Premier PHYSICAL THERAPY & SPORTS PERFORMANCE

Driver's License _____
Insurance Card(s) _____
Script _____
Paperwork Complete _____
FOTO Setup _____
WebPT case setup _____
Appt. Reminder call _____

Schedule Date: _____
Schedule Time:_____
Scheduled with: _____
In Take Completed by:_____

Personal Information Form

Today's Date: _____

Last Name:_____ First Name: _____ Middle: _____

Date of Birth:_____ Age:_____ Sex: Male / Female SSN:_____

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Contact Phone: _____

Body Part Injured: _____

Did you have Surgery for your Injury? Yes / No If Yes- date of surgery: _____

Have you had physical therapy during the current calendar year? Yes / No

If Yes- Where? _____ And for How long? _____

If Medicare- are you currently receiving Home Health Services? Yes / No If Yes- Discharge Date:

Did a Doctor provide you with a prescription or recommendation to go to physical therapy? Yes / No

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Is your Injury/ Condition due to:

An Automobile Accident? Yes / No

A Worker's Compensation Claim? Yes / No

Is this a Slip and Fall/No Fault Claim? Yes / No

If Yes to any of the above: Do you have an attorney? Yes / No

Please sign this form verifying the accuracy of your personal information and/or the personal information of the minor on whose behalf you are providing the information.

**Print Name**- Patient or Guarantor:_____ Patient Relationship to you: _____

**Signature** of Patient or Guarantor: _____ Date: _____

Guarantor Information- *if applicable*

Guarantor Name: _____ Guarantor DOB:_____

Guarantor Address:_____ City: _____

State: _____ Zip: _____ SSN: _____ Phone: _____

## Consent to Treatment

I, the undersigned, give the staff and/or affiliates of Premier Physical Therapy & Sports Performance, LP consent to evaluate and treat me for the condition or conditions which I am reporting today. I acknowledge that by discussing additional conditions with the staff and/or affiliates of Premier Physical Therapy & Sports Performance, LP during the course of my treatment, I am also implying consent to treat those conditions.

I, the undersigned, understand that the information concerning my condition and treatment is confidential and will only be released upon my written consent. All management of clinical data, which may include evaluation, treatment information or photographs, may be used in publications or presentations about diagnoses or physical therapy management. No identifying information will be disclosed and use of the data will fulfill compliance with HIPAA guidelines.

Signature: _____ Date:_____

Staff Witness Signature: _____ Date: _____

# Insurance Information *(complete all that apply)*

## *Primary Health Insurance Information*

Name of Primary Insurance: _____

Policy/ID #: _____ Group of Account #: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Employer of Policy Holder: _____

Relationship of Policy Holder to Patient: _____

Effective Date of Policy: _____ Insurance Phone #: _____

## *Secondary Health Insurance Information*

Name of Primary Insurance: _____

Policy/ID #: _____ Group of Account #: _____

Name of Policy Holder: _____ DOB of Policy Holder:_____

Employer of Policy Holder: _____

Effective Date of Policy: _____ Insurance Phone #: _____

## *Automobile Insurance Information (or No Fault/Liability Insurance)*

Name of Insurance Company: _____

Claim # : _____

Adjuster Name: _____ Adjuster Phone #: _____

Date of Accident: _____ State where Accident Occurred: _____

## *Worker's Compensation Insurance Information*

Name of Insurance Company: _____

Claim # : _____

Name of Employer:_____ Employer Phone #: _____

Employer Address: _____ City: _____

State: _____ Zip: _____

Adjuster Name: _____ Adjuster Phone #: _____

Date of Injury: _____ State where Injury Occurred: _____

Job Title of Employee: _____

Is there a Case Manager? Yes / No

Case Manager Name: _____Case Manager Phone #: _____

## *Attorney Information*

Attorney Name: _____

Attorney Phone #: _____

## HIPAA Compliance Statement

I consent to the use or disclosure of my protected health information by Premier Physical Therapy & Sports Performance, LP, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Premier Physical Therapy & Sports Performance, LP. I understand that diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Premier Physical Therapy & Sports Performance, LP, is not required to agree to the restrictions that I request. However, if Premier Physical Therapy & Sports Performance, LP, agrees to a restriction that I request, the restriction is binding on Premier Physical Therapy & Sports Performance, LP.
I have the right to revoke this consent, in writing, at any time, except to the extent that Premier Physical Therapy & Sports Performance, LP, has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Premier Physical Therapy & Sports Performance, LP Notice of Privacy Practices prior to signing this document. Premier Physical Therapy & Sports Performance, LP Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Premier Physical Therapy & Sports Performance, LP. Premier Physical Therapy & Sports Performance, LP Notice of Privacy Practices is provided at the registration desk.

Premier Physical Therapy & Sports Performance, LP, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices at the registration desk.

**May we send you text messages related to your care with us? Yes ___ No ___**

**By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.**

**May we send you emails relating to your care with us? Yes ___No ____**

**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**

**Email: _____**

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

Premier PHYSICAL THERAPY & SPORTS PERFORMANCE

## Benefit Assignment/ Release of Information

As a courtesy Premier Physical Therapy and Sports Performance, LP (hereforward - PPTSP) will submit charges to your insurance company for their consideration for payment. You are ultimately responsible for any and all charges incurred as a result of the services provided to you by PPTSP. In order to secure payment from your insurance company, you must assign your medical benefits to PPTSP. By signing below you are indicating that you are assigning your benefits to PPTSP.

I hereby assign all medical benefits to include major medical, Medicare and any other government sponsored programs, private insurance and any other health plans, worker's compensation insurances, or automobile insurances, to which I am entitled, to PPTSP.

_____
Print Patient/Guarantor

_____ _____
Signature Patient/Guarantor Date

## Financial Policy

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for all charges when services are rendered. Required co-pays are to be paid at the time of service. Co-insurances and amounts not covered by your insurance will be billed monthly if you comply with our payment policy outlined below. If you wish not to comply with our payment policy we will require payment of estimated co-insurance and other amounts not covered by your insurance at the time of service. Please note that all co-insurance and other amounts not covered by your insurance paid at the time of service are estimated. Your liability may be more. You are responsible for any difference between the estimated and actual amount owed. If we over-estimate the amount, we will send you a refund for any difference when all of your dates of service are paid in full.

_____ Copays- are due at the time of service

Co-Insurance Amounts:
_____ I will be paying my estimated co-insurance /deductible amount at the time of service

_____ I will be leaving a credit card on file for any co-insurance / deductible amounts due to my account

Signature:_____

## Payment Policy

It is our policy to secure a method of payment (ie credit, debit or HSA card) for any balances on your account owed to PPTSP. You will receive a monthly bill for your portion of the charges as a result of services provided to you. 15 days following the date on your bill, PPTSP will debit the method of payment that you provided. Failure to provide a valid method of payment will result in an additional charge of $25.

If you wish to dispute your bill or request other payment options, you must notify PPTSP in writing. Written requests must be received within 15 days of the date on your bill.

By providing your method of payment below, you are agreeing to comply with the policies described above. If you are unable to provide a method of payment described above, please ask to speak with our staff.

I have read and understand the Financial and Payment Policies as outlined above.

_____ _____
Print Name/Guarantor Date

_____
Signature Patient/Guarantor

Credit Card Being Provided: MC ( ) Visa ( ) Dis ( ) Amex ( )

*Provide Card to Front Office Team Member for secure recording of credit card information.*

Card Billing Address:_____

# HEALTH HISTORY

Patient Name:_____ Today's Date:_____

Have you ever had these symptoms before (circle): Yes / No - If yes, when:_____

Date of Injury/onset:_____ Do you currently exercise moderately three times per week? Yes No

The following is a list of common health problems. In the first column please indicate if you currently or have ever had any of the problems in the past. In the second column please indicate if you are currently receiving treatment for the problem. In the last, please indicate if the problem currently limits any of your daily activities.

| | Do you or have you had the problem? | | Do you currently receive treatment for this problem? | | Does this problem limit your daily activities? | |
|---|---|---|---|---|---|---|
| Smoking/Tobacco Use | Yes | No | Yes | No | Yes | No |
| Drug or Alcohol Abuse | Yes | No | Yes | No | Yes | No |
| Anxiety or Depression | Yes | No | Yes | No | Yes | No |
| Diabetes | Yes | No | Yes | No | Yes | No |
| Cardiovascular Condition | Yes | No | Yes | No | Yes | No |
| Cancer | Yes | No | Yes | No | Yes | No |
| Lung Disease or Asthma | Yes | No | Yes | No | Yes | No |
| Heart Disease/Heart Attack | Yes | No | Yes | No | Yes | No |
| High Cholesterol | Yes | No | Yes | No | Yes | No |
| Pacemaker | Yes | No | Yes | No | Yes | No |
| High or Low Blood Pressure | Yes | No | Yes | No | Yes | No |
| Ulcer or Stomach Disease | Yes | No | Yes | No | Yes | No |
| Nausea or Vomiting | Yes | No | Yes | No | Yes | No |
| Hernia | Yes | No | Yes | No | Yes | No |
| Kidney Disease | Yes | No | Yes | No | Yes | No |
| Liver or Gall Bladder Problems | Yes | No | Yes | No | Yes | No |
| Bipolar Disorder | Yes | No | Yes | No | Yes | No |
| Anemia or Blood Condition | Yes | No | Yes | No | Yes | No |
| Ringing in the Ears | Yes | No | Yes | No | Yes | No |
| Autism Spectrum Disorder | Yes | No | Yes | No | Yes | No |
| Sexual Dysfunction | Yes | No | Yes | No | Yes | No |

(Please view other side)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Seizures | Yes | No | Yes | No | Yes | No |
| Headaches | Yes | No | Yes | No | Yes | No |
| Dizziness, Fainting, or Vertigo | Yes | No | Yes | No | Yes | No |
| Nerve Disease or Disorder | Yes | No | Yes | No | Yes | No |
| Muscle Disease or Disorder | Yes | No | Yes | No | Yes | No |
| Auto Immune Disease | Yes | No | Yes | No | Yes | No |
| Hearing Loss | Yes | No | Yes | No | Yes | No |
| Vision Loss | Yes | No | Yes | No | Yes | No |
| Arthritis | Yes | No | Yes | No | Yes | No |
| Allergies | Yes | No | Yes | No | Yes | No |
| Skin Disorders | Yes | No | Yes | No | Yes | No |
| Are you Pregnant? | Yes | No | Yes | No | Yes | No |
| Bowel or Bladder Irregularities | Yes | No | Yes | No | Yes | No |
| Menstrual Irregularities | Yes | No | Yes | No | Yes | No |
| Recent Unexplained Weight Gain or Loss | Yes | No | Yes | No | Yes | No |
| History of Stroke | Yes | No | Yes | No | Yes | No |
| Osteoporosis/Osteopenia | Yes | No | Yes | No | Yes | No |
| Numbness or Tingling | Yes | No | Yes | No | Yes | No |
| Shortness of Breath | Yes | No | Yes | No | Yes | No |
| History of falls in past 12 months | Yes | No | Yes | No | Yes | No |

Surgeries with corresponding dates: _____

_____

Are you currently taking any opioids? Yes No

Current Medications and reasons for taking: _____

_____

Signature: _____ Date: _____

Relationship to patient: _____

# HIPAA POLICIES/PROCEDURES MANUAL

| P/P TITLE: Authentication of Electronic Signature, Attestation, and Authorship for Medical Record Documentation | P/P#: HIPAA 1.027 | PAGE Page 1 of 2 |
|---|---|---|
| **EFFECTIVE DATE:** 04/01/19 | **REVIEWED AND APPROVED BY:** Senior Management Team | |

**Policy**

The Company, its clinics and its employees shall accept electronic signatures as defined within this policy for author validation of documentation, content accuracy and completeness with all the associated ethical, business and legal implications. This process shall operate with a secured infrastructure, ensuring integrity of process and minimizing risk of unauthorized activity in the design, use and access to the medical record. Electronic signature is used for medical records as a means of attestation of electronic medical record entries for computer generated documents. Properly executed electronic signatures are considered to be legally binding as a means to identify the author of health record entries, confirm content accuracy and completeness as intended by the author, and to ensure e-signature integrity is maintained in the electronic medical record.

---

**Procedures**

1. This clinic utilizes electronic signatures of the responsible clinician to authenticate his/her own entries in the electronic health record by using a unique signature/password that shall verify the identity of the signer.

2. Each clinician is assigned unique credentials at the initiation of employment with the clinic to be used when entering all information into the electronic medical record system.

3. The password cannot be retrieved by any other user working within the electronic health record software program.

4. Passwords are required to contain at least one (1) capital letter, one (1) number and one (1) symbol, must be at least 8 characters, and can only be reset by the Support Team for the electronic health record software program.

5. Employees shall not share their e-signature password or disciplinary action may be taken up to and including termination.

6. Authentication includes the identity, professional discipline and professional license number of the author, as well as the date and the time signed.

7. No edit or alteration of any electronic signature, which has been completed (saved and signed-off), can occur.

8. After an entry has been completed and the electronic signature has been applied, modification is addressed through amendments.

9. An amendment to a note is made when a therapist deems it necessary to clarify information recorded in the original document or to add to the original document.

    a. Amendments are linked to the original created document;

    b. Amendments must be authenticated in the manner outlined above; and

    c. Amendment note will be dated the date that it is written.