Patient Information:

Diagnosis (part of body being treated):
Approximate Onset/Injury Date:
Referring Doctor:
Have you had previous treatment for this injury? Y N
If so, what?
Have you had Home Health Services in the last 60 days? Y N (Note: Patient cannot be seen by Home Health and Outpatient Physical Therapy at the same time.)

Last Name:	**First:**	**Middle:**
Home Phone:	Cell Phone:	Sex: M F
Email:		
Social Security #	Birth Date:	Age:
Mailing Address:		
City:	State:	Zip Code:
Responsible Party Name/Address:		
Emergency Contact Name/Phone #:		
If this case is litigated, please give your attorney's name, address and phone #:		

Primary Insurance:	Medicare Part B? Y N
Name of Insured:	DOB:
Secondary Insurance:	
Name of Insured:	DOB:
Who is the holder of the policy? Self ____ Parent ____ Spouse____ Other____	
Are you a student? Y N Is this a Workman's Comp or auto accident claim? Y N	

Do you have any of the following conditions (please circle all that apply)?		
Allergies	Gastro	PVD
Angina	Headaches	Previous Accidents
Anxiety	Hearing	Prior Surgery
Arthritis	Hepatitis	Prosthesis/Implants
Asthma	High Blood Pressure	Sleep Dysfunction
Back Pain	Heart Attack	Stroke or TIA
Cancer	Incontinence	Visual
COPD	Kidney, Bladder, Prostate	Pacemaker
Congestive Heart Failure	Neurological Disease	Seizures
Depression	Obesity (BMI>=30)	Other _____
Diabetes Type I or II	Osteoporosis	_____

_____ _____

Patient Signature Date

Communication Preferences:

Every once in a while, a situation comes up where a loved one, of one of our patients, a husband or mother for example, calls the office asking for information about you. They may ask for medical information, ask if you have an appointment, or if you are in the office being seen. Because of patient confidentiality (HIPAA), we are unable to give out any kind of information on our patients, even to a husband or mother. We are asking, if at any time you would like information given to a certain person or persons about your care, that you would sign this form and list any individual to whom we can give your information. This form may be revoked at any time in writing.

May we leave a detailed message on your voicemail? Yes No

Type of information that may be released:

□ All Information

□ Only the following information: _____

□ Make/Change Appointments

Persons we may give information to:

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

Patient Name: _____
(Please Print)

_____ _____
Patient Signature Date

Appointment No-Show/Cancellation Agreement:

1. If you are a New Patient and you fail to come to your first appointment, you will not be rescheduled and we will notify the referring provider of the outcome.

2. If you are a Current Patient, we will send you a warning notice for the 1st missed or no-show appointment. In the event of a 2nd no-show appointment, you may be discharged from care and charged a $90 no-show fee.

3. Please notify us of your need to cancel/reschedule at least 24 hours in advance. If you fail to cancel your appointment, a $90 cancellation fee may be billed directly to you. Your insurance company will not pay these fees.

4. Cancellations less than the 24 hour period will be considered a missed appointment and are subject to the patient being discharged from care after two missed appointments. You may also be charged a $90 cancellation fee.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

Notice of Privacy Practices:

Please review this notice carefully!!

In compliance with the **Health Insurance Portability and Accountability Act (HIPAA),** EPT Physical Therapy is informing you of your privacy rights. Please review the information below:

What is HIPAA? HIPAA is a law that passed in congress in 1990 to improve efficiency and effectiveness of the health care system. It required health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). PHI is confidential information about a patient, including demographic information.

What are my rights under HIPAA? Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If it is denied we will explain why in writing.

- **You have a right to inspect and obtain a copy of your PHI**. We will respond to your request within 30 days. In most cases your request will be honored and a copy will be mailed to you.
- **You have a right to request an amendment of PHI**. If you feel that your PHI is inaccurate or incomplete, you may request an amendment of your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your PHI was not created by us, or if PHI is not available for inspection.
- **You have the right to know what disclosure(s) of your PHI have been made**. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge for your initial request. Additionally, your request may not include disclosures made for national security purposes, to law enforcement officials/ correctional facilities, or disclosures made prior to April 14th, 2003.
- **You have a right to request confidential communication of PHI**. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact, and provides detailed information on how payment will be handled.
- **You have a right to request restrictions on the use and disclosure of PHI**; however we are not required to agree to your request. Your request must state specific restrictions and whom the restrictions would apply to.

How will EPT Physical Therapy Use and Disclose PHI under HIPAA? HIPAA allows us to use and disclose your PHI for the purposes of **Treatment, Payment and Healthcare Operations.** We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for use and disclosure of PHI for the purpose of **Treatment, Payment and Healthcare Operations.**

Insurance Benefits:

EPT Physical Therapy checks insurance benefits as a courtesy to our patients. This check is not a guarantee of payment nor will EPT Physical Therapy be held responsible for incorrect information given to our employees regarding your insurance benefits.

You are advised to call your insurance company to find out your physical therapy benefits and, if applicable, deductibles and copays.

If your insurance refuses to pay for any unforeseen reasons, you will be financially responsible for any balance on your account. If you have any questions about your bill, we encourage you to contact our Billing Department at 1-855-408-0304.

Should any account be referred to an attorney or collection agency, you agree to pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

I understand the above statements and agree to accept financial responsibility for services rendered by EPT Physical Therapy.

_____	_____
Patient Name (Please Print)	DOB
_____	_____
Patient Signature	Date
_____	_____
Witness Signature	Date

List of Medications:

Patient Name: _____ Date:_____
(Please Print)

Height_____ Weight _____

Name of Medication	Dose/ Mg.	Frequency	How is Medication Taken? O = Oral R = Rectal N = Nasal I = Injection T = Transdermal	Purpose of Medication

Reactions and Allergies: (example: Latex = rash)

_____
_____
_____
_____
_____

Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

- ***Disclosure to those involved in the individuals care*** – When necessary, we make professional decisions to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or are not able or present to approve.
- ***Use and Disclosures Required by Law*** - as required by law we are required to use and disclose PHI for the following reasons.
  - Use and Disclose PHI for Public Health Activities- Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
  - Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence- Examples include: child abuse and neglect, an abused or neglected nursing home resident, a patient over 60 years old involved in elder abuse.
  - Uses and Disclosure of Health Oversight Activities- We may use and release PHI to be used for audits, investigations and licensure issues, etc.
  - Disclosure for Judicial and Administrative Proceedings- We may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.
  - Disclosure for Law Enforcement Purposes- We may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
  - Uses and Disclosures Related to Decedents - We may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
  - Uses and Disclosures to Avert a Serious Threat to Health or Safety- We may use and release PHI to public health or other authorities required by law in order to prevent a serious threat to your health or safety.
  - Uses and Disclosures for Specialized Government Situations- we may use and release PHI for military/veterans activities and national security/intelligence.
  - Use and Disclosure of PHI in Emergency Situations- in the event of eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen threat.
- ***Uses and Disclosures of PHI for Research purposes-*** We do not use or disclose PHI for research purposes, unless you authorize such a disclosure.
- ***Uses and Disclosure requiring the patients authorization***- We must obtain your written authorization if we are interested in using or disclosing your PHI for reasons other than treatment, payment, and health operations. You may revoke your authorizations at any time.

What does HIPAA require of EPT Physical Therapy? EPT Physical Therapy must maintain the privacy of PHI, abide the terms of this notice and provide patients with a revised notice, if necessary.

Where can I file a privacy complaint? If you feel your privacy rights have been violated, contact the regional Department of Health and Human Services at (707) 441-4600.

I acknowledge receipt of The Notice of Privacy Practices, which describes how my medical information may be used, disclosed and accessed as required by law.

Patient Name: _____
(Please Print)

_____ **_____**
Patient Signature **Date**

_____ **_____**
Relationship of Representative **Reason for Representative**

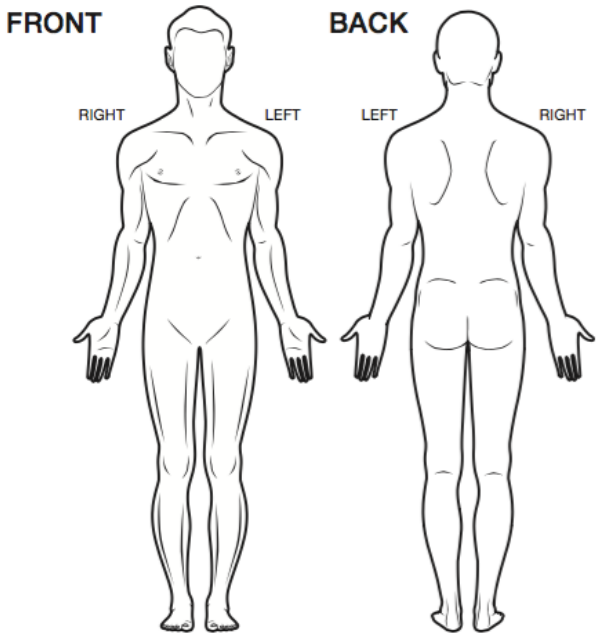
Pain Questionnaire:
Short-Form McGill Pain Questionnaire

Patient's Name:

_____
(Please Print)

Date:_____

Please circle the area(s) of your body where you are experiencing pain today:



Rate your overall pain level on the scale below at your best, current, and worst:

Rating At:	No Pain ----------->>> Worst Possible Pain									
Best	1	2	3	4	5	6	7	8	9	10
Current	1	2	3	4	5	6	7	8	9	10
Worst	1	2	3	4	5	6	7	8	9	10

Fall History:

Have you had any falls within the past year (please circle)? Yes No
If yes, how many? _____

Exercise History:

How often do you exercise?
At least 3x/week _____ 1-2x/week _____ Seldom or Never _____

Patient Information Consent:

1. I, the undersigned give my consent for physical therapy evaluation and treatment.	_____ Initial
2. I understand that I am financially responsible for physical therapy charges not covered by my insurance plan or for the total charges if no insurance applies.	_____ Initial
3. I hereby authorize the staff of EPT Physical Therapy, to release my medical records to my physician(s), attorney, insurance company, hospital and/or other health care provider.	_____ Initial
4. I hereby authorize any physician, hospital and/or other medical providers to furnish medical records to the staff of EPT Physical Therapy.	_____ Initial
5. I understand EPT Physical Therapy has reserved the right to change its privacy practices that are described in the notice. I also understand a copy of any revised notice will be posted in the office or provided to me upon request.	_____ Initial
6. I understand that EPT Physical Therapy does not allow recording devices to be used or photos be taken during my visit(s) at their facilities without prior permission.	_____ Initial
7. I hereby give EPT Physical Therapy my permission to communicate with me through email and understand that email is an unsecure method of communication.	_____ Initial

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

_____

If you are not the patient, please specify your relationship to the patient