RESPIRE PHYSICAL THERAPY LLC

**WOULD YOU BENEFIT FROM A HOME SAFETY ASSESSMENT?** **YES** **NO**

## PATIENT INFORMATION

Last Name: _____ First Name: _____ SS#: _____

Date of Birth: _____/_____/_____ Gender: Male Female __

Address: _____ Apt/Ste #: _____

City: _____ State _____ Zip _____

Day Phone _____-_____-_____ Home Phone _____-_____-_____

Cell Phone _____-_____-_____ Work Phone _____-_____-_____

Email _____@_____

Marital status: Married Single Domestic Partner Widowed

Employer/School Name: _____ Occupation/Grade: _____
Primary Care Physician: _____ Diagnosis: _____

Referring Physician: _____ Referred By: _____

**Injury:** Work Related? Yes No If Yes, Date of Injury: _____

Auto Related? Yes No If Yes, Date of Accident: _____

## BILLING INSURANCE INFORMATION

**Primary Insurance Company** _____
Name of Policy Holder_____ Relationship _____

Policy Holder Date of Birth ___/____/_____ ID# _____ Group#_____

Policy Holders Employer: _____

**Secondary Insurance Company** _____

Name of Policy Holder _____ Relationship _____
Policy Holder Date of Birth ___/____/_____ ID# _____ Group# _____

Policy Holders Employer: _____

**Work Comp or MVA Related**
Have you retained an Attorney? Yes No Law Firm Name _____
Attorney Name _____ Phone _____-_____-_____

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# PATIENT MEDICAL HISTORY & INTAKE QUESTIONNAIRE

**Name:** _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

**Date of next physician appointment:** _____

**What problems are you being treated for today? (Describe type and location of symptoms)** _____

_____

**What are your top 3 concerns/difficulties related to your injury/reason for coming?** _____

_____

**What date (roughly) did your present symptoms start?** _____

**How did your pain/problems begin:** _____

**My symptoms are currently:** GETTING BETTER GETTING WORSE STAYING THE SAME

**What makes your symptoms better?** _____

**What makes your symptoms worse?** _____

**What time of day are your symptoms worse?** MORNING AFTERNOON EVENING OVERNIGHT

**Indicate Treatment/Special tests you have received for this problem (mark all that apply):** *Include Dates if known*

_____**Physical Therapy** _____**Occupational Therapy** _____**Chiropractic** _____**Injections**
_____**Surgery-(Date_____)** _____**X-ray** _____**Bone Scan** _____**CT scan** _____**MRI**
**Other-*please list*:** _____

**Have you received Physical/Occupational therapy within the last calendar year?** YES NO
**If Yes**, approximately how many sessions? _____

## MEDICAL HISTORY/CO-MORBIDITIES

Do you now or have you ever had any of the following?

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| _____ | _____ | Anemia | _____ | _____ | Gout |
| _____ | _____ | Anxiety | _____ | _____ | Headaches/Migraines |
| _____ | _____ | Asthma | _____ | _____ | Heart Attack |
| _____ | _____ | Cancer | _____ | _____ | Heart Murmur |
| _____ | _____ | Chest Pain/Trouble breathing | _____ | _____ | Hepatitis |
| _____ | _____ | Chronic Bronchitis | _____ | _____ | High Blood Pressure |
| _____ | _____ | Clotting Disorder | _____ | _____ | High Cholesterol |
| _____ | _____ | Depression | _____ | _____ | HIV positive/AIDS |
| _____ | _____ | Diabetes | _____ | _____ | Kidney Disease |
| _____ | _____ | Difficulty Sleeping | _____ | _____ | Osteoarthritis |
| _____ | _____ | Dizziness/Vertigo | _____ | _____ | Osteoporosis |
| _____ | _____ | DVT/PE | _____ | _____ | Pace Maker/Defibrillator |
| _____ | _____ | Emphysema | _____ | _____ | Rheumatoid Arthritis |
| _____ | _____ | Epilepsy | _____ | _____ | Stroke/TIA |
| _____ | _____ | Fibromyalgia | _____ | _____ | Thyroid Disease |
| _____ | _____ | Fractures | _____ | _____ | Ulcers |
| _____ | _____ | Glaucoma | _____ | _____ | TBI |

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## MEDICATIONS

Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking.

_____ **Copy of a detailed Medication list has been provided**

**If not, list medications** *(use back of paper if needed)*

| Medication Name | How much (dose) | How often | How taken (circle one) |
|---|---|---|---|
| _____ | _____ | _____ | ointment pill drop patch injection inhaler |
| _____ | _____ | _____ | ointment pill drop patch injection inhaler |
| _____ | _____ | _____ | ointment pill drop patch injection inhaler |

**Any allergies to medication(s)/other?** _____
If so, what are your reactions? _____

## PERSONAL FACTORS

**Please circle which applies:** House Condo/Apartment Group Residence Mobile Home

**Do you live alone?** Yes No

**Do you currently use any Assistive Devices?** ___Cane __Wheeled Walker ___Crutches ___None Other: _____

**Do you have someone to help you if needed due to your current injury?** Yes No

**Do you drive?** Yes No ____No Restrictions ____Day Time only ____Night Time only ____Local only

**Occupation:** _____
Daily Physical/Emotional demands: High Moderate Minimal

Are you currently working? Light duty Full Duty Not Working
If not working, date last worked? _____/_____/_____

**Leisure Activities/Hobbies**: _____

**Overall activity level**: Sedentary Light Moderate Heavy

**What Estimated % (0% Best - 100% Worst) of your daily activities that are affected due to current condition:** ____%

**Are you pregnant?** Yes No If yes, number of weeks? _____

**Tobacco Use** Yes No If yes, amount? _____

**Alcohol Intake** Yes No If yes, frequency? _____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient/Guardian Signature _____ Date _____/_____/ _____

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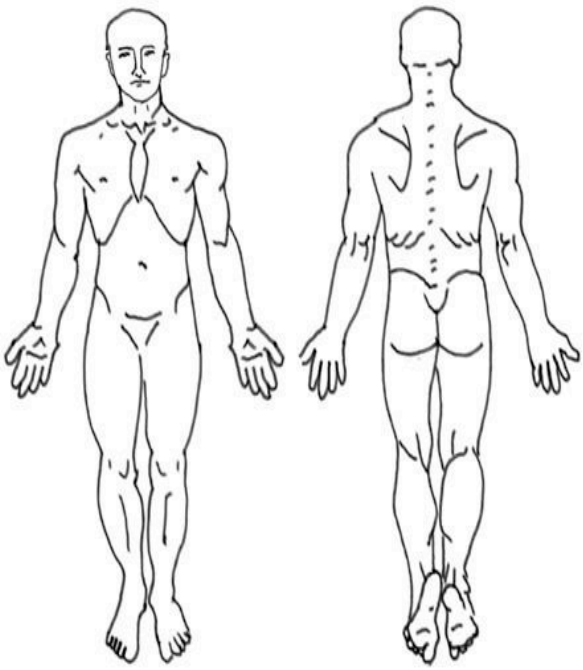
## Rate your pain

Patient Name: _____ Date Completed: _____/_____/_____

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours.

**Be VERY precise when drawing the location of you pain.** Use the key below to indicate symptoms.

| Key: | Pins and Needles = 000000 | Stabbing = ////// |
|---|---|---|
| | Burning = xxxxxx | Deep Ache = zzzzzz |



Please rate your current level of pain on the following scale (circle one):

No Pain 1 2 3 4 5 6 7 8 9 10

Please rate your worst level of pain in the last 24 hours on the following scale (circle one):

No Pain 1 2 3 4 5 6 7 8 9 10

Please rate your best level of pain in the last 24 hours on the following scale (circle one):

No Pain 1 2 3 4 5 6 7 8 9 10

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## CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. **CONSENT FOR TREATMENT**: I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment/tests.

2. **RESPONSIBILITY FOR PAYMENT**: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Sports Physical Therapists, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Sports Physical Therapists with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

**Please note that refusal to sign this form does not change responsibility for payment in any way.**

3. **ASSIGNMENT OF BENEFITS**: I hereby assign to Sports Physical Therapists all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

4. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that Sports Physical Therapists may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Sports Physical Therapists administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Sports Physical Therapists Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

5. **HIPAA CONSENTS**: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

| _____ | _____ | _____ |
|---|---|---|
| Name/Relationship | Name/Relationship | Name/Relationship |

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

6. **CONSENT FOR EMERGENCY CONTACT INFORMATION**
Person to contact in case of an emergency:

| _____ | _____ | _____ |
|---|---|---|
| Name | Telephone Number | Relationship |

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

| _____ | _____ |
|---|---|
| Signature of Patient or Legally Responsible Person | Date |
| _____ | _____ |
| Printed Name of above | Date |

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# 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 REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI about you is maintained as a written and/or electronic record. Specifically, it individually identifies you and relates to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare.

We are required by law to maintain the privacy of your health information and provide you with a copy of this notice. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice, and make the revised or changed notice effective for all health information that we maintain. Any changes to this notice will be posted in our facilities and on our website. Paper copies will be available upon request.

## HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

**For Treatment.** We may use health information about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care.

**For Payment.** We may use and disclose health information, as needed, about you so the treatment and services you receive may be billed, and payment may be collected from you, an insurance company or a third party. For example, this may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage of health benefits.

**Healthcare Operations.** We may use or disclose, as-needed, your protected health information for our day-to-day health care operations to ensure that you and other patients receive quality care. For example, we may use or disclose PHI relating to the evaluation of patient care, business management activities, quality assessment and improvement, employee reviews, legal services, and auditing functions. All disclosures of your PHI will be limited to the minimum necessary or that which is contained in a limited data set (e.g. PHI that excludes certain identifiers including demographic information, photographs, etc.).

## OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

**Special Notices.** We may contact you at the address and phone number you provide (including leaving a voice message) about scheduled or canceled appointments, billing and/or payment matters. We may also contact you about health related services or Sports Physical Therapists and its affiliates locations that may be of interest to you.

**Required by Law.** We may use or disclose your health information when required to do so by federal or state law. We must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements under the Privacy Rule.

**Public Health Risks.** We may release your health information for public health activities. For example, disclosures related to the quality, safety or effectiveness of a product, prevention or disease control, to coroners, medical examiners and funeral directors as needed to perform their duties as required by law, and organ procurement organizations for the purpose of facilitating organ, eye or tissue donation and transplantation

**Victims of Abuse, Neglect or Violence.** We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly.

**Health Oversight Activities.** We may disclose your health information to health agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of government regulatory programs.

**Judicial and Administrative Proceedings.** We may disclose your health information in the course of an administrative or judicial proceeding in response to a court order. Under most circumstances, when the request is made through a subpoena, a discovery request, or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

**Law Enforcement.** We may disclose your health information for law enforcement purposes.

**Research.** Your health information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

**To Avert a Serious Threat to Health or Safety.** We may disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of a particular person or the general public.

**Specialized Government Functions**. We may disclose health information for military and veterans' affairs, or national security and intelligence activities.

**Worker's Compensation.** Both state and federal law allow, without your authorization, the disclosure of your health information that is reasonably related to a worker's compensation injury. These programs may provide benefits for work-related injuries or illness.

**Others Involved in Your Healthcare**. Unless you object, we may disclose to a family member, relative or close friend your PHI that directly relates to that person's involvement in your care. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of PHI.

**Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us services if the PHI is necessary for those functions or services. For example, we may use a shredding company to destroy paper medical records. To protect your health information, we require the business associate to appropriately safeguard your information.

**Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Non-Custodial Parent.** We may disclose PHI about a minor equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.

**USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:**

If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Your decision to revoke authorization will not affect or reverse any use or disclosure that occurred before you notified us of your decision.

**SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH, AND GENETIC INFORMATION:**

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Please contact our Manager of Privacy and Compliance for more information.

**YOUR HEALTH INFORMATION RIGHTS:**

You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of your healthcare information. This includes health and billing records. Your request to inspect and obtain a copy of your healthcare information must be made in writing to: The Facility Manager/Front Desk Coordinator where treatment was rendered. In addition, we may charge you a reasonable fee to cover our expenses for copying your health information.

We may deny your request to inspect and copy your PHI in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who participated in the original decision to deny the request for access.

**Right to an electronic copy of electronic medical records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request an electronic copy of your record be given to you or transmitted to another individual or entity.

**Right to receive a security breach notice.** You have the right to receive written notification if Sports Physical Therapists or its affiliates discovers a breach of unsecured PHI, and determines through a risk assessment that notification is required.

**You have the right to request an amendment to your protected health information.** If you believe the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. An amendment request must be made in writing, and must provide reasons to support your request. In certain cases, we may deny your request for an amendment if: Your request is not in writing or does not include reasons to support the request; the medical record was not created by us, the person who created the information is no longer available to make the amendment, the record is not part of the health information we maintain, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete.

**You have the right to request a restriction of your protected health information.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to family members or friends who may be involved in your care or payment for your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your requested restriction. If we agree, we will comply unless we terminate our agreement or the information is needed to provide emergency treatment too you.

**Out-of-pocket payments.** If you paid out-of-pocket in full for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We are required to agree to your request.

**You have the right to request that you receive confidential communications.** You have the right to request confidential communication from us by alternate means or at an alternate location. For example, you may ask that we only contact you at work or by mail.

**You have the right to receive an accounting of certain disclosures.** You have the right to receive a list of disclosures of your PHI that we have made, except for disclosures pursuant to an authorization, for purposes of treatment, payment, healthcare operations, or required by law. Your request must state a time period which may not be longer than 6 years before your request.

**You have the right to obtain a paper copy of this notice, even if you agreed to receive the notice electronically.**

**HOW TO EXERCISE YOUR RIGHTS**: To exercise your rights described in this notice, you must submit your request in writing to: Respire Physical Therapy LLC, 5663 Columbia Pike, Falls Church, VA 22041.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our practice. We request that you file your complaint in writing so we may better assist in the investigation of your complaint. Send your written complaint to:

Manager of Privacy and Compliance, Respire Physical Therapy LLC, 5663 Columbia Pike, Falls Church, VA 22041.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Washington D.C. 20201, or through the DHHS. Additional information can also be found on their website at www.hhs.gov/ocr/hipaa/.

You will not be penalized or otherwise retaliated against for filing a complaint.

If you want more information about our privacy practices or have questions please contact:

Manager of Privacy & Compliance, Respire Physical Therapy LLC, 5663 Columbia Pike, Falls

Church, VA 22041.

Phone: 703-671-1871 Fax: 703-671-1790