druid hills physical therapy

Name/Contact Information

Name: ______________________________ Date: _________________________

Date of birth: _________________________

Address: ____

City: _________________________ State: ___________ Zip: __________

Home phone: ____________________ Cell phone: _____________________

Work phone: ____________________ Email address: __________________

____

Emergency contact name   Emergency contact phone #   Relationship

How did you find out about Druid Hills Physical Therapy?
(please circle one)

Physician   Google   Saw the sign   Facebook   Word of mouth

Other: ____

Physician Information

____   ______________________

Name of physician   Physician phone #

____

What is the date of your next scheduled visit with your physician?

____

Medical History Form

Patient Name:______________________________________ Date:__________

What are your goals for physical therapy?

____

Please describe your physical limitations as a result of this injury or condition:

____

Please describe any activities or movements that aggravate your symptoms:

____

Please describe any previous injury or injuries that could affect care:

____

Have you had any of the following diagnostic tests in relationship to this injury?
(circle all that apply)

X-Ray CT Scan MRI Doppler Ultrasound

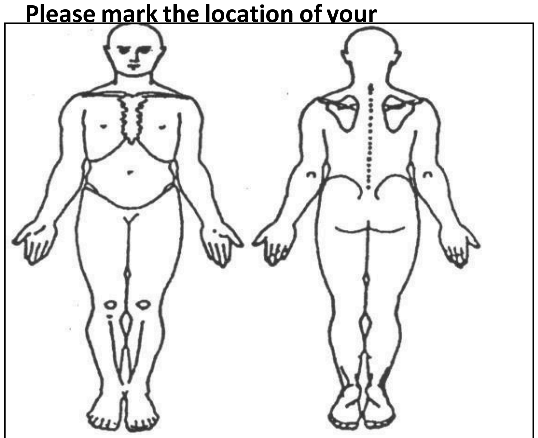
Have you received previous treatment for this injury/condition? □ Yes □ No

If yes, please explain what type of treatment: ______________________________

If yes, what was the date(s) of treatment: ___________

Have you had any falls this past year? □ Yes □ No If yes, how many?__________

Please mark the location of your



Which of the following describes your pain? *(circle all that apply)*

Sharp Aching Burning Tingling Numbness Other

Please rate your pain: (0 = None, 1=Minimal, 10 = Severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

Are you currently taking medications? ◻ Yes ◻ No

Please list allmedications: ____

____

Have you recently noticed any of the following?

- ❒ Breathing Difficulty
- ❒ Change in Vision
- ❒ Fatigue
- ❒ Fever/Chills/ Sweats
- ❒ Insomnia
- ❒ Nausea/ Vomiting
- ❒ Pain at Night
- ❒ Pregnancy
- ❒ Weakness
- ❒ Weight Loss

Do you have now or have you ever had any of the following?

- ❒ Allergies/Skin Sensitivity
- ❒ Asthma/Breathing Problems
- ❒ Autoimmune Deficiency
- ❒ Cancer
- ❒ Circulation Problems
- ❒ Diabetes
- ❒ Easy Bruising/ Bleeding
- ❒ Fainting
- ❒ Fractures
- ❒ Heart Problems
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Indigestion/ Heartburn
- ❒ Kidney Disease
- ❒ Leg/Ankle Swelling
- ❒ Loss of Consciousness
- ❒ Lung Disease
- ❒ Metal Implant
- ❒ Motor Vehicle Accident
- ❒ Multiple Sclerosis
- ❒ Osteoporosis/ Osteopenia
- ❒ Sprains/Strains
- ❒ Stroke
- ❒ Surgeries
- ❒ Thyroid Problems
- ❒ Urinary
- ❒ Problems/ Infections
- ❒ Other

Please explain and give approximate dates for any conditions marked above:

____

____

____

____

Signature of patient or guardian (if patient is a minor):______________ Date:______________

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Practice Policies

Informed Consent for Treatment

The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Insurance

We accept Medicare and most other commercial insurance plans. It is the patient’s responsibility to confirm that we are in-network with your policy. If we are out-of-network for your insurance, we will provide you with all necessary and detailed information for you to submit to your insurance company. It is the patient’s responsibility to follow up on reimbursements with the insurance company. Not all insurance plans cover all services. In the event your insurance plan determines a service “not to be covered,” you will be responsible for those charges. Please be aware that some insurance companies have a maximum number of visits that you are allowed; some companies also require prior authorizations. It is the patient’s responsibility to know their physical therapy benefits and check with their insurer if the prior authorization is required. All co-pays or out-of-pocket costs are due at the time of service. We accept Visa, MasterCard, American Express, cash, and checks.

Cancellation Policy

With the exception of serious emergencies your recovery depends upon attending all your appointments. If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the cancelled or rescheduled visit as possible. If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you $65 no-showfee. If you need to reschedule a session, you are more than welcome to do so, as long as you provide more than 24 hours’ notice before your scheduled appointment. In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care.

Late policy

If you are less than 15 minutes late and have contacted Druid Hills Physical Therapy to warn us that you’ll be late, you may complete the remaining time scheduled for your session, knowing that you will not receive a full session. If you are more than 15 minutes late and have not contacted Druid Hills Physical Therapy, we hold the right to consider your appointment a “No- Show.” As per the no-show policy, we reserve the right to charge you a $65 fee.

I have read and understood the notices and policies set forth on this page and I agree to be bound by their terms. I also understand that such terms may be amended by the practice from time to time.

Patient/guardian signature:_______________________Date: ________________

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HIPAA Regulations and Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty
The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure
To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment:
We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Release of Medical Information and Assignment of Benefits; Acknowledgement of Understanding

By signing below, I am verifying that the following are true:

- I authorize the release of medical information necessary for filing health insurance claims for me by Druid Hills Physical Therapy.
- I authorize my insurance carrier(s) to make payment directly to Druid Hills Physical Therapy.
- I have read, understand, and agree to use of my information as listed above.

____________________	____________________	__________
Print name	Patient/legal guardian signature	Date

Email Authorization

Druid Hills Physical Therapy is equipped to relay information to you using email. Due to the "HIPAA Notice of Privacy Practices" we need your permission to communicate with you electronically.

Please note, although every effort is made to ensure patient privacy, Druid Hills Physical Therapy cannot assure confidentiality of information sent electronically Druid Hills Physical Therapy cannot be held liable for security risks.

By signing below you grant permission for practitioners and staff of Druid Hills Physical Therapy to contact you via email to discuss your care.

Patient/legal guardian name:_________________ Patient DOB: __________

Patient personal email: _____________________

PLEASE NOTE: We will never share your email address with anyone.

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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 require 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, 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 operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical therapy examination.

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 for your visit to your insurance company for payment.

Health care operations includes the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment 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 or 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 Druid Hills Physical Therapy.

- The right to request restrictions on certain issues 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.
- 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 receive an accounting disclosure of protected health information.
- The right to receive 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 your 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 new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a 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, Civil Rights, about violations of the provisions if this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information, please speak to a member of our staff.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue SW Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6755

I, the undersigned Patient, acknowledge that I have received and reviewed this Notice of Privacy Practices:

Patient/legal guardian name: ___________________________________

Patient/legal guardian signature: _________________________________

Date: ___________________________