ACTION
Physical Therapy & Sports Medicine

HEALTH HISTORY

Patient's Name________________________________ Occupation ________________________________

Age ____________ Height____________ Weight____________ Date of Injury ______________

Referring Physician ________________________

What is your main complaint? ____

____

How and when did your symptoms begin? ____

____

On the scale below, with 0 being no pain and 10 being worst pain, rate your pain at worst pain possible, current pain, and pain at its best.

WORST 0 1 2 3 4 5 6 7 8 9 10 **CURRENT** 0 1 2 3 4 5 6 7 8 9 10 **BEST** 0 1 2 3 4 5 6 7 8 9 10

What activities increase your pain? ____

What activities decrease your pain? ____

Have you received Physical Therapy for this condition or any other condition in the past? __________

If yes, please list where, when, and for what condition? **Some insurances have a limit, and this is important for authorization purposes!** ____

Please list all surgeries, accidents, and other medical conditions and dates:

Surgeries	Dates	Surgeries	Dates

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Do you have any of the following?

- ☐ High Blood Pressure
- ☐ Abnormal Heart Condition
- ☐ Circulatory Problems
- ☐ Breathing Abnormalities
- ☐ Pacemaker
- ☐ Metal Implants
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Cancer
- ☐ Pregnancy
- ☐ Difficulty Sleeping
- ☐ Weakness
- ☐ Headaches/Migraines
- ☐ Numbness/Tingling
- ☐ Fainting/loss of consciousness
- ☐ Falls
- ☐ Dizziness
- ☐ Fractures/Sprains
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Tremors
- ☐ Muscle spasms/cramp

Please list all Medications: if you have a list, we will be happy to copy it for you.

Medicine	Dosage	Frequency	Physician

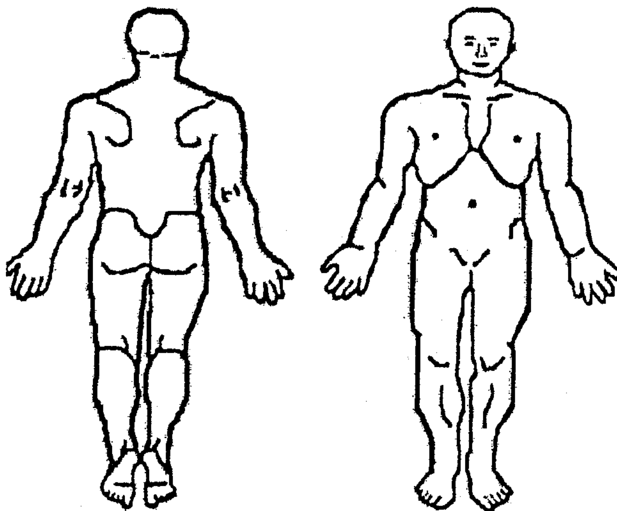
Is there any other medical information that we should know about? ______________________________

____

What are your physical therapy goals currently? ______________________________

____

***Please shade in the areas in which you feel your symptoms**



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PATIENT INFORMATION FORM

(Please print)

Patient Full Name ______________________ Nickname: ______________

Parent/Guardian Name: ______________________

Date of Birth ____________ ❒ Male ❒ Female

Home Address ______________________ City__________ State ________ Zip __________

Mailing Address (if different than above) ______________________

Home Phone ______________ Cell ______________ Work ______________

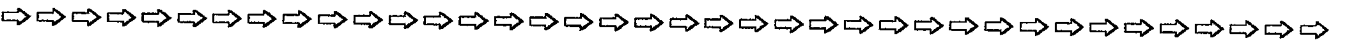
Email ______________________

How did you hear about us? ______________________

WHAT IS THE BEST WAY TO REMIND YOU OF YOUR APPOINTMENTS: TEXT ME ☐ CALL ME ☐ EMAIL ☐

Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Employer ______________________ Occupation ______________________



WORKERS COMPENSATION ONLY: Date of Injury: ____________ Claim #: ______________

Adjuster: ______________________ Adjuster's Contact #: ______________________

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Are you currently receiving any healthcare services in your home? Yes ☐ No ☐

INSURANCE INFORMATION

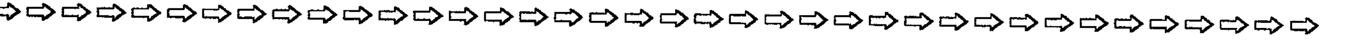
(Please list the POLICY HOLDER'S information here if you are a dependent)

Primary Insurance: ______________ Policy #: ______________ Group #: ______________

Policy Holder: ______________ Relationship: ______________ Date of Birth: ______________

Secondary Insurance: ______________ Policy #: ______________ Group #: ______________

Policy Holder: ______________ Relationship: ______________ Date of Birth: ______________



EMERGENCY CONTACT INFORMATION

(This is not a release of information)

Name ______________________ Relation ______________________

Home Number (______) ______________ Cell # (______) ______________

Address: ______________________

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CONSENT FOR TREATMENT

Physical therapy is often a hands-on process which does include but is not limited to palpation, massage, and therapeutic touch. Physical therapy treatment can also include the application of thermal or electrical agents producing heating, cooling or stimulation of the body tissues. It is very important to communicate with your therapist immediately any perceived ill effects of treatment to allow the therapist the ability to timely and appropriately modify the treatment parameters.

We recognize your right to refuse any treatment procedure we may recommend or employ during your treatment. We will make every effort to insure both your privacy and confidentiality.

By signing below, you understand and agree to the above information.

Patient Name: ________________________________ Patient's Signature ________________________________
(parent/guardian IF patient is a minor) (parent/guardian IF patient is a minor)

CANCELLATION POLICY

We try our best to schedule your appointments for you to receive the best care. We do ask that you **call 24 hours** in advance to cancel an appointment. We have a cancellation list and expect each patient to respect that others want your appointment time also. We reserve the right to charge you $25.00 each cancellation, which needs to be paid in full upon your return, when your cancellations become excessive and impacts your plan of care. ***Your treatment is important, and it is essential to follow your plan for you to have the best outcome.***

ASSIGNMENT OF BENEFITS

I understand that services rendered to me by Action Physical Therapy are my financial responsibility and that Action Physical Therapy will bill my insurance company from the information I provide. I authorize my insurance company to pay my benefits directly to Action Physical Therapy and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. I also understand that should my insurance company send payment to me; I will forward the payment to Action *within 48 hours*. I authorize Action Physical Therapy to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Patient Signature: ____ Date: ________________
(parent/guardian IF patient is a minor)

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, ______________________________, hereby authorize, Action Physical Therapy & Sports Medicine to release medical information contained in the course of my treatment to my doctor(s) and insurance company as authorized by HIPAA.

Please list any additional person/facility that you give permission to access your medical information:* **WE WILL NOT GIVE ANYONE ANY INFORMATION WITHOUT YOUR PERMISSION INCLUDING: FAMILY, CLOSE FRIENDS, HUSBANDS, WIVES, ETC.

Person to release to and/or facility name & address	____________________ ____________________

The disclosure of this information is for the purpose of Physical Therapy Treatment and shall be limited to the following specific types of information:

____

____

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. I have carefully read, and I understand the foregoing. I consent to the release of the above specified information about my condition and the treatment and services I have received to those persons and agents listed.

I further release SRS and its employees and agents, from any liability arising from the release of this information to such designated agencies and persons. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon, and if not earlier revoked, it shall not terminate unless requested.

Patient's Name: ______________________________ Date: ____________

Patient's Signature: ______________________________ Relationship to patient: ______________
(Parent/guardian IF patient is a minor)

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HIPAA NOTICE OF PRIVACY PRACTICES

FOR A COMPLETE DESCRIPTION, PLEASE REFER TO: Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that releases to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your PHI to support the business activities of your physician's practice. These activities include, but are not limited to, qualify assessment activities employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use or disclose your PHI to medical school students that see patients at our offices. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call your name in the waiting area room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food or Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security; Workers' Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: You have the right to inspect and copy your PHI: Under federal law, however you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding, and PHI that is subject to law the prohibits access to protected health information.

You have the rights to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of you PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part or your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to
agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

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You may have the right to have your physician amend your PHI: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information: We reserve the right to charge the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provider in this notice.

Complaints: You may to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledging that you have received this Notice of our Privacy Practices. You may revoke this at any time in writing; otherwise this authorization will expire upon termination or transfer from current insurance plan.

Patient's Name: ______________________________

Signature (parent/guardian if minor): ______________________________

Date: ______________

COVIND-19 PANDEMIC EMERGENCY PHYSICAL THERAPY TREATMENT NOTICE AND ACKNOWDLEGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization (WHO) has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contacting COVID-19 associated with physical therapy care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other PT patients, the characteristics of the virus and the characteristics of PT procedures, there is an elevated risk of you contracting the virus simply by being in a PT clinic.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus such as: abnormal temperature, trouble breathing, dry cough, runny nose, have you or have you been in contact with someone who has tested positive or COVID-19 or awaiting COVID-19 results, have you traveled outside of the USA or within the USA by air, bus or train with the last 14 days.

I confirm that I have read the notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the PT clinic. I understand and accept the additional risk of contracting COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

____
Signature

____
Date

____
Witness

Cancellation Policy

We try our best to schedule your appointments for you to receive the best care. We do ask that you call **24 hours in advance to cancel an appointment.** We have a cancellation list and expect each patient to respect that others want your appointment time. ***We reserve the right to charge you $25.00 for EACH cancellation,*** which is required to be paid in full before your next visit. When cancellations become excessive, it can impact your plan of care. Your treatment is important, and it is essential to follow your plan of care to ensure the best treatment outcome. Thank you for your understanding and cooperation.

Patient Signature: ______________________________

(parent/ guardian sign if patient is a minor)

Date: ______________________________