Westchase Physical Therapy

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How did you hear about us?

☐ *Family/Friend* ☐ *Physician* ☐ *Online (google, facebook, etc)* ☐ *Insurance* ☐ *Other:*_____

SECTION 1 - PATIENT INFORMATION

Patient Name:_____ M / F Date of Birth (mm/dd/yyyy):_____ /_____ /_____

Street Address:_____ City/State/Zip Code:_____

Contact Number(s): Primary (_____)_____-_____ Secondary (_____)_____-_____

Patient Email:_____ Primary Care Physician: _____

Are you currently working? YES or NO PCP Contact Number: (_____)_____-_____

Occupation:_____ Retired - Past Occupation:_____

If yes, how much? ☐Full Duty ☐ Restricted Duty ☐Other:_____ Hours/Week:_____/_____

If no, last day worked:_____/_____/_____ Any restrictions?_____

What is your job title/responsibilities?_____

SECTION 2 - INSURANCE INFORMATION

Primary Insurance:_____ ID#:_____ Group#:_____

Claims Address:_____ City/State/Zip Code:_____

Policy Holder Name (if different from patient):_____ Date of Birth:____/____/_____

Relationship to patient:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

Claims Address:_____ City/State/Zip Code:_____

Policy Holder Name (if different from patient):_____ Date of Birth:____/____/_____

Relationship to patient:_____

FOR MOTOR VEHICLE ACCIDENT INJURIES ONLY:

If you are receiving care for a Motor Vehicle Accident, in what state did the accident occur?

Date of Accident:_____/_____/_____ **Claim #:** _____

Adjustor:_____ **Attorney:** _____

FOR WORKER'S COMPENSATION INJURIES ONLY:

If you are receiving care for a worker's compensation injury, in what state did the accident occur?

W/C Plan:_____ **Case ID:**_____ **Claim #:**_____

SECTION 3 - MEDICAL HISTORY

Injury Onset Date:____/____/_____ Surgery (specify type & date):_____ Prior Hospitalization? YES or NO

What is your primary concern/chief complaint?_____

_____

What problems, if any, are you having at work due to your injury/illness?_____

_____

What can't you do now as a result of this injury/illness that you could do before?_____

_____

_____

_____

Pain Rating (**0 = No Pain → 5 = Mod Pain → 10 = Extreme Pain**):

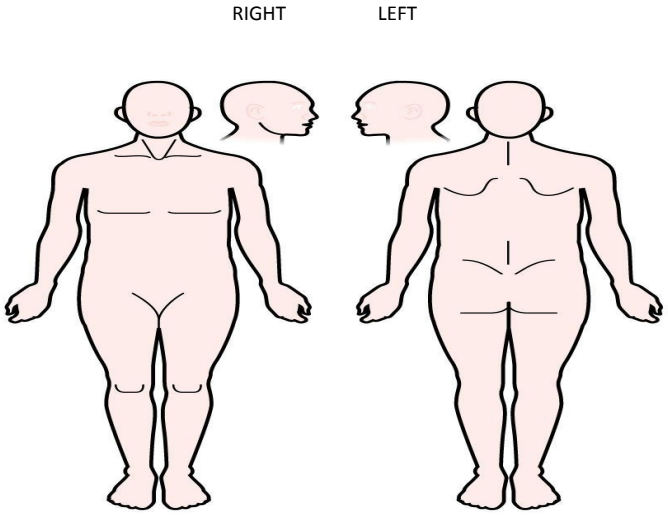
Worst:____/10 Current:____/10 Best:____/10

What increases your pain? _____

What decreases your pain? _____

Do you have numbness/tingling? YES or NO Location:_____

SHADE IN THE PAINFUL AREAS BELOW



History of Falls? YES or NO

Have you or do you have any of the following conditions? (**Check all that apply)**

- ▫ No Known Significant PMH To Affect Treatment
- ▫ Alzheimer's
- ▫ Cardiovascular Disease
- ▫ Cauda Equina Syndrome
- ▫ Cerebral Vascular Accident
- ▫ Current Infection
- ▫ Diabetes Mellitus Type 1
- ▫ Other (please describe):
- ▫ Diabetes Mellitus Type 2
- ▫ Fibromyalgia
- ▫ Fracture Or Suspected Fracture
- ▫ High Blood Pressure
- ▫ History Of Cancer
- ▫ Huntington's
- ▫ Immunosuppression
- ▫ Lupus
- ▫ Muscular Dystrophy
- ▫ Obesity
- ▫ Osteoarthritis
- ▫ Parkinson's
- ▫ Rheumatoid Arthritis
- ▫ Traumatic Brain Injury

Diagnostic Testing/Imaging (circle all that apply): X-Rays, MRI, CT Scan, EMG, Etc.:

Date of Test:_____/_____/_____ Testing/Imaging Findings: _____

Have you had any previous therapy? YES or NO

Please list all current medications you are currently taking (with dosages):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

What do you want to achieve in therapy?_____

_____

Authorization to Release Confidential Information to Designee

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I grant permission for the following individual to receive or pick up copies of my medical records:

Designated Person:_____ Relationship to Patient:_____

Emergency Contact Name:_____ Phone:(_____)_____-_____

PLEASE BE ADVISED THAT WESTCHASE PHYSICAL THERAPY REQUIRES 24 HOURS NOTICE FOR ANY CANCELLATION. IF ADEQUATE NOTICE IS NOT PROVIDED A $35.00 FEE WILL BE APPLIED TO YOUR ACCOUNT, IF YOU ARE A "NO SHOW" A $50.00 FEE WILL BE APPLIED.

Privacy Notice

The undersigned recognizes that he/she has read a copy of Westchase Physical Therapy Notice of Privacy. If you would like a copy for your records they are available at the front office.

Date:_____ /_____ /_____

Print Patient Name: _____

Signature of Patient: _____
(Legal Guardian if under the age of 18)

VERY IMPORTANT – PLEASE READ CAREFULLY!

APPOINTMENT CANCELLATION and 'NO SHOW' POLICY

Please be advised that we require **24 HOURS** notice for appointment rescheduling or cancellations.

If less than 24 hours notice is provided a $35 fee may be charged.

If you **'NO SHOW'** for an appointment without any prior notice you will be charged $50.

The undersigned recognizes that he/she has read and understands the Westchase Physical Therapy CANCELLATION and NO SHOW policy.

Print Name: _____

Signature: _____

Date: _____/_____/_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA, including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment.Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.