FIT CORE PHYSICAL THERAPY

PATIENT INTAKE FORM

Today's Date: _____

Last Name: _____ First Name: _____

Middle Name: _____

Date of Birth: _____ Age: _____ Gender: _____

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

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

If Patient is a minor, name of parent/guardian: _____

Emergency Contact (Name, Relationship): _____

Patient's Primary Insurance Company: _____

Member ID: _____ Phone Number: _____

Address: _____

Patient's Secondary Insurance Company (If Applicable): _____

Member ID: _____ Phone Number: _____

Address: _____

If Patient is a minor, name of parent/guardian: _____

Emergency Contact (Name, Relationship): _____

Emergency Phone: _____

Referred by:

☐ Physician ☐ Friend ☐ Personal Trainer ☐ Chiropractor

☐ Website ☐ Family ☐ Massage Therapist ☐ Pilates Instructor

Please provide name and contact information of the referral source: _____

Primary Physician (for contact in case of medical emergency) _____

Primary Physician Name/Company _____

Address _____ City _____ State _____

Zip Code _____ Phone _____ Fax _____ Website _____

CASE HISTORY

Primary Complaint: _____

_____

Date of Injury/Surgery/Onset: _____

Surgery Performed: _____

Have you Fallen in the past year? Y/N _____ Is your injury related to the fall? Y/N _____

Which treatments have you had for this condition?

☐ Medication ☐ Massage ☐ Injection ☐ Chiropractic ☐ Physical Therapy ☐ Acupuncture

Diagnostic Testing/Imaging You received?

☐ X-ray ☐ Cardiac Stress Test ☐ CT Scan ☐ MRI ☐ Doppler Study ☐ Ultrasound

☐ Nerve conduction/EMG ☐ Bone Scan ☐ Blood Test ☐ Other

MEDICATIONS/SUPPLEMENTS

Type _____ Dosage _____ Reason for Taking _____

_____

Type _____ Dosage _____ Reason for Taking _____

_____

Type _____ Dosage _____ Reason for Taking _____

_____

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ Allergies	☐ Asthma	☐ Anxiety	☐ Arthritis
☐ Anemia	☐ Bladder conditions	☐ Bowel conditions	☐ Cancer
☐ Cardiac Conditions	☐ Cardiac Pacemaker	☐ Chemical Dependency	☐ Cholesterol Condition
☐ Circulatory Problems	☐ Depression	☐ Diabetes Type 1	☐ Diabetes Type 2
☐ Dizziness	☐ Dysmenorrhea	☐ Eating Disorder	☐ Emphysema/Bronchitis
☐ Endometriosis	☐ Fibroids	☐ Fractures	☐ Gallbladder Problems
☐ Hepatitis	☐ High Blood Pressure	☐ Incontinence	☐ Kidney Problem
☐ Menopause	☐ Motorized Accident	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Parkinson's Disease	☐ Prostate Condition	☐ Rheumatoid Arthritis	☐ Seizures
☐ Straining with Urination	☐ Stroke	☐ Thyroid Disease	☐ Urgency with Urination
☐ Vestibular Condition	☐ Vision Problem	☐ Recent Weight Loss/Gain	

If you indicated "Yes" on any of the above, or if you have any other medical conditions not listed above, please describe in further detail, including any precautions

_____

_____

SURGICAL HISTORY

Body Region_____ Surgery Type_____ Date of Surgery _____

Body Region_____ Surgery Type_____ Date of Surgery _____

Body Region_____ Surgery Type_____ Date of Surgery _____

Body Region_____ Surgery Type_____ Date of Surgery _____

Body Region_____ Surgery Type_____ Date of Surgery _____

OCCUPATION

Occupation:_____ Physical requirements:_____

Work Status:

☐ Full time ☐ Part time ☐ Retired ☐ Unemployed

SYMPTOMS

What is the cause of your symptoms?

☐ Work ☐ Overuse ☐ Auto Accident ☐ Sports Injury ☐ Surgery ☐ Trauma ☐ Chronic

What is the EASES your symptoms?

☐ Modifying activity ☐ Cessation of activity ☐ Lying down ☐ Medication ☐ Standing ☐ Heat

☐ Ice ☐ Rest ☐ Sitting ☐ Walking

What AGGRAVATES your symptoms:

☐ Modifying activity ☐ Cessation of activity ☐ Lying down ☐ Medication ☐ Standing ☐ Heat

☐ Ice ☐ Rest ☐ Sitting ☐ Walking

What is the quality of your pain/symptoms?

☐ Dull ☐ Sharp ☐ Radiating ☐ Steady ☐ Throbbing ☐ Pins/Needles

☐ Numbness

What is the frequency of your pain/symptoms:

☐ Constant ☐ Intermittent/daily ☐ Occasional (less than daily) ☐ Sporadic (less than weekly)

Is your pain worse/better in the morning?_____

Is your pain worse/better at night?_____

PAIN SCALE Using the above scale, how do you rate your pain (0-10)?

0 ☐ No Pain

1 ☐ Mild Pain: you are aware of it, but it does not bother you

2 ☐ Mild Pain: you become more aware of it, but only begins to bother you

3 ☐ Mild Pain: you can tolerate it without medication

4 ☐ Moderate Pain: requires medication to tolerate

5 ☐ Moderate Pain: you begin to feel antisocial

6 ☐ Severe Pain: you cannot participate in recreational activities

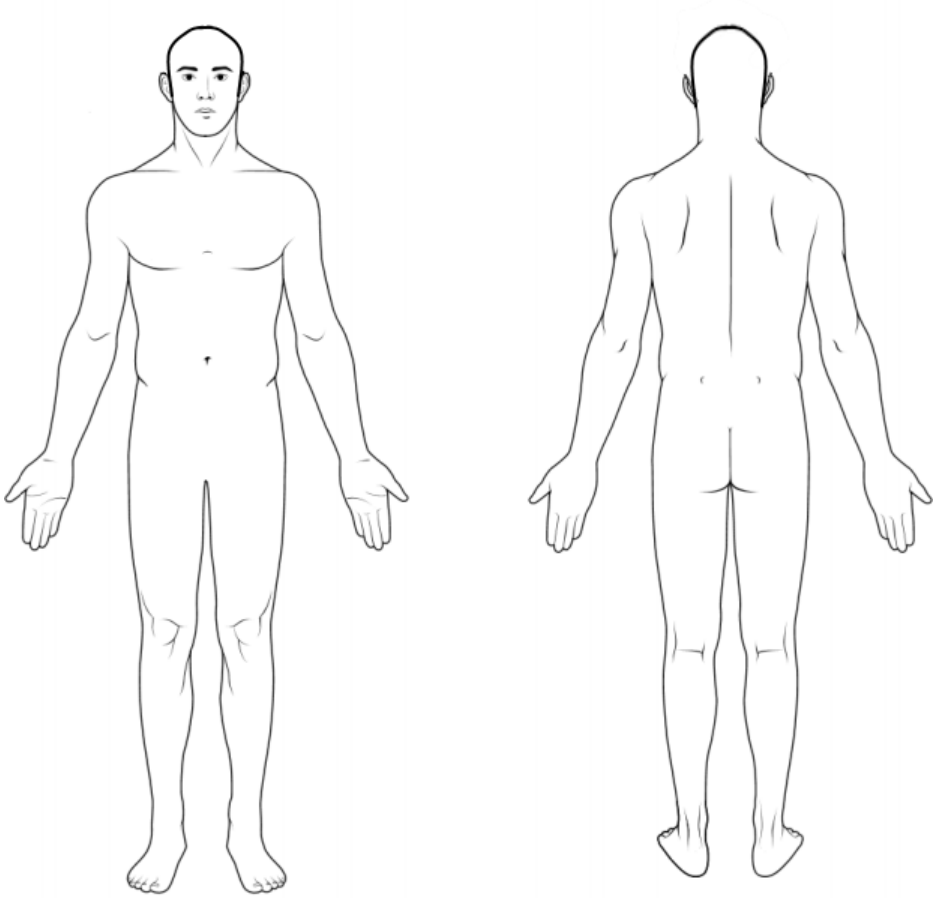
7 ☐ Very Severe Pain: you cannot participate in activities of daily living

8 ☐ Intensely Severe Pain : you cannot participate in activities of daily living

9 ☐ Extremely Severe Pain: you cannot get out of bed

10 ☐ Most Extreme Pain: it may make you contemplate suicide

Please use the body diagram to indicate the affected areas:



LIFESTYLE

What is your current exercise routine?_____

_____

Which activities do you wish to return to?_____

_____

What are your GOALS for treatment in Physical Therapy? _____

Patient Signature:_____Date: _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Print Name), do hereby acknowledge that I have been given a copy of Fit Core Physical Therapy, Inc.'s Notice of Privacy Practices and have been given the opportunity to ask any questions that I may have regarding it.

Signature: _____ Date:_____

PATIENT PRIVACY NOTICE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding the use, disclosure, and security practices related to protected health information (PHI).
It is our policy not to leave messages containing confidential and/or unauthorized information on an answering machine or voice messaging service. Information will also not be disclosed to an individual not previously authorized, who might answer the phone number that you provide us to contact you. If you would like to have information released to someone other than yourself please complete the following:
I hereby authorize Fit Core Physical Therapy, Inc. to disclose protected health information about me to the following individuals that is directly relevant to such individual's involvement in my health care or payment related to that care
Name:_____Relationship:_____
Name:_____Relationship:_____

Signature:_____ Date:_____

CONSENT TO TREATMENT

I do hereby consent to such treatment by the authorized personnel of Fit Core Physical Therapy, Inc. as may be dictated by prudent medical practice for my illness, injury, or condition. This is intended as a waiver of liability for such treatment, excepting acts of negligence.
Physical therapy diagnosis is not a medical diagnosis by a physician or based on radiological imaging and such services might not be covered by the patient's health plan or insurer.

Signature:_____ Date:_____

HEALTH INSURANCE INFORMATION

Fit Core Physical Therapy is devoted to the provision of optimal quality of care and a unique and individualized approach to patient treatment. Each session is 55 minutes of exclusive one-on-one time with an extensively-qualified Doctor of Physical Therapy. In order to provide such exclusive service, Fit Core Physical Therapy is a predominantly out-of-network provider.

As a courtesy, upon request we are able to verify your benefits before your initial visit, and handle all of the claim submissions directly to your insurance provider. It is important to understand, however, that it is still the patient's responsibility to be informed of their own policy benefits. The patient is responsible to pay for any balances that are not covered by insurance, including existing co-insurance amounts, and deductibles. If the Patient disputes any Invoice, or portion thereof, the Patient shall notify in writing Fit Core Physical Therapy within ten (10) days of receipt of the Invoice in question. The Patient shall identify the specific cause of disagreement and shall pay when due that portion of the Invoice not in dispute. The Patient and Physical Therapist shall work promptly and in good faith to resolve any disagreement regarding the Invoice. Fit Core Physical Therapy reserves the right to charge interest up to the legal interest rate on any Invoice not paid within thirty (30) days of the Invoice date and Fit Core Physical Therapy may, at its sole option, suspend all services upon giving the Patient seven (7) days written notice of any past due amounts and intent to suspend treatment until all past due amounts are paid in full.

Please feel free to contact us with any additional questions or concerns regarding our insurance policies.

Should the patient opt out of filing with their insurance, a courtesy discount will be offered for private pay

CANCELLATION POLICY

Appointments that are cancelled less than 24 hours prior to the appointment will be assessed a $100.00 fee, excluding cancellations made as a result of sickness or other verifiable emergency.

By signing below, I agree to the above terms.

Patient Signature:_____

Date:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Fit Core Physical Therapy's Legal Duty

Fit Core Physical Therapy is required by law to protect the privacy of your personal health information (PHI), to provide this notice about our information practices, to notify you following a breach of your unsecured protected health information, and to abide by the information practices that are described herein.

Uses and Disclosures of Health Information with Authorization

Fit Core Physical Therapy may use and disclose your PHI for the following purposes: treatment, payment, and health care operations.

Treatment: Your PHI will be used to make decisions about the provision and management of your health care. It may also be necessary to share your medical information with another healthcare provider with whom a consultation is indicated.

Payment: We may need to use or disclose information in your medical record in order to verify coverage by your health insurance provider, as well as for billing/collections purposes.

Administrative Purposes: Your PHI may be used in our business operations to assist with internal quality assessment reviews, auditing functions, cost-management analysis, and customer review feedback.

Fit Core Physical Therapy may change its policy at any time. If changes are made, a new Notice of Information Practices will be posted in a common area of our facility. You may also request an updated copy of our Notice of Information Practices.

4779 S. Atlanta Road • Suite 200 • Atlanta, GA • 30339
Phone: 404•479•1739

Use and Disclosure Without Acknowledgement or Authorization

Fit Core Physical Therapy may also use or disclose your PHI without prior authorization for the following reasons: public health purposes, auditing purposes, research, emergencies, or when required by law. We are required to report to certain agencies information related to suspected or documented abuse, neglect or domestic violence. We are also required to report to the appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity.

Patients' Individual Rights

- You have the right to review or obtain a copy of your PHI at any time. We will provide you your PHI within thirty (30) days from the date of request.
- You have the right to request that we restrict the use and disclosure of your medical records for certain instances of treatment, payment, and administrative purposes, except when required by law, or in emergency situations. Fit Core Physical Therapy will review such request on a case-by-case basis, but the company is not legally required to accept the request.
- You have the right to request in writing that any information in your medical record that is incorrect or inaccurate be corrected. Fit Core Physical Therapy must respond to the request within 60 days.
- You have the right to request and receive an accounting of disclosures. The accounting will cover up to six years prior to your request date, and will be provided within 60 days of receiving the request. Fit Core Physical Therapy will provide the first accounting free of charge within any 12-month period. Any additional accounts requested within that same 12-month period will be assessed a reasonable fee.

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Complaints

If you believe that Fit Core Physical Therapy may have violated your privacy rights, or if you disagree with any decisions we have made regarding access or disclosure of your PHI, you may file a complaint by contacting our office at the address listed below. We will not retaliate against you for filing such a compliant:

Fit Core Physical Therapy, 4779 S. Atlanta Road, Suite 200

Atlanta, GA 30339

Phone: 404-479-1739

You may also file a written complaint to the Department of Health and Human Services at the following address, or call for more information regarding HIPAA:

The U.S. Department of Health and Human Services, Office of Civil Rights

200 Independence Avenue, SW, Washington, DC 20201

P: (202) 619-0259

This Notice is effective as of : 06/22/2015