Stafford Physical Therapy New Patient Intake Form

Name _____ Middle _____ Last Name_____

Date of Birth_____ Male/Female Age _____ Social Security Number _____-____-_____
(Veterans please type FULL SSN)

Address _____ Apt #_____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____

Email _____ Marital Status S M W D

How did you hear about us? _____

Occupation (if dependent, list parent's occupation) _____

Employer _____ Phone _____

Address_____ State/Zip_____

Emergency Contact/Relationship _____ Phone _____

Referring Physician _____ Phone Number _____

Person Responsible for this account (Parent/Tricare Sponsor)

Name _____ Phone _____

Sponsor Social Security Number _____-_____-_____Sponsor Date of Birth _____

Address_____ City_____ State_____Zip_____

Please check which apply to your visit

☐ Work related injury
☐ Motor vehicle accident
☐ Unknown cause
☐ Recurrence of previous injury
☐ Injury related to lifting
☐ Athletic/recreational injury
☐ Injury related to falling
☐ Other _____

Date of injury/onset _____ Date of surgery (if applicable) _____

Workers' Compensation/Attorney

Attorney _____ Phone Number _____

Workers Compensation Provider _____

Workers Compensation Case Manager/Adjustor Name _____

Phone Number _____ Fax Number _____

Employer Address _____State/Zip_____

Employer Phone _____Claim Number _____

Do you have, of have you had any of the following? (Please check all that apply)

☐ Diabetes
☐Chest pain/Angina
☐ High Blood Pressure
☐ Heart Disease
☐ Allergies/poor tolerance to cold
☐ Other allergies
☐ Pacemaker
☐Headaches
☐Cancer
☐ Osteoporosis
☐Metal Implants
☐ Surgeries
☐ Skin Abnormalities
☐Sexual Dysfunction
☐ Nausea/Vomiting
☐ Ringing in your ears
☐ Rheumatoid Arthritis
☐ Heart Attack
☐ Heart Palpitations
☐Allergies
☐ Allergies to heat
☐ Hernia
☐ Seizure
☐ Kidney problems
☐ Are you pregnant? ☐ Yes ☐ No
☐ Osteoarthritis
☐ Hypoglycemia
☐ Special Diet Guidelines
☐ Bowel/Bladder Abnormalities
☐ Urine leakage
☐ Asthma/Breathing Difficulties
☐ Liver/Gallbladder Problems
☐ Smoking
☐ Stroke/CVA

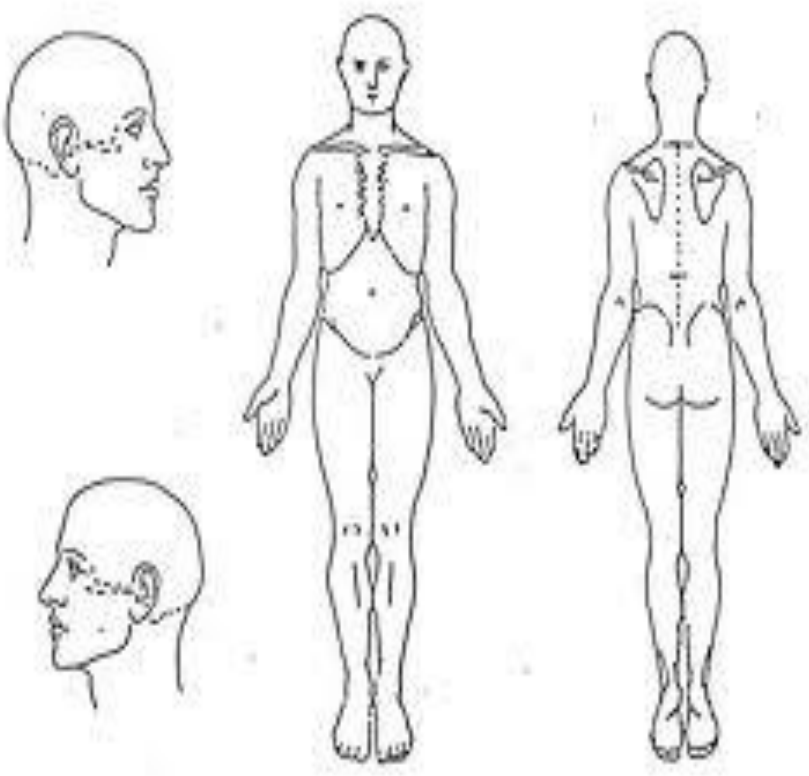
If any aforementioned box(es) checked, briefly explain and give approximate date.
Past Surgical History (Surgery/Date

_____
_____
_____
_____
_____
_____
_____

Please list all prescribed medications and non-prescribed medications you are currently taking

Medication	Dosage	Frequency	Administration (oral, injection, etc.)

Please indicate where your symptoms are located on picture below



If you have pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain, and 10 being the worst pain possible

Current _____

Best _____

Worst _____

Weight _____

Height _____

Please describe your present symptoms and complaints

_____
_____
_____
_____
_____
_____

CREDIT AND INSURANCE AGREEMENT

_____Responsibility for Payment:
I understand that I am responsible for paying all charges (e.g. copays, cost shares, deductibles, co-insurance and entire bill if insurance will not cover the claims at all) as well as any interest, collection fees, penalties and attorney's cost if the need arises.

_____Insufficient Funds
Should I present a check that is unable to be processed due to insufficient funds, I understand that a $50.00 fee will be assessed. The replacement funds are to be in the form of:
1) cash, 2) money order, or 3) cashier's check. Should your account go to collections for an outstanding balance, there will be a fee of 35% of the outstanding balance added to your account.

_____Cancellation Fees
I understand that if I fail to call to cancel an appointment, I will be charged $50.00.

_____Assignment of Benefits
I hereby assign to Stafford Physical Therapy medical benefits otherwise payable to me or my insured dependent by virtue of medical insurance obtained at Stafford Physical Therapy.

_____Release of Information
I authorize Stafford Physical Therapy to release my insurance company(ies) or other third-party agencies, Whatever information necessary in connection with payment of medical services.

_____Validation
It is my understanding that I am to pay the agreed upon copay and/or payment arrangement as set by my insurance plan/or Stafford Physical Therapy on a weekly basis unless other arrangements have been made.

Signature: _____Date:_____
Guarantor

Signature of Guardian if patient is a minor:

_____ Date: _____

STAFFORD & FREDERICKSBURG
PHYSICAL THERAPY

Notice of Privacy Practices for Protected Health Information (PHI)

<u>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!!</u>

- We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
- We may disclose your health information to you insurance provider for the purpose of payment or health care operations.
- We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
- We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
- As required by law, We may disclose your health information to the public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- We may disclose your health information in the course of any administrative or judicial proceeding.
- We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose your health information to coroners or medical examiners.
- We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
- It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular or to the general public.
- We may disclose your health information for military, national security and government benefits purposes.
- We may leave a message on an automated answering device or person answering the phone for the purpose of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your appointment along with a request to call our office if you need to cancel or schedule your appointment.
- In the event that we are sold or merged with another organization, your health information/records will become the property of the new owner.
  - You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
  - You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
  - You have the right to inspect and copy your health information.
  - You have the right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
  - You have the right to receive an accounting of disclosures of your protected health information made by us.
  - You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of privacy Practice at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at **(540)659-6408**.

Complaints about your Privacy Rights, or how we have handled your health information should be directed to our Office Manager/ Privacy Officer by calling our office at **(540)659-6408**.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the privacy notice and understand my rights contained in the notice.

By way of my signature, I provide **Stafford Physical therapy and Fredericksburg Physical Therapy** with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operation as described in the Privacy Notice.

Stafford Physical Therapy
572 Garrisonville Road
Stafford VA 22554
(T)540-659-6408
(F)540-659-6445

Fredericksburg Physical Therapy
1206 Bragg Road
Fredericksburg VA 22407
(T)540-786-5535
(F)540-786-9225

Patient's Name (PRINT)

Patient's Signature DATE

Authorized Facility signature **DATE**

STAFFORD & FREDERICKSBURG
PHYSICAL THERAPY

Peter Horricks, PT, Owner Taylor Horricks, PT, DPT, Owner

CANCELLATION/LATE POLICY

_____ All patients will have **24 hours** before their scheduled appointment to cancel there appointment with no penatly. If you are unable to cancel your appointment within that 24 hour period there will be a **$50 Fee** placed on your account. This fee will need to be paid before your next appointment.

_____ If you are running late to your appointment and you call to inform us we will allow you to have a **10 minute grace period**. If you do not call us and you are late, your appointment will be canceled and rescheduled and there will be a **$50 fee** applied to your account. This fee will need to be paid before your next appointment.

Signature_____ Date _____