neurological problems
☐ Circulation problems
☐ Neck or back problems
☐ Breathing problems
☐ Incontinence

☐ Other: _____
_____
_____
_____

FINANCIAL AND CANCELLATION POLICIES

MEDICARE PATIENTS:

PhysioWorks, Inc. is a "Medicare A" facility. We will accept Medicare Assignment. This means that we will accept the charge that Medicare approves. Medicare patients are still expected to pay the portion of the fee that Medicare allows but does not pay, which is 20% of the Medicare fee schedule charges and applicable deductibles.

ALL PATIENTS:

I authorize PhysioWorks, Inc. to submit insurance claims on my behalf. I understand any amount not covered by my insurance company is my responsibility, and I, being the patient/guarantor, am solely responsible for the payment of any balance on my account.

I further understand that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs and collection agency fees.

PhysioWorks, Inc. has a cancellation policy. This policy states if you cancel your physical therapy appointment without 24 hour notice prior to your appointment, you will be charged $25.00 per occurrence. Your insurance company does not cover this charge.

I hereby authorize PhysioWorks, Inc. to furnish information to necessary parties such as insurance carriers, physicians, attorneys, etc. concerning my condition and treatments rendered. I accept responsibility for copays, deductibles and any services not covered by insurance.

_____ _____

SIGNATURE OF PATIENT DATE

IF YOU ARE HAVING ANY HOME HEALTH SERVICES, YOU MAY **NOT** HAVE OUTPATIENT PHYSICAL THERAPY AT THE SAME TIME.

ARE YOU CURRENTLY RECEIVING HOME HEALTH? _____

IF **YES**, PLEASE FILL OUT THE FOLLOWING:

NAME OF AGENCY _____

PHONE NUMBER OF AGENCY _____

IF YOU HAVE BEEN RECENTLY DISCHARGED FROM HOME HEALTH:

NAME AND PHONE NUMBER OF HOME HEALTH AGENCY

_____

DATE OF LAST HOME HEALTH VISIT _____

***** IF YOUR PHYSICAL THERAPY CLAIM IS DENIED DUE TO A HOME HEALTH EPISODE, YOU WILL BE HELD RESPONSIBLE FOR PAYMENT *****

_____ _____

SIGNATURE **DATE**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO INCLUDE SUPER CONFIDENTIAL PHI DIRECTLY TO THE PATIENT

I,_____, (Name of Patient making Request), hereby request a copy of my health records and authorize PhysioWorks, Inc. (hereafter collectively referred to as "this Healthcare Facility") to use and disclose a copy of my health records to me.

I prefer my records be sent to me in the following format, but understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. I know this Healthcare Facility will supply me these records within 30 days of this request and will contact me should there be any reason they need to extend this time frame. I understand, by law this Healthcare Facility and request an extension for more time but, can only request an extension, once for an additional 30 days. The format which I prefer to receive my electronic records in is:

☐ Email a word document to (email address): _____
☐ Email a PDF copy to (email address): _____
☐ Fax a copy to (fax number): _____
☐ Send a hard copy to (address: _____
☐ I will pick up a copy on or after (date): _____

I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

☐ HIV records (including HIV test results) and sexually transmissible diseases
☐ Alcohol and substance abuse diagnosis and treatment records
☐ Psychotherapy records
☐ Not Applicable

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient: _____ Date: _____
(Print name and sign)

OR

By Patient's Representative _____ Date: _____
(Print name, sign, and describe authority below)

OFFICE USE ONLY

Describe what alternative communications were denied this _____ day of _____, 20_____

_____

Describe what alternative communications were accepted this _____ day of _____, 20_____

_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization.
In refusing we *may not be allowed* to process your insurance claims.

Date: _____

I hereby consent to physical therapy treatment provided to me by PhysioWorks, Inc. as prescribed by my physician. I give consent to PhysioWorks, Inc to use and disclose my protected health information (PHI) for the purposes of treatment, payment and health care options. I have been given options on how to obtain a copy of the currently effective Notice of Privacy Practices for this healthcare facility. I have the right to request PhysioWorks, Inc to restrict how they use and disclose my PHI for the purposes of treatment, payment and health care options. PhysioWorks, Inc. is not required to grant my request, but if they do, the restriction will be binding on them. I may revoke this consent at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this facility or sent by mail, but it will be effective only when PhysioWorks receive it. My revocation will not be effective to the extent that we (or others) have acted in reliance upon consent. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT RECORDS BE SENT TO OTHER FACILITIES IN THE FUTURE

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents:
_____
_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

EMERGENCY CONTACT:
Name: _____ TELEPHONE NUMBER:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation ☐ Does not Apply
- ☐ Leave messages on my Cell Phone/Home Phone
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ Leave messages with persons answering my Home Phone
- ☐ Leave messages on my Voice Mail at Work ☐ Does not Apply
- ☐ Discuss my appointment information with another person
  Name: _____
- ☐ Discuss my billing information with another person
  Name: _____
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation ☐ Does not Apply
- ☐ Leave messages on my Cell Phone/Home Phone
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ Leave messages with persons answering my Home Phone
- ☐ Leave messages on my Voice Mail at Work ☐ Does not Apply
- ☐ Discuss my Health Information/Treatment with another person
  Name: _____
- ☐ **Any of the Above**

_____ _____
PLEASE PRINT NAME PLEASE SIGN NAME

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____

_____
Signature of Privacy Officer