OLYMPIC PHYSICAL THERAPY

TODAY'S DATE: ______________________ PT:____

PATIENT'S FULL NAME:____

ADDRESS:____________________________ CITY:________________________ STATE: ______ ZIP CODE: _________

HOME PH #:_____________________ WORK PH #: _______________________ CELL PH #: ______________________

DATE OF BIRTH: ______________ SEX:_______ STUDENT: *YES* OR *NO*

SOCIAL SECURITY NUMBER: ____

REFERRING DR. NAME:________________________________ REFERRING DR PH #: ____________________________

PRIMARY CARE DR NAME:_____________________________ PRIMARY CARE DR PH #: _________________________

EMAIL ADDRESS (optional): ____________________________ EMPLOYER: ____________________________________

IS THIS DUE TO A MOTOR VEHICLE ACCIDENT YES: (SEE BACK) / NO
IS THIS A WORK-RELATED INJURY? YES: (SEE BACK) / NO

PARENT OR RESPONSIBLE PARTY (PLEASE PRINT) IF DIFFERENT FROM PATIENT.

NAME: ____

ADDRESS:____________________________ CITY:________________________STATE: ______ ZIP CODE: ___________

DOB: _________________ SEX: ________ SS #: ___________________________________

INSURANCE INFORMATION (Please present insurance card at time of check in)

PRIMARY INSURANCE: _______________________ SECONDARY INSURANCE: _______________________

_______________________ _______________________

BASE STATE OF INSURANCE: _________________ BASE STATE OF INSURANCE: ____________________

INS. ID #: ___________________________________ INS. ID #: _______________________________________

GROUP#:_____________________________________ GROUP#:_______________________________________

RELATIONSHIP TO PATIENT:___________________ RELATIONSHIP TO PATIENT: _____________________

DIAGNOSIS / REASON FOR PHYSICAL THERAPY: ____

EMERGENCY CONTACT NAME: _____________________________________ PH#: _____________________________

HOW DID YOU HEAR ABOUT US: ____

I authorize the use of the above information on my insurance claims. I understand that I am responsible for knowing my particular health insurance coverage. I request that payment of authorized benefits be made on my behalf to Olympic Physical Therapy for any services rendered. I understand that I am responsible for any deductible or co-pay amount designated in my insurance contract or for services denied by my insurance. I understand that I am responsible for any unpaid balance on my account. I permit a copy of this authorization to be used in place of the original. I understand that my signature authorizes that payment be made and that my medical information may be released in order to pay my claim.

PATIENT SIGNATURE: ____ DATE: _____________________________

PLEASE SIGN BELOW FOR NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

PRINTED NAME: ____ DATE: ____________________

PATIENT SIGNATURE: ____ DATE: ____________________

WE RESERVE THE RIGHT TO CHARGE $25 FOR A MISSED APPOINMENT OR CANCELLATION WITHOUT 24-HOURS NOTICE

IF THIS IS A CAR ACCIDENT:

DATE OF INJURY / ACCIDENT: ____________ STATE IN WHICH ACCIDENT TOOK PLACE: ________

INSURANCE COMPANY NAME: ____

INSURANCE COMPANY ADDRESS: ____

CITY, STATE, ZIP CODE: ____

INSURANCE COMPANY PHONE NUMBER: ___________________________________

ADJUSTOR'S NAME: _______________________ ADJUSTOR'S PHONE NUMBER: ________________

CLAIM #: __________________________

ATTORNEY INVOLVED: YES NO

ATTORNEY NAME: ____

ATTORNEY ADDRESS: _____________________ CITY: _______________ STATE: ____ ZIP: _______

ATTORNEY'S PHONE NUMBER: ______________________

IF THIS IS A WORKER'S COMPENSATION CLAIM:

EMPLOYER'S NAME AND NUMBER: _______________________________________

W/C INSURANCE COMPANY NAME: _______________________________________

W/C INSURANCE COMPANY ADDRESS: ____________________________________

____

ADJUSTOR NAME: _________________________

ADJUSTORS PHONE NUMBER: _______________ ADJUSTORS FAX NUMBER: ________________

FILE / CLAIM #: _______________________________ DATE OF INJURY: __________________________

HAS A REPORT OF INJURY BEEN FILED WITH YOUR EMPLOYER? YES NO

OF VISITS APPROVED: ___________________________________ EXPIRES: ____________________

OLYMPIC PHYSICAL THERAPY

Middletown, Tiverton, Bristol, Wakefield

Medical History Form

Patient's Name___________________________________ **Date**____________________

Diagnosis_____________________________ **Current Medications**_________________
____

YES	NO		YES	NO	
☐	☐	high blood pressure?	☐	☐	history of neck/back pain?
☐	☐	any heart problems?	☐	☐	night sweats or fever, (unrelated to menopause)?
☐	☐	heart palpitations?			
☐	☐	angina?	☐	☐	bowel and/or bladder problems?
☐	☐	heart murmur			
☐	☐	abnormal heart rate?	☐	☐	thyroid problems?
☐	☐	chest pain with exertion?	☐	☐	diabetes?
☐	☐	shortness of breath?	☐	☐	low blood sugar?
☐	☐	pace maker?	☐	☐	cancer?
☐	☐	asthma or allergies?	☐	☐	osteoporosis?
☐	☐	lung problems?	☐	☐	headaches?
☐	☐	chance of pregnancy?	☐	☐	frequent joint sprains/muscle strains?
☐	☐	heartburn, stomach or intestinal upset?	☐	☐	joint pain & swelling?
☐	☐	history of ulcers?	☐	☐	history of fractures
☐	☐	experienced recent weight loss or gain	☐	☐	metal implants?
			☐	☐	history of trauma?
☐	☐	experienced loss of appetite?	☐	☐	history of seizure/epilepsy?

Surgery/Dates:____
____

Are there any other medical conditions that we must know about?
____
____

Signature: ____**Date:**________________

This information has been reviewed by the following Physical Therapist.

PT Signature: _______________________________________**Date:** ________________

Name: ____ Date: __________________

Olympic Physical Therapy

Functional Scale

Please answer the following questions to assist your physical therapist in the creation of a program to address your current deficits and goals. Rate your ability to perform the activities below on a 0 to 10 scale. For example, if you feel you are able to complete the listed activity at all times you would circle 10, if not at all you would circle 0, if 50% of the time you would circle 5.

1. I am able to perform activities relating to my personal care without significant difficulty, (washing, dressing).
   0 1 2 3 4 5 6 7 8 9 10

2. I am able to perform activities of daily living, (i.e. meal prep., household chores, laundry, etc.) independently.
   0 1 2 3 4 5 6 7 8 9 10

3. I am able to participate in the activities / hobbies that I enjoy, (i.e. sports, music, knitting, etc.)
   0 1 2 3 4 5 6 7 8 9 10

If applicable please list the degree / type of assistance that you may be receiving at this time.

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4. I am able to sleep without interruption due to my injury / pain. **0 1 2 3 4 5 6 7 8 9 10**

5. I am independent in all transfers, (I can get out of bed, out of a chair without the assistance of others).
   0 1 2 3 4 5 6 7 8 9 10

6. I can walk without losing my balance when I walk in the community. **0 1 2 3 4 5 6 7 8 9 10**

7. I can walk without losing my balance when I walk in my place of residence. **0 1 2 3 4 5 6 7 8 9 10**

8. I can move up and down stairs and curbs without difficulty. **0 1 2 3 4 5 6 7 8 9 10**

9. I am able to carry objects, (i.e. laundry, meals) without difficulty. **0 1 2 3 4 5 6 7 8 9 10**

Are you able to carry / hold objects, (yes or no): 1-5lbs ___, 5-10lbs ___, >20lbs ___

10. I can perform activities involving pushing / pulling / overhead reaching. **0 1 2 3 4 5 6 7 8 9 10**

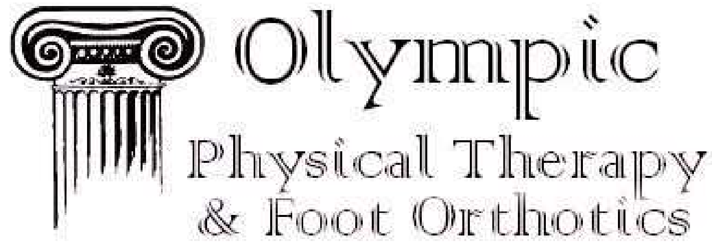
Yes or No: Does your injury/ pain interfere with your social life? If yes how? ______________________________

Please list three (3) activities that are especially difficult for you to participate in or achieve at this time due to your injury and/or pain, (i.e. driving, playing a sport, getting in or out of your car).

1. ____
2. ____
3. ____

Please rate your pain level, (with respect to your current injury / complaint) on a scale of 0 to 10 where 0 represents no pain and 10 represents the most extreme pain you have ever experienced. __________

Therapists, please total the above 10 question set: _______ / 100



BILLING STATEMENT

We strongly recommend that all patients check their physical therapy benefits by calling the number on the back of the insurance card. Physical therapy often falls under the major medical portion of the benefits, resulting in different co-pays and deductibles than an office or doctor visit.

We can only bill a patient for their portion once we have received payment from the insurance. Rarely does an insurance company pay all visits at once. They usually pay in several smaller installments, potentially resulting in multiple patient bills.

Insurance companies can sometimes take up to 4-6 weeks for payment, so patients often receive bills after physical therapy has terminated.

Any benefits quoted by your insurance company over the phone are not a guarantee of payment.

There are many diverse United Health Plans. We can provide you with an estimated co-pay to hopefully alleviate a larger final bill.

If you do not pay all co-pays at the time of service, we will be balance billing you.

Your signature below verifies that you have read the above information.

____________________________ Signature

__________________ Date

Notice of Privacy Policies for

Olympic Physical Therapy and Sports Medicine Inc.

Middletown, Tiverton, Bristol, Wakefield

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction: At Olympic Physical Therapy we are committed to protecting your health information. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 4th, 2003 and applies to all protected health information as defined by federal regulation.

Understanding your Health Record / Information

Each time you visit Olympic Physical Therapy; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you have received.
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professions
- A source of data for medical research
- As source of information for public health officials charged with improving the health of this state and the nation.
- As source of data for planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcome we achieve.

You:

Understanding what is in your medical record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the property of Olympic Physical Therapy, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices on request
- Inspect and receive a copy of your health records as provided in 4 CFR 165.524
- Amend your health record as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided in 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities: Olympic Physical Therapy is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mil a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we received a written revocation of this authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, please let our front office staff know and they will return your answer as soon as possible. If you believe your privacy rights have been violated, you can file a complaint with the

practice's Privacy Officer, or with the Office of Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy officer or the Office for Civil Rights. The address for the COR is listed below:

Office for Civil Rights
US Dept. of Health and Human Services
200 Independence Ave, S.W.
Room 509 F, HHH Building
Washington D.C., 20201

Examples of Disclosures for Treatment, Payment and Health Operation

We will use your health information for treatment: For example: Information obtained by a physical therapist, an aide or other member of your health care team will be recorded and used to determine the course of treatment that works best for you. Your physical therapist will document in your record his o her observations and expectations. In that way, the physical therapist will know how you are responding to treatment.
We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in your treatment. This is to include all health care providers in our practice and those assisting in coverage of our practice.

We will use your health information for payment: For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations: For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include brace fitting and durable medical equipment consultants.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for you care, your location, and general condition. We may leave a message on your answering machine or voicemail as a means of communication. We may mail you a postcard or written notice as a means of communication. We may email you or use a transcriptionist as a means of communication.

Communication with Family: Health professionals using their best judgment may disclose to a family member, other relative, close personal fiend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure to ensure the privacy of your health information has approved their research.

Fund Raising: We may contact you as part of a fund raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respects to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, replacement.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to the public health or legal authorities charted with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.