Elite Physical Therapy

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI ____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature:_____ Date:_____

***If filling out electronically, all signatures will be done at patient's first office visit.

Medicare Secondary Payer (MSP) Form

Patient name: _____ Acct#: _____

Medicare requires us to identify if Medicare is the primary or secondary payer, please answer all the required questions below.

1. Do you receive Veteran's benefits? ☐ Yes ☐ No
2. Are the services to be paid by a government research program? ☐ Yes ☐ No
2. Are you receiving benefits under the Black Lung Program? ☐ Yes ☐ No
   If yes, date benefits began _____
   Black lung is primary payer only for claims related to black lung
3. Was this injury/illness due to a work-related accident/condition? ☐ Yes ☐ No
   If yes, date of injury/illness _____; *Please provide the WC information*
4. Was the injury/illness related to accident? ☐ Yes ☐ No
   If yes, date of accident _____
   Is no-fault insurance available? ☐ Yes ☐ No
   If yes, please provide no-fault insurance information
5. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? ☐ Yes ☐ No *If yes, please provide the Attorney's information*

(If answered YES to any of the questions above, Medicare is the secondary payer)

6. Are you entitled to Medicare based on:
   ☐ Age (65 & over)—go to question 7
   ☐ Disability—go to question 8
   ☐ End Stage Renal Disease—if **yes to both questions below-group health plan (GHP) is primary**
   1. Do you have group health plan coverage? ☐ Yes ☐ No
   2. Are you within the 30-month coordination period? ☐ Yes ☐ No

7. Are you currently employed? ☐ Yes ☐ No - Date of retirement _____
   a. Is your spouse employed? ☐ Yes ☐ No - Date of retirement _____
   b. Do you have a GHP as primary coverage based on your own or spouse's current employment? ☐ Yes ☐ No
   c. Does the employer that sponsors the GHP employ <u>20 or MORE</u> employees? ☐ Yes ☐ No

If you OR your spouse is currently employed and answered YES to BOTH b and c, GHP is primary, please provide your insurance information

8. Are you currently employed? ☐ Yes ☐ No Date of retirement _____
   a. Is your spouse/family member employed? ☐ Yes ☐ No
   b. Do you have a GHP as primary coverage based on your own or spouse's or family member's current employment? ☐ Yes ☐ No
   c. If you have group health coverage, does employer that sponsors the GHP employ <u>over 100 or more</u> employees? ☐ Yes ☐ No

If you have GHP coverage based on your or spouse's or family member's current employment and answered YES to BOTH b and c, GHP is primary, please provide your insurance information.

_____ _____

Signature of Patient/Representative Date

Relationship to patient _____

Medical Screening Questionnaire

Name:_____

Date:_____ Gender: M O F O Age:_____ Smoker: Y O N O Pregnant: Y O N O

Have you received any Home Health or Hospice services in the last 90 days or are currently enrolled in Home Health/Hospice? ☐ yes ☐ no **Where?** _____

Have you had Physical Therapy this year? ☐ yes ☐ no **Where?** _____

Were you injured at work? ☐ yes ☐ no **When?** _____

Surgical history & dates:_____

_____

List all current medications:_____

_____

Have you had an x-ray, MRI, or other study regarding your current condition? Y O N O

Past Medical History: Please circle each condition that you have been told you have (or had)

Cancer ☐ High Blood Pressur ☐ Heart Disease ☐ Liver Disease ☐

Stroke ☐ Angina/Chest Pai ☐ Osteoarthritis ☐ Osteoporosis ☐

Ulcers ☐ Fibromyalgia ☐ Rheumatoid Arthritis ☐ Sexually Transmitted Diseases ☐

Diabetes ☐ Lung Disease ☐ Allergies ☐ Asthma ☐

Have you had any other recent illness?_____

Are you allergic to latex? Y O N O Do you take blood thinners? Y O N O

I currently have: (circle all that apply): Fever/chills/sweats ☐ Poor balance (Falls) ☐

Unexplained weight loss ☐ Numbness/tingling ☐ Difficulty swallowing ☐

Shortness of breath ☐ Dizziness ☐ Headaches ☐ Changes in appetite ☐

Changes in bowel & bladder function ☐ Nausea/Vomiting ☐ Increased pain at night ☐

Current Symptoms

Where are you having symptoms?_____

What date (approximate) did your present pain start?_____

How (gradually, suddenly, injury?)_____ My symptoms are: Getting better ☐ About the same ☐ Getting worse ☐

Have you received any treatment for this problem?_____

Have you ever had this problem before? Y O N O Previous treatment?_____

If so, how long did it take for you to feel better?_____

How are you able to sleep at night? ☐ Fine ☐ Moderate difficulty ☐ Only with medicine

What is your personal goal with therapy?_____

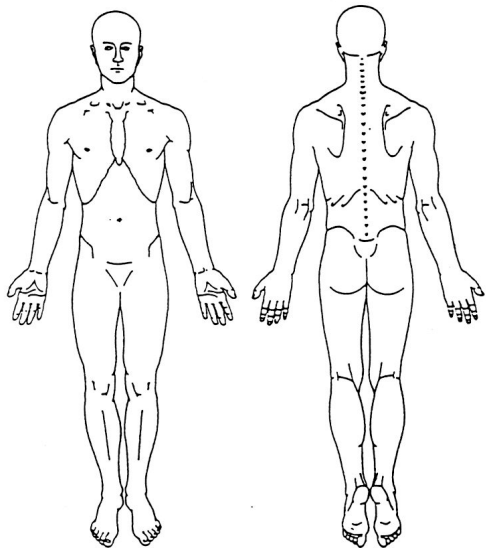
Do you have any barriers to learning that you know of? Y O N O

OVER→

Body Chart:

Please mark the areas where you feel pain, numbness or other symptoms on the chart to the right

If filling out electronically, this section can be completed upon arrival.



On the scales below, please circle the number which best represents the severity of your pain

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

Please circle the number below that best represents your overall average level of function

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do everything**

What makes your symptoms better?_____

_____

Pease circle any of these activities that make your pain worse:

Sitting ☐ Lying down ☐ Standing ☐ Walking ☐ Stress ☐

Any other specific activities make your pain worse?_____

What is typically your best time of day? **Worst?**

Aggravating factors: Please identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

_____

_____

_____

Texting and Appointment Reminder Consent

Complete this form and sign below to give your permission for Elite PT to provide automatic appointment reminder service by email or by cell phone text message. **By signing this letter, I also approve text messages to be sent to my cell for missed visits, missing/needed information, or for any requests or changes to my appointment that are made.**

Step One: Select One Option Below

☐ Elite PT may send email messages to confirm my upcoming appointments to _____.

☐ Elite PT may send cell phone text messages to confirm my upcoming appointments to _____.
I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

PLEASE DO NOT reply to text or email reminders. If you would like to contact our office, you can TEXT OR CALL us at 318-443-3311.

_____
Signature of Patient or Guardian

_____
Date

*If filling out electronically, all signatures will be done at patient's first office visit.

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.

PATIENT HEALTH INFORMATION (PHI)
Under federal law, your patient health information is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your PHI also includes payment, billing and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

HOW WE USE AND DISCLOSE PATIENT HEALTH INFORMATION:
For Treatment. We may use PHI 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 PHI for payment purposes to ensure services you receive can 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 your PHI for standard internal operations including evaluation of patient treatment, business management activities, quality assessment and improvement, employee reviews, legal services, and auditing functions.

SPECIAL USES OR DISCLOSURES:
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.
Required by Law. We may use or disclose your PHI when required to do so by federal or state law. We must also disclose your protected PHI 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 disclose information 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. We may disclose PHI to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of government regulatory programs.
Judicial and Administrative Proceedings. We may disclose information 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. We may disclose information for medical research.
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. 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.

SPECIAL 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 the Contact Person listed below.

YOUR HEALTH INFORMATION RIGHTS: You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

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.

Right to an electronic copy of electronic medical records for your records or to be transmitted to another individual or entity.

Right to receive a security breach notice. If we discover a breach of unsecured PHI, and determines through a risk assessment that notification is required, you will be notified.

You have the right to request an amendment to your protected health information. An amendment request must be made in writing, and must provide reasons to support your request.

You have the right to request a restriction of your protected health information 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.

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.

Right to request that you receive confidential communications via 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, contact the Contact Person below.

OUR LEGAL DUTY: We are required by law to protect and maintain the privacy of your health information to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Contact Person listed below. We request that you file your complaint in writing so we may better assist in the investigation of your complaint.

You may also file a complaint with the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request or visit www.hhs.gov/ocr/hipaa/.

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

CONTACT PERSON: Ryan Guillot @ 318-443-3311 or rguillot@elitephysicaltherapy.us.

I, _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained:_____

_____

Staff Witness seeking acknowledgement:

Date: _____

*If filling out electronically, all signatures will be done at patient's first office visit.