ELITE PHYSICAL THERAPY AND SPORTS REHABILITATION, LLC.

PATIENT INFORMATION

First Name _____ MI ____ Last _____ Preferred Name _____

Mailing Address _____City_____State____ Zip _____

Primary Phone _____ Alternate _____ Email_____

Date of Birth ____/____/_____ Age ____ Gender _____ Marital Status _____ SS# _____

Emergency Contact _____ Phone _____ Relationship_____

How did you hear about APT? _____ Profession_____

Would you like to receive courtesy appointment reminders? ☐ E-mail ☐ Phone Call: Cell or Home ☐ Decline reminder

Primary Care Provider _____ Referring Provider (if different) _____

Next appointment with Primary Care or Referring Provider (if applicable) _____

Medical Diagnosis or Primary Concern _____

Approximate Date of Onset _____ Have you received Home Health services this year? ☐ NO ☐ YES

Is the pain or injury listed above related to a motor vehicle accident or an accident at work? ☐ YES ☐ NO

If yes, choose one: ☐ MOTOR VEHICLE ACCIDENT ☐ WORKPLACE ACCIDENT **Date of Accident** ____/____/_____

INSURANCE/GUARANTOR INFORMATION

Primary Insurance _____ Member ID #_____ Group #_____

Responsible Party Name _____ Date of Birth _____ SS# _____

Secondary Insurance _____ Member ID #_____ Group #_____

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of Advance Physical Therapy, to administer evaluation and treatment necessary and advisable for my condition, including teletherapy. If patient is a minor, a parent or legal guardian must sign. **Consent must be signed before we begin treatment.**

_____ _____

Signature of Patient (or Legal Guardian) Date

ELITE PHYSICAL THERAPY AND SPORTS REHABILITATION, LLC.

ALLERGIES & CURRENT MEDICATIONS

ALLERGIES (choose one)

□ NO KNOWN ALLERGIES

□ MEDICATION ALLERGIES _____

□ LATEX ALLERGY

_____

□ I am not currently taking any prescription medications, supplements, or over-the-counter medications.

1. Medication _____
   Frequency _____
   Dosage _____ Route _____

2. Medication _____
   Frequency _____
   Dosage _____ Route _____

3. Medication _____
   Frequency _____
   Dosage _____ Route _____

4. Medication _____
   Frequency _____
   Dosage _____ Route _____

5. Medication _____
   Frequency _____
   Dosage _____ Route _____

6. Medication _____
   Frequency _____
   Dosage _____ Route _____

7. Medication _____
   Frequency _____
   Dosage _____ Route _____

8. Medication _____
   Frequency _____
   Dosage _____ Route _____

9. Medication _____
   Frequency _____
   Dosage _____ Route _____

10. Medication _____
    Frequency _____
    Dosage _____ Route _____

_____ _____

Signature of Patient (or Legal Guardian) Date

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MEDICAL HISTORY INTAKE FORM

Have you or an immediate family member ever been told you have any of the following:
(please circle and indicate relation) i.e. "self", "mother", "brother", etc.

Allergies
Arthritis
Cirrhosis/Liver Disease
Diabetes
Heart Attack
High Cholesterol
Osteoporosis
Tuberculosis
Angina or chest pain
Asthma or other breathing problems
Chemical Dependency (Drugs/Alcohol)
Eating Disorder (Anorexia, Bulimia)
Hemophilia or slow healing
Kidney Disease/Stones
Scoliosis
Other(please describe)
_____
Anxiety/Panic attacks
Cancer
Depression
Headaches
High Blood Pressure
Multiple Sclerosis
Stroke

HAVE <u>YOU</u> EVER HAD (please check any that apply)

_____ *Anemia*
_____ *Epilepsy/Seizures*
_____ *Fibromyalgia*
_____ *Hepatitis/Jaundice*
_____ *GERD/Ulcers*
_____ *Gout*
_____ *Hypoglycemia*
_____ *Hypo/Hyper Thyroid*
_____ *Joint Replacement*
_____ *Parkinson's*
_____ *Peripheral Vascular*
_____ *Polio/Post-Polio*
_____ *Rheumatic Fever*
_____ *Skin Problems*
_____ *Urinary Problems*
_____ *Sleep Apnea*

ALLERGIES ☐ NO KNOWN ALLERGIES ☐ LATEX ALLERGY

☐ MEDICATION ALLERGIES _____

<u>FOR WOMEN</u> (please circle)
Endometriosis
Pelvic Inflammatory Disease

Are you pregnant? **Y / N**
# of pregnancies? _____
# of live births? _____

<u>FOR MEN</u> (please circle)
Prostate Pain / Problems
Genital Pain / Problems

GENERAL HEALTH

1. I would rate my health as: ***Excellent*** ***Good*** ***Fair*** ***Poor***
2. Have you been sick in the last 3 weeks? **YES / NO** if YES, describe _____
3. Have you noticed any lumps or thick skin/muscle anywhere on your body?_____
4. How many alcoholic drinks do you consume per week? _____
5. How much caffeine do you consume daily (soda, coffee, tea, chocolate)?_____
10. Are you on any special diet? _____

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11. Do you currently exercise? □ **NO** □ **YES**, how often? _____

    Types of exercise _____

12. How many falls have you had in the past year? _____

13. Describe problems with your balance or fear of falling? _____

    _____

14. Do you have, or have you recently had any of these problems (please check any that apply)

_____ *Blood in urine, stool, vomit, or mucous*
_____ *Dizziness, fainting, or blackouts*
_____ *Fever, chills, day or night sweats*
_____ *Nausea, vomiting, loss of appetite*
_____ *Changes in bowel and/or bladder function*
_____ *Throbbing sensation in belly or elsewhere*
_____ *Skin rash or changes*
_____ *Cough*
_____ *Urinary issues/Stress incontinence*
_____ *Heart palpitations*
_____ *Numbness or tingling*
_____ *Swelling or lumps anywhere*
_____ *Problems seeing and/or hearing*
_____ *Unusual fatigue or drowsiness*
_____ *Difficulty swallowing or speaking*
_____ *Memory loss*
_____ *Confusion*
_____ *Sudden weakness*
_____ *Trouble sleeping*
_____ *Jaw pain, noise, teeth grinding*

MEDICAL / SURGICAL HISTORY

1. Have you ever been treated with chemotherapy, or radiation therapy?

   _____

2. Have you had any X-rays, sonograms, CT scans, MRI, bone scans or other imaging tests recently?

   □ **NO** □ **YES**, What? _____

   When? _____

   Results _____

3. Have you had any lab work done recently? □ **NO** □ **YES**, Results _____

   _____

4. Please describe any other recent clinical tests

   _____

5. Please list any significant operations that you have had and the dates

   _____

   _____

6. Do you have a pacemaker, transplanted organ, breast implant, or other implants?

   _____

   _____

   _____

ELITE PHYSICAL THERAPY AND SPORTS REHABILITATION, LLC.

Financial Policy

I authorize Elite Physical Therapy and Sports Rehabilitation, LLC. to bill my insurance company directly as an **Out of Network Provider** for the covered portion of charges, and I authorize payment of benefits directly to Elite Physical Therapy and Sports Rehabilitation, LLC. I authorize. Elite Physical Therapy and Sports Rehabilitation, LLC to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

_____ _____

Signature of Patient (or Legal Guardian) Date

Elite Physical Therapy and Sports Rehabilitation, LLC.
Notice of Privacy Rights and Practices

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. PLEASE ASK TO HAVE THIS FORM TRANSLATED FOR YOU TO ENSURE YOU UNDERSTAND ITS CONTENTS.

We are required under the Health Insurance Portability and Accountability Act (HIPAA) to maintain the privacy of your health information, and to provide you with this Notice of Privacy Rights and Practices if requested.

This document explains in detail how we use your Protected Health Information (PHI) which is any information about you that could identify you, your past, present, or future physical or mental health condition(s). Your acknowledgment of receipt of this document will be required the first time you receive services. This policy went into effect April 14, 2003.

Our Pledge: We understand that medical information about you and your health is personal and we are committed to protecting that privacy.

We create a record of the care and services that you receive at Elite Physical Therapy and Sports Rehabilitation, LLC. in order to help us provide quality care and to comply with certain legal requirements. The information that follows applies to all of the records of your care created by our practice, whether made by our practice or your personal physician. When you enter our practice, we will ask you to sign a Consent Form. Your consent grants us permission to use medical information and disclose your information without your authorization for the following:

☐ Treatment	**We keep a record of each visit. These records may include your test results, diagnoses, medications or other therapies. These records are used and disclosed to allow doctors, nurses, therapists and other healthcare and clinical staff providers to offer high quality care to meet your needs. Your medical information may also be used to remind you about an appointment.**
☐ Payment	**We maintain a record of and may use and disclose information related to, services and supplies you receive at each visit so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payers about an upcoming treatment or service, which requires their prior approval and authorization.**
☐ Health Care	**We use and disclose your medical information to improve the Operations services we provide, to train staff and students, for business management – including marketing, and for customer service purposes.**

Your information may be shared amongst Elite Physical Therapy and Sports Rehabilitation, LLC other health care providers, third party payers, and our Business Associates to facilitate treatment, payment or health care operations.

Additional Uses and Disclosures: There are additional times when we are permitted or required to use and/or disclose medical information without your permission. These circumstances are listed below:

- **In emergency treatment situations**
- **To assist incommunicative patients**
- **For organ donations**
- **For law enforcement**
- **If required by law**
- **For public health activities such as tracking diseases**
- **To protect victims of abuse, neglect, or domestic violence**
- **For health oversight activities such as fraud investigations**
- **To Workers' Compensation if you are injured at work**
- **For certain judicial or administrative proceedings**
- **To coroners, medical examiners and funeral directors**
- **For government functions such as national security and intelligence**
- **To a correctional institution if you are an inmate**
- **To avert serious threat to public health or safety**

- recommend treatment alternatives
- tell you about health benefits and/or services
- send, text, email or call you with appointment reminders
- to communicate with those involved in your care

Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. You may revoke any authorization you provide at any time by delivering a written statement directly to the HIPPA Privacy Officer (listed below), except to the extent that we have already taken action in reliance on your authorization.

Please know that federal and state law requires special privacy protections for certain highly confidential information about you, including but not limited to:

- Psychotherapy notes
- Mental health and developmental disabilities services
- Alcohol and drug abuse prevention, treatment and referral
- HIV / AIDS testing, diagnosis or treatment
- Venereal disease(s)
- Genetic testing
- Child abuse and neglect
- Domestic abuse of an adult with a disability
- Sexual assault

In order for us to disclose your highly confidential information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS: Under HIPAA, you have the right to request in writing:

- Restrictions on how we use or disclose your medical information
- Confidential communications to an alternate phone or address other than your home
- Access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply)
- An amendment to your medical information if you feel you or your health care provider needs to make additions or corrections
- An accounting of disclosures of your medical information for purposes other than treatment, payment, health care operations or made pursuant to an authorization
- A paper copy of this Notice even if you have received it electronically
- A revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research

While we will consider all requests for privacy restrictions carefully, we are not required to agree to any requested restrictions.

OUR RESPONSIBILITIES: we are required by law to maintain the privacy of your medical information, to provide you with this written Notice of Privacy Rights and Practices if requested, and to abide by the terms of the Notice currently in effect. We reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our offices, and will be available from your direct treatment provider.

FOR MORE INFORMATION: If you would like further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your Protected Health Information, you may contact our HIPPA Privacy Officer at the address or phone number below. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the HIPPA Privacy Officer will provide you with the correct address for the Director. All complaints will be investigated thoroughly and you will not be penalized for filing a complaint.

Elite Physical Therapy and Sports Rehabilitation, LLC and its employees are committed to protecting patient privacy.

_____ _____

Signature of Patient (or Legal Guardian) Date