Physical and Sports Rehab

1401 Mercantile Lane, Suite 107
Upper Marlboro, MD 20774
(301)658-6881-Office (301)322-2563-Fax
www.physicalandsportsrehab.com

Patient Intake Form

AUTO OR NON-WORK RELATED ACCIDENT

Please fill this form out completely. Thank You!

Patient Information

Date _____

Patient Name _____
(Last Name, First Name, Middle Initial)

Address _____

City/State/Zip_____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

Social Security Number _____

Sex (M) (F) *(Circle One)*

Age_____Date of Birth _____

Referring Physician(s) _____

Date of last Doctor Visit _____

Date of next Doctor Visit _____

Date of Onset _____

Related to Accident? Y Work Auto Other N
(Circle One)

Employed: Full-Time Part-Time Retired Not working
(Circle One)

Employer _____

Employer Address _____

Marital Status: Single Married Other *(Circle One)*

Student: Full-time Part-Time Not a Student *(Circle One)*

How did you hear about PTSRehab?_____

Responsible Party

Name _____
(Last Name, First Name, Middle Initial)

Address _____

City/State/Zip_____

Home Phone _____

Work Phone _____

Employer Name _____

Employer Address _____

City/State/Zip _____

Emergency Contact Information

Relative/Friend _____

Telephone _____

Relative/Friend _____

Telephone _____

Insurance Information – Auto/Non-Work Accident

This Claim will be paid by:

_____ Your Personal Car Insurance

_____ Liability Claim (Another Person's Insurance

Claim #: _____

Insurance Company _____

Adjustor's Name _____

Phone #:_____ Fax #:_____

Mailing Address _____

Medical Insurance (provide a copy of insurance care & complete this section in the event your Auto claim is denied)

Insurance Co. Name:_____

Insurance Co. Phone #: _____

Insured's Name: _____

Insured is _____Patient _____Spouse _____ Parent

Claims Mailing Address _____

_____

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Patient Health History

Patient Information

Condition to be treated in Physical Therapy _____

Patient Age _____
Patient Occupation _____
When did the pain start? _____
(Approximate Date)

Patient History

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Coughing
- ☐ Sneezing

What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Pain pills
- ☐ Injection for pain
- ☐ Muscle relaxants
- ☐ Nothing
- ☐ Other

How long have you had this pain?

_____Years_____Months_____Weeks

How long have you had similar pain?

_____Years_____Months_____Weeks

Have you had any of these diagnostic tests?

X-rays	☐ Yes	☐ No	Date _____
CT scan	☐ Yes	☐ No	Date _____
EMG/NCV	☐ Yes	☐ No	Date _____
MRI	☐ Yes	☐ No	Date _____
Arthrogram	☐ Yes	☐ No	Date _____
Injections	☐ Yes	☐ No	Date _____

Have you been hospitalized for your problem?

Yes / No_____Date _____
(Circle One)

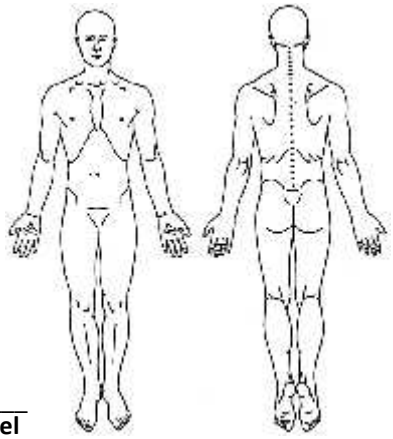
Have you had surgery for your problem?

Yes / No_____Date _____
(Circle One)

Pain/Symptoms

On the Body Diagram to the right, indicate your region of pain using the symbols below:

(**X**) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(**B**) Burning



_____
Pain Level (0-10)

What medications are you currently taking?

_____
_____

Yes	No		Yes	No	
☐	☐	Allergies	☐	☐	Night sleep disturbance
☐	☐	Diabetes	☐	☐	Change in bowel or bladder habits
☐	☐	High blood pressure	☐	☐	Change in stool color or rectal bleeding
☐	☐	Heart disease	☐	☐	Increased thirst or hunger
☐	☐	Stroke (CVA)	☐	☐	Frequent urination
☐	☐	Cancer or tumors	☐	☐	Indigestion or heartburn
☐	☐	Lung problems	☐	☐	Nausea or vomiting
☐	☐	Arthritis-joint difficulties	☐	☐	Changes in memory
☐	☐	(Ir)regular headaches	☐	☐	Unusual fatigue-weakness
☐	☐	Dizziness-blackouts	☐	☐	Fever or chills
☐	☐	Seizures-nerve disorders	☐	☐	Frequent or easy bruising or bleeding
☐	☐	Visual problems	☐	☐	Frequent cramping
☐	☐	Menstrual problems	☐	☐	Do you have pain 24 hrs?
☐	☐	Immunity disorders	☐	☐	Do you awaken from pain?
☐	☐	Gout	☐	☐	Do you smoke?_____#/Day
☐	☐	Are you pregnant?	☐	☐	Do you drink?_____#/Day
☐	☐	Joint replacement			

What other types of doctor/healthcare _____
providers have you seen for this condition? _____

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Medical Assignment of Benefits and Financial Policy

Please read this document in its entirety

Financial Policy, Release of Information, Assignment of Benefits

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with us prior to beginning therapy.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us.
  In other words, you agree to have your insurance company pay us directly. If your insurance company does not pay us within a reasonable time period, we will have to look to you for payment of the outstanding balance.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This
  means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services is due at the time of service.

- You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian for payment.

- **We have made prior arrangements with many insurers and other health plans to accept an as- signment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service. If you have a copay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a state- ment each month for the amount you owe – i.e. deductible, coinsurance, copay, until all claims have been processed. Payment is due upon receipt of our bill**.

- **All health plans are not the same and do not cover the same services. We will do our best to deter- mine what services are covered by your insurance and let you know if there is a recommend treat- ment that is not a benefit of your insurance so that you may decide to proceed with the treatment or elect not to have the treatment performed. In the event your health plan determines a service to be "not covered" and we are unaware or you do not have authorization, you will be responsible for the complete charge.**

Patient/Responsible Party Signature:

_____

Date: _____

Payments and Patient Signature

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.

- There is a **$40.00** service fee for all returned checks. Your insurance company does not cover this fee.

- A **$50.00** fee will be charged for all "No Shows" & Cancellations without a 24-hour notice. This fee is not reimbursable by insurance.

- I have read and understand the financial policy of PTSRehab and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.

- I authorize the release of information necessary for treatment, payment & health care operations.
  I also authorize assignment of benefits for services rendered by PTSRehab.

Patient/Responsible Party Signature:

_____

Date: _____

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Privacy Practices

Please read this document in its entirety

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician.

- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.

- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be sending charts to the physical therapy network for quality assurance review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, reschedule appointments, or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

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- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
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For more information about HIPAA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
Toll Free: 1-877-696-6775

Patient Information and Signature

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

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IF PURSUING LITIGATION

Name of Law Firm: _____

Name of Attorney: _____

Address of Law Firm: _____
Street City State Zipcode

Phone No. of Law Firm: _____ Fax No.: _____

Sign A or B

A) I understand that I and my attorney must agree to the terms of **Physical and Sports Rehab, Inc.** "Letter of Protection/Lien" in order for a liability claim to be considered as a payment source.

Patient Signature: _____ Date: _____

B) I understand that if I am using my personal car insurance I must assign payment benefits to **Physical and Sports Rehab, Inc.** and be prepared to pay should I exhaust the medical funds.

Patient Signature: _____ Date: _____