



PATIENT INFORMATION

Date ____/____/____ Clinic _____

Name _____
(First) (Middle) (Last)

Address _____ Apt / Ste # _____

City _____ State _____ Zip _____

Day Phone ____-____-____ Home Phone ____-____-____

Cell Phone ____-____-____ Work Phone ____-____-____

Birth date ____/____/____ Email _____@_____

Marital status: Married Single Other Gender: Male Female

Have you had Physical Therapy before? Yes No If yes, When: _____ Where: _____

Referred by: _____

Other than your doctor, how did you hear of Sports Physical Therapists?

Professional Org. * Website * Insurance * Sports Physical Therapists Location/Signage * Advertisement *
* Club/Organization *

If a category was circled above, please specify name/organization _____

CURRENT EMPLOYMENT/SCHOOL INFORMATION

Employer/School _____ Title/Grade _____

PHYSICIAN INFORMATION

Referring Physician _____ Phone ____-____-____

Address _____

If you would like us to send copies of correspondence to your primary care physician, please complete below:

Primary Care Physician _____ Phone ____-____-____

Address _____

ADDITIONAL INFORMATION

What is your Primary Language? _____

Do you need an interpreter? Yes No



AUTO/3RD PARTY AUTO INFORMATION

Is this an auto accident? Yes No Date of Accident ___/___/___

In what city and state did the accident occur? _____

Your Motor Vehicle Insurance Name _____

Claim # _____ Phone _____

Have you retained an Attorney? Yes No Law Firm Name _____

Attorney Name _____ Phone _____ - _____ - _____

BILLING INFORMATION

Primary Insurance Company _____

Name of Policy Holder _____ Relationship _____

Policy Holder Date of Birth ___/___/___ ID# _____ Group# _____

Policy Holders Employer: _____

Secondary Insurance Company _____

Name of Policy Holder _____ Relationship _____

Policy Holder Date of Birth ___/___/___ ID# _____ Group# _____

Policy Holders Employer: _____

Have you verified your therapy benefits with your insurance?

Yes No if not, we strongly encourage you to do so

WORKERS COMPENSATION

Is this a Workers Comp accident? Yes No Date of Injury ___/___/___

Employer Contact name _____ Phone _____ - _____ - _____

Work Comp Insurance Company _____

Work Comp Claim # _____

Work Comp Adjuster Name _____ Phone _____ - _____ - _____

Is this an approved Worker's Comp Injury? Yes No Have you retained an Attorney? Yes No

Law Firm Name _____

Attorney Name _____ Phone _____ - _____ - _____



PATIENT MEDICAL HISTORY & INTAKE QUESTIONNAIRE

Name: _____ Age: _____

Date of next physician appointment: _____

What problem(s) are you being treated for today? (Describe type and location of symptoms) _____

What date (roughly) did your present symptoms start? _____

How did your problem(s) begin? _____

My symptoms are currently: GETTING BETTER GETTING WORSE STAYING THE SAME

My symptoms currently: COME AND GO ARE CONSTANT CONSTANT, BUT CHANGE WITH ACTIVITY

What makes your symptoms better? _____

What makes your symptoms worse? _____

What time of day are your symptoms worse: MORNING AFTERNOON EVENING OVERNIGHT

Indicate special tests performed for this problem and results if known (circle all that apply):

X-ray _____ Bone Scan _____ CT scan _____ MRI _____

Other: _____

Treatment received so far for this problem (please circle): Chiropractic Acupuncture Injections

Physical Therapy Occupational Therapy Other: _____

Have you received physical/occupational therapy within the last calendar year? YES NO

Approximately how many treatment sessions have you received this calendar year? _____

MEDICAL HISTORY Circle all that apply:

Asthma Angina/Chest Pain Anemia Arthritis Glaucoma Chronic Bronchitis

Clotting Disorder Diabetes Emphysema Epilepsy Fractures Heart Attack

Heart Murmur Headaches/Migraines Hepatitis High Blood Pressure Stroke/TIA

High Cholesterol HIV positive/AIDS Kidney Disease DVT/PE Ulcers

Thyroid Disease Cancer: _____

Other: _____



Are you pregnant? YES NO If Yes, number of weeks: _____

MEDICATIONS

Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking. We can copy a detailed list if you have one.

Table with 4 columns: Medication Name, How much (dose), How often, How taken (circle one). Rows include ointment, pill, drop, patch, injection, inhaler.

Any allergies to medication(s) / other? _____

If so, what are your reactions? _____

Living Accommodations

Please circle which applies: House Condo/Apartment Group Residence Nursing Home

Do you live alone? Y N

Occupation: _____

Are you currently working: Light duty Full Duty Not Working

If not working, date last worked: ___/___/_____

Leisure Activities/Hobbies/Exercise Routine:

What activities comprise your day? (Circle all that apply): Sitting Standing Walking Lifting Other: _____

Do you use tobacco? YES NO If yes, indicate type, amount, and frequency: _____

Alcohol intake and frequency: _____

Is there anything else we should know that is pertinent to your treatment? _____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient/Guardian Signature _____ Date ___/___/_____



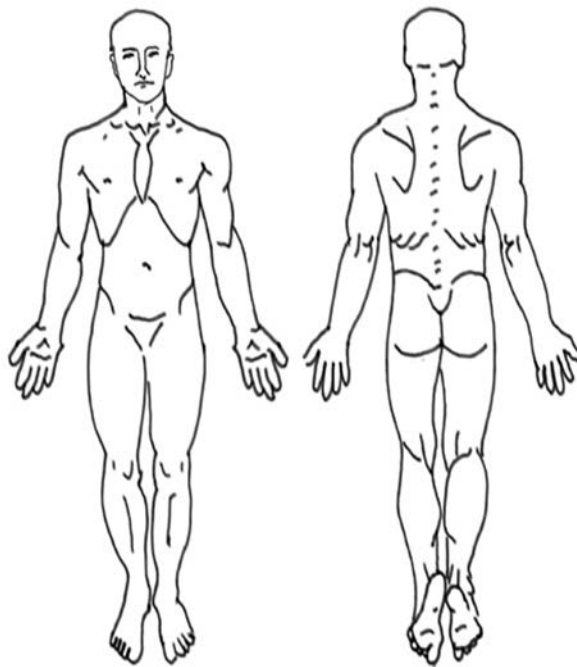
Rate your pain!

Patient Name: _____ Date Completed: ____/____/____

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours.

Be VERY precise when drawing the location of you pain. Use the key below to indicate symptoms.

Key:	Pins and Needles = 000000	Stabbing = /////
	Burning = xxxxxx	Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (circle one):

1 2 3 4 5 6 7 8 9 10

Please rate your worst level of pain in the last 24 hours on the following scale (circle one):

1 2 3 4 5 6 7 8 9 10

Please rate your best level of pain in the last 24 hours on the following scale (circle one):

1 2 3 4 5 6 7 8 9 10



CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment/tests.

2. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Sports Physical Therapists, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Sports Physical Therapists with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

Please note that refusal to sign this form does not change responsibility for payment in any way.

3. **ASSIGNMENT OF BENEFITS:** I hereby assign to Sports Physical Therapists all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

4. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that Sports Physical Therapists may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Sports Physical Therapists administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Sports Physical Therapists Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

5. **HIPAA CONSENTS:** In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

6. CONSENT FOR EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency:

_____	_____	_____
Name	Telephone Number	Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____	_____
Signature of Patient or Legally Responsible Person	Date

_____	_____
Printed Name of above	Date



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.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI about you is maintained as a written and/or electronic record. Specifically, it individually identifies you and relates to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare.

We are required by law to maintain the privacy of your health information and provide you with a copy of this notice. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice, and make the revised or changed notice effective for all health information that we maintain. Any changes to this notice will be posted in our facilities and on our website. Paper copies will be available upon request.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

For Treatment. We may use health information about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care.

For Payment. We may use and disclose health information, as needed, about you so the treatment and services you receive may be billed, and payment may be collected from you, an insurance company or a third party. For example, this may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage of health benefits.

Healthcare Operations. We may use or disclose, as-needed, your protected health information for our day-to-day health care operations to ensure that you and other patients receive quality care. For example, we may use or disclose PHI relating to the evaluation of patient care, business management activities, quality assessment and improvement, employee reviews, legal services, and auditing functions. All disclosures of your PHI will be limited to the minimum necessary or that which is contained in a limited data set (e.g. PHI that excludes certain identifiers including demographic information, photographs, etc.).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Special Notices. We may contact you at the address and phone number you provide (including leaving a voice message) about scheduled or canceled appointments, billing and/or payment matters. We may also contact you about health related services or Sports Physical Therapists and its affiliates locations that may be of interest to you.

Required by Law. We may use or disclose your health information when required to do so by federal or state law. We must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements under the Privacy Rule.

Public Health Risks. We may release your health information for public health activities. For example, disclosures related to the quality, safety or effectiveness of a product, prevention or disease control, to coroners, medical examiners and funeral directors as needed to perform their duties as required by law, and organ procurement organizations for the purpose of facilitating organ, eye or tissue donation and transplantation



Victims of Abuse, Neglect or Violence. We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly.

Health Oversight Activities. We may disclose your health information to health agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of government regulatory programs.

Judicial and Administrative Proceedings. We may disclose your health information in the course of an administrative or judicial proceeding in response to a court order. Under most circumstances, when the request is made through a subpoena, a discovery request, or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

Law Enforcement. We may disclose your health information for law enforcement purposes.

Research. Your health information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

To Avert a Serious Threat to Health or Safety. We may disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of a particular person or the general public.

Specialized Government Functions. We may disclose health information for military and veterans' affairs, or national security and intelligence activities.

Worker's Compensation. Both state and federal law allow, without your authorization, the disclosure of your health information that is reasonably related to a worker's compensation injury. These programs may provide benefits for work-related injuries or illness.

Others Involved in Your Healthcare. Unless you object, we may disclose to a family member, relative or close friend your PHI that directly relates to that person's involvement in your care. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of PHI.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us services if the PHI is necessary for those functions or services. For example, we may use a shredding company to destroy paper medical records. To protect your health information, we require the business associate to appropriately safeguard your information.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Non-Custodial Parent. We may disclose PHI about a minor equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Your decision to revoke authorization will not affect or reverse any use or disclosure that occurred before you notified us of your decision.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH, AND GENETIC INFORMATION:

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Please contact our Manager of Privacy and Compliance for more information.



YOUR HEALTH INFORMATION RIGHTS:

You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of your healthcare information. This includes health and billing records. Your request to inspect and obtain a copy of your healthcare information must be made in writing to: the Facility Manager/Front Desk Coordinator where treatment was rendered. In addition, we may charge you a reasonable fee to cover our expenses for copying your health information.

We may deny your request to inspect and copy your PHI in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who participated in the original decision to deny the request for access.

Right to an electronic copy of electronic medical records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request an electronic copy of your record be given to you or transmitted to another individual or entity.

Right to receive a security breach notice. You have the right to receive written notification if Sports Physical Therapists or its affiliates discovers a breach of unsecured PHI, and determines through a risk assessment that notification is required.

You have the right to request an amendment to your protected health information. If you believe the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. An amendment request must be made in writing, and must provide reasons to support your request. In certain cases we may deny your request for an amendment if: Your request is not in writing or does not include reasons to support the request; the medical record was not created by us, the person who created the information is no longer available to make the amendment, the record is not part of the health information we maintain, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete.

You have the right to request a restriction of your protected health information. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to family members or friends who may be involved in your care or payment for your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your requested restriction. If we agree, we will comply unless we terminate our agreement or the information is needed to provide emergency treatment to you.

Out-of-pocket payments. If you paid out-of-pocket in full for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We are required to agree to your request.

You have the right to request that you receive confidential communications. You have the right to request confidential communication from us by alternate means or at an alternate location. For example, you may ask that we only contact you at work or by mail.

You have the right to receive an accounting of certain disclosures. You have the right to receive a list of disclosures of your PHI that we have made, except for disclosures pursuant to an authorization, for purposes of treatment, payment, healthcare operations, or required by law. Your request must state a time period which may not be longer than 6 years before your request.



You have the right to obtain a paper copy of this notice, even if you agreed to receive the notice electronically.

HOW TO EXERCISE YOUR RIGHTS: To exercise your rights described in this notice, you must submit your request in writing to: Sports Physical Therapists, 600 52nd Street, Kenosha, WI 53140.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our practice. We request that you file your complaint in writing so we may better assist in the investigation of your complaint. Send your written complaint to:

Manager of Privacy and Compliance, Sports Physical Therapists, 600 52nd Street, Kenosha, WI 53140.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Washington D.C. 20201, or through the DHHS. Additional information can also be found on their website at www.hhs.gov/ocr/hipaa/.

You will not be penalized or otherwise retaliated against for filing a complaint.

If you want more information about our privacy practices or have questions please contact:

Manager of Privacy & Compliance, Sports Physical Therapists, 600 52nd Street, Kenosha, WI 53140

Phone: 262-925-5000

Fax: 262-925-5001