Bodyworx PHYSICAL THERAPY

Patient Intake Form

Full Name: _____ Preferred Name: _____

Parent/Guardian (if minor): _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Email Address: _____

What is primary choice of communication: _____phone call _____email _____ text

Marital Status: _____ Employment Status: _____

Birth Date: _____ Gender: ____male ____female

Social Security Number (for billing your insurance): _____

Emergency Contact: _____ Phone Number: _____

Name of physician who referred you to us: _____

Are you seeing us for a work injury or auto accident injury: ____ yes ____no

- **If yes, we will ask you for specifics after you return this form.**

Medicare patients only:

1. Are you currently receiving any services from a home health agency (nursing, aide, therapy, speech, any in-home assistance): ____ yes ____no

2. Are you covered under black lung disease, end stage renal disease, or are you covered under group insurance: ____ yes ____no

Your **primary** insurance company: _____
Relationship to policy holder: ____self ___spouse ____dependent
If spouse or dependent, what is their date of birth:_____

Your **secondary** insurance company: _____
Relationship to policy holder: ____self ___spouse ____dependent
If spouse or dependent, what is their date of birth:_____

Please describe what we are seeing you for: _____

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Consent to Treat

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending physical therapist. The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. After reading the above, I hereby consent to receive physical therapy treatment at Bodyworx Physical Therapy, PLLC, commencing today and terminating when determined by myself, my physician, or my physical therapist.

Patient Initials: _____

Authorization to Release/Receive Information

I give my consent to Bodyworx Physical Therapy, PLLC to disclose health information to my insurance carrier for the purpose of billing, to my physician or other healthcare professionals involved in my care, or receive health information from other healthcare professionals as it relates to my treatment, as permitted/required by law. I understand that confidentiality of my health information is protected under state and federal law, and that this release gives consent to Bodyworx Physical Therapy, PLLC only, and not to any party to whom such information is released. (Please refer to the Privacy Notice for a more complete description of such uses and disclosures. You have the right to review the notice prior to signing this consent.)

Patient Initials: _____

Patient Payment Policy

The fee schedule of Bodyworx Physical Therapy, PLLC is based on usual and customary fees for the type of services provided. Generally, your insurance policy will cover some portion, if not all, of the payment for services provided. **There is, however, no guarantee of payment. The balance amount that your insurance carrier does not cover will be your responsibility. You are also responsible for any deductible and co-pay. **PLEASE NOTE, IF YOU HAVE A COPAY WITH YOUR PRIMARY INSURANCE, AND YOU HAVE A SECONDARY INSURANCE, WE WILL AS A COURTESY TO YOU SUBMIT THIS TO YOUR SECONDARY INSURANCE A MAXIMUM OF TWO TIMES. IF NO PAYMENT IS RECEIVED OR YOUR SECONDARY INSURANCE DOES NOT RESPOND, YOU WILL BE BILLED AND EXPECTED TO PAY THE BALANCE, AT WHICH TIME YOU WILL BE GIVEN A "PAID" RECEIPT THAT YOU WILL THEN BE ABLE TO SUBMIT TO YOUR SECONDARY INSURANCE FOR REIMBURSEMENT.** We request that any insurance payments that are sent directly to you be presented promptly to Bodyworx Physical Therapy, PLLC along with the explanation of benefits and/or any other information you received with the payment. You are directly responsible for payment of medical supplies. Monthly statements will be sent to you if you have an outstanding patient balance. Payment for your portion of services, as outlined in the statement under the "Due From Patient" column is requested to be paid within fifteen (15) days of receipt of the statement. I attest that my insurance coverage and personal financial responsibilities regarding physical therapy treatments have been fully explained to me.

Patient Initials: _____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made to me or on my behalf to the practitioner named above. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I have read this information and understand its content.

Patient Initials: _____

Receipt of HIPAA Notice of Privacy Practices

Signature below is acknowledgement that you have received the notice of our privacy practices:

Patient Initials: _____

Patient Signature: _____ Date: _____

Bodyworx Physical Therapy

MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Date of Injury/Onset: _____ Date of next physician's visit: _____

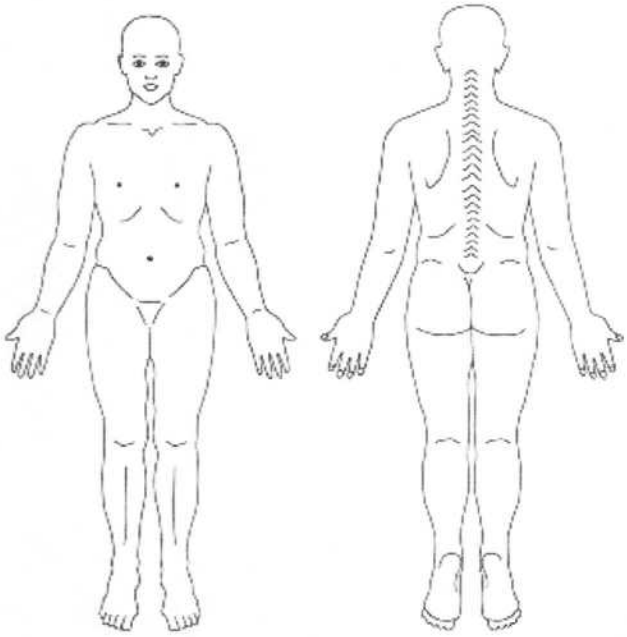
Briefly describe how you were injured or onset of condition: _____

_____

Date of surgery for this condition (if applicable): _____

Do you/Have you experienced any of the following:

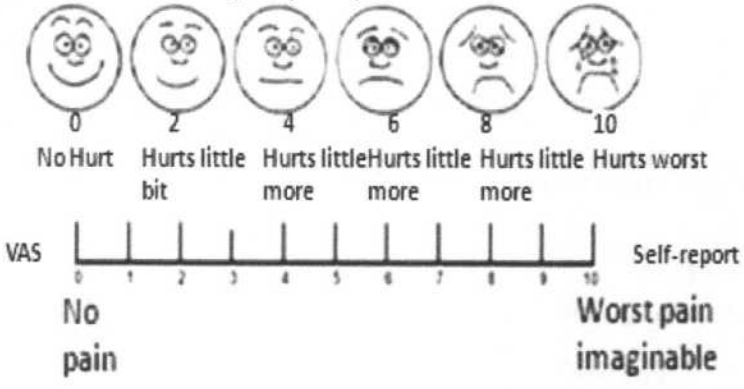
Diabetes	Y / N	Heat intolerance	Y / N
Chest Pain/Angina	Y / N	Cold intolerance	Y / N
High Blood Pressure	Y / N	Allergies	Y / N
Heart Attack	Y / N	Hernia	Y / N
Heart Disease	Y / N	Seizures	Y / N
Pacemaker	Y / N	Metal Implants	Y / N
Headaches	Y / N	Dizziness/Fainting	Y / N
Kidney problems	Y / N	Recent Fractures	Y / N
Are you pregnant?	Y / N	Surgeries	Y / N
Cancer	Y / N	Nausea/Vomiting	Y / N
Osteoporosis	Y / N	Ringing in Ears	Y / N
Bowel/Bladder Condition	Y / N	Arthritis	Y / N
Asthma/COPD	Y / N	Hypoglycemia	Y / N
Stroke/TIA	Y / N	Other:_____	Y / N



Pain

Indicate on the diagram where you are having pain.

Circle the intensity of your pain below



Bodyworx PHYSICAL THERAPY

HIPAA Notice of Privacy Practices

(Effective December 1, 2013)

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 DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCE SS TO THIS INFORMATIO. PLEASE REVIEW IT CAREFULLY.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide y ou with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share y our information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat t o health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as pub lic health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Serv ices if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be a vailable upon request, in our office, and on our web site.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices wi th respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by pho ne at our main phone number.