



Health in Balance Physical Therapy

Name _____ Date _____ Age _____

Referring Doctor _____

Reason for seeking physical therapy: _____

When did symptoms begin: _____

What caused the symptoms to begin?
(i.e. athletic injury, fall, etc) _____

Rate your worst pain on a scale of 0-10,
10 being the worst: _____

What increases the pain _____

What decreases the pain _____

Please list any diagnostic tests performed (i.e. x-ray, MRI, CT scan)

What medications are you currently taking (for this and other conditions)

Please list any allergies

Are you employed? Full Time Part Time Not employed due to injury Not employed outside the home

What is your occupation? _____

Pain Diagram

Please mark your pain/symptoms on the model



Do you have difficulty completing your job tasks because of pain? What tasks?

What goals would you like to achieve through physical therapy?

Check activities that you have difficulty completing at home:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Prolonged standing | <input type="checkbox"/> Up/down stairs | <input type="checkbox"/> Recreational Activities |
| <input type="checkbox"/> Personal Care | <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Carrying | <input type="checkbox"/> Lifting | <input type="checkbox"/> Driving | <input type="checkbox"/> Squatting |

List any past injuries, surgeries, or reasons for seeking a doctor/ physical therapists' care

Past Medical History: Have you ever been diagnosed with any of the following? (Check all that apply)

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Epilepsy | Other: _____ | | |

Do you: Smoke If Yes, How much?

Have you recently experienced any of the following? (Check all that apply)

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Unexplained Weight Change | <input type="checkbox"/> Malaise | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Bowel Dysfunction |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Urinary Frequency Changes/Difficulty | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Dizziness/lightheadedness | | |



NEW PATIENT INFORMATION

PERSONAL INFORMATION

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone Home _____ Work _____ Cell _____

Email address _____

Date of Birth _____ Gender M F

Marital Status Single Married Divorced Widowed

Social Security Number _____

Emergency Contact _____

Referred by _____

Employer _____

Spouse _____ Date of Birth _____

Responsible Party _____ Relationship _____

Is This Injury Due to an Auto Accident? _____

Is This a Worker's Compensation Claim? _____



Patient Privacy Signature

I, _____, have read and understand the patient privacy policy for
Health and Balance Physical Therapy.

Signature: _____

Date: _____

By signing below I agree to allow Health In Balance Physical Therapy to leave pertinent messages regarding appointment times or related medical information on the voice mail or answering machine of the phone numbers provided to Health In Balance Physical Therapy.

Signature: _____

Date: _____



FINANCIAL POLICY

In order to keep your cost of physical therapy services to an absolute minimum, Health In Balance Physical Therapy, LLC has adopted the following financial policy. This policy applies to all clients and specifies responsibility regarding payment for services rendered.

HEALTH INSURANCE

The client's health insurance is a contract between client and insurance company, and is a vehicle to help pay for medical care. As a service to you, we will call your insurance company prior to your first visit in an attempt to determine your benefits (if you provide us with the information before you come in). Please keep in mind that insurance companies DO NOT guarantee payment for service over the phone, and you are ultimately responsible for any expenses incurred if your insurance does not pay what you expected they would. It is in your best interest to be aware of your physical therapy benefits before you come in for your first appointment. We will submit claims to your insurance company if you provide us with current insurance information. Depending on the insurance company, our fees may or may not be considered usual and customary. Insurance companies use many different equations to form a fee schedule.

Clinic policy requires that all anticipated co-pays and visit fees be collected at time of service. These payments may be applied against any applicable unmet deductibles. If your insurance company pays more than anticipated, your account will be credited. We accept cash (exact amount is appreciated), personal checks, and credit cards (Visa and MasterCard). The clinic charges a \$30 fee to you for any NSF checks received, which is payable before or at the time of your next scheduled visit.

The client is ultimately responsible for timely payment of services rendered. Any insurance balances outstanding after 60 days are due in full by the client. It is the client's responsibility to negotiate with the insurance company for any unpaid services.

PRIVATE PAY

If you will be paying for visits privately (not through an insurance company), clinic policy requires payment at time of service. Acceptable methods of payment are cash, check, or credit card. Please be prepared to make payment at the time of your visit. If you have questions regarding clinic fees, please contact our office staff.



ASSIGNMENT OF BENEFITS (client signature required for clinic to bill insurance)

Since my health insurance may cover the cost of service, I hereby authorize Health In Balance Physical Therapy, LLC to release to my insurance company and/or associated professionals any information from my medical records which may be necessary to determine benefits payable under my policy. This information may be transmitted electronically. I authorize payment directly to Health In Balance Physical Therapy, LLC for the benefits otherwise payable to me for the amount which covers but does not exceed services delivered. I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits.

Date: _____ **Client Signature:** _____

CANCELLED APPOINTMENTS

Clinic policy requires 24 hours notice for cancellation of any appointment. You can call our office staff to cancel or you can, after hours or on weekends, leave a message in the clinic voice mail system; our voice mail is time-stamped. If cancellation is not received on time, a \$50 “reserved time” fee will be added to your account, payment of which is due on or before your next visit. Additionally, if you fail to show for a scheduled appointment, the same charge applies.

FAILURE TO PAY

Our staff of physical therapy clinicians and office support professionals provide confidential, compassionate, and effective care to our clients. We adhere to the highest standards of ethical practice and service your needs in good faith. In order to continue our services to you and other members of our community, we expect payment for services rendered in a prompt manner. If payment is denied by your primary insurance company and you have a secondary insurance company they will be billed. If extenuating circumstances arise, please consult with our office staff regarding an acceptable payment arrangement. Failure to do so may result in the need to curtail further sessions until the financial situation is resolved.

If it becomes apparent that a client does not intend to satisfy his/her financial responsibility, a collection agency or attorney may be contacted to pursue collection of the account. If a fee is charged to Health In Balance Physical Therapy, LLC for collection agency services, it will be charged to the client’s delinquent account.

I have read and understood the above financial policy

Date: _____ **Client Signature:** _____



HIPPA PRIVACY AND DISCLOSURE POLICY NOTICE

Privacy and Disclosure Authorization Policy:

For Storage and Disclosure of Confidential Information and Records

1. This Notice describes how your health information, including therapy records, may and may not be used and disclosed to others, and how you may gain access to this health information. Please review the information in this Notice carefully.

2. **The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)** provides strict guidelines about the maintenance, use, storage, and disclosure of client medical information called Protected Health Information (PHI). HIPAA also requires that those who receive health services be given written statements of the privacy policies of the health providers. In addition to HIPAA guidelines, there are many other federal, state, and professional guidelines and ethical standards that inform our policies and practices at Health In Balance Physical Therapy, LLC. While we are required to keep records of services provided, we are also required to safeguard this information. Health In Balance Physical Therapy, LLC personnel make every effort to safeguard your privacy and your rights.

3. You as a health services consumer have a right to know how information about you and about services you receive may be used. You also have rights to ask for limits on the disclosures made on your behalf, and to have appropriate access to your records for review and release.

4. The **Policies and Practices of Health In Balance Physical Therapy, LLC**, regarding PHI privacy and disclosure are contained in the Notice. The purposes for the maintaining and disclosing of client records relates to providing services, as requested by our clients, and generally are involved in treatment, payment, and other health care operations, such as those required by government agencies or in emergency situations.



5. Based on legal regulations and ethical guidelines, Health In Balance Physical Therapy, LLC will only disclose information about you to persons or organizations outside of our clinic in a limited number of situations:

- a. With your written and specific permission (consent).
- b. If required to do so by certain specific court orders, subpoenas, or Workers' Compensation inquires.
- c. In cases where laws require reporting for protection, such as significant danger to self or others, child, or elder abuse or neglect.
- d. When confidential audits are lawfully conducted by governmental or insurance oversight agencies (such as for clinic licensing).
- e. When an emergency required immediate communication with appropriate persons in order to secure appropriate help or treatment: in these situations, the minimum disclosure necessary to secure services will be provided.
- f. In order to bill for services provided by Health In Balance Physical Therapy, LLC. Payers are typically insurance companies or other responsible parties. Billing services and insurance companies are also bound by HIPAA and other governmental agencies.
- g. When a client in treatment is transferred or completes treatment, follow-up contact is required by statute.
- h. Note: when the client is a minor, privacy rights belong to the parents, except in certain situation. Please discuss age-related rights with your therapist.

6. Based on legal regulations and ethical guidelines, Health In Balance Physical Therapy, LLC therapists will use or disclose your PHI within the clinic:

- a. To provide services to you, including: Consultation and coordination of services among personnel and professional consultants (as appropriate), in order to aid in diagnosis, assessment and treatment planning, and in facilitation of ongoing treatment, with professional supervision as required by law.
- b. To maintain business records, as required legally and ethically. We maintain client records in file folders, kept in locked file cabinets, and are destroyed by shredding after they have been held as required by law (and not less than seven years after client discharge). Health In Balance Physical Therapy, LLC also maintains records on computer, respecting legal and ethical privacy guidelines.
- c. To share and discuss with you your PHI as contained in clinic records, with a prior written request; also, you may update or correct (add to) your PHI as needed. State law does provide some restrictions on these rights (when judged to be in your best interest). In addition, you may request a listing of non-routine disclosures made of your PHI records. You may also choose how we communicate with you, as via an alternative address or phone number.
- d. Examples of other situations that might involve disclosure: Consultation regarding emergency planning, defense of lawsuits, or processing of grievances, or you bringing a friend with you during therapy sessions.

7. **Physical Therapy notes**, kept by the therapist to support the treatment process, are not considered part of the formal clinic record, and will not generally be disclosed within or outside of the clinic. Only in very special situations will the authorization (permission above and beyond general consent) for release of these more sensitive records be considered. For example, insurance companies are not permitted to request access to physical therapy notes for billing purposes.



8. **Consent:** Your signature below indicates that you are aware of the collection and storage of treatment, payment and other health care information, and that you consent to its use in the course of services provision, billing and collection procedures, and within Health In Balance Physical Therapy, LLC clinic, as discussed above. This form has no expiration date, unless amended or revoked. You may revoke this consent with written notice at any time, except to the extent that it has already been acted upon.

You may restrict the released information and its use, as indicated on the appropriate form, or restrict its use within Health In Balance Physical Therapy, LLC clinic, but doing so may legally or ethically compromise our ability to provide you with therapy services. We may therefore determine that we are unable to provide those services in good faith.

9. There is a separate form for consent to release/exchange information with your insurance company or other third party payer.

10. Other relevant information: **Fees for Copying Records:** A uniform and reasonable fee may be charged for copying records. That fee may be reduced or waived in accordance with Health In Balance Physical Therapy, LLC clinic's policy. Health In Balance Physical Therapy, LLC will ordinarily have 2 weeks to respond to a request to copy records. **Transportation of Records:** Whenever records must be transported out of the office, great care will be taken to protect client privacy. **Electronic Transmissions:** E-mail and Internet communications may be used within Health In Balance Physical Therapy, LLC clinic. In those rare instances, Health In Balance Physical Therapy, LLC clinic's staff will take care to limit identifying information within the messages, and to make sure the recipient is authorized to receive the information. **Future Changes:** Health In Balance Physical Therapy, LLC clinic will revise and update this information and form as needed, and in compliance with the law.

Complaints: Health In Balance Physical Therapy, LLC has a Grievance Policy posted in the office: clients may ask any Health In Balance Physical Therapy, LLC therapist for a copy of the policy. You may also contact any Health In Balance Physical Therapy, LLC therapist for further information about our privacy and disclosure policies, or about HIPAA questions. Privacy concerns may be addressed to the Secretary of the U.S. Department of Health and Human Services. Information and assistance may be found through the HHS Office for Civil Rights (website: <http://www.hhs.gov/ocr/hipaa>).