HOME TEAM
PHYSICAL THERAPY

Patient Information

Patient Name			Appt. Date	
Address		City	State	Zip
Home Phone	Cell Phone		Email	
Date of Birth	SSN	Gender:	Marital Status: M S D	
Emergency Contact:		Phone #	Relationship	

Employer Information

Employer Name	Employment Status: FT PT Self-Employed		Retired Student	
Employer Address			State	Zip
Work Number	Occupation			

Appointment Reminders: We have an automated, call, email or text reminder. If you would like us to send you reminders, please let us know by filling out this section,

How would you like your appointment reminders? **Text** **Call** **Email** *(circle one)*

For your convenience we now send balance reminder text messages to your mobile phone. The message provides a secure link for you to pay your balance right then or log in to see your statement. If you would like to opt out of receiving these messages, you may do so within that text message or by letting office staff know.

Have you received chiropractic care or physical therapy in the current year at another provider or clinic? **Yes or No** *(circle one)*

If you have, please let us know how many visits you have received so that we may calculate your benefits correctly.

Insurance Policy Holder/Guarantor Information

Name		Contact #	Gender:	
Address			State	Zip
Date of Birth	SSN	Relationship to Patient		
Employer Name		Employer Phone Number		

_____ _____

Patient Signature Date

HOME TEAM PHYSICAL THERAPY

MEDICARE QUESTIONNAIRE

Patient Name:_____

Please read each of the following and respond ONLY to those that apply to your current situation.

1. If you have received Home Health Care of any kind in the past 60 days, please provide the name and phone number of the Home Health Agency.

   HHA Name:_____ Phone:_____

   Date Discharged from Home Health_____

2. If you are entitled to benefits under Black Lung Program, Department of Veteran Affairs or other government program, please provide the name, address and phone number of that program.

   Program Name:_____

   Address:_____

   City, State & Zip:_____

   Phone:_____

   This government program will be primary to Medicare.

3. Was your illness/injury due to any of the following:

   ._____ Work Related Accident Date:_____

   _____ Automobile Accident Accident Date:_____

   _____ Accident on Property other than your own Accident Date:_____
   (example: store, restaurant, etc.)

   Please give details of the accident:_____

   _____

   Please provide the name, address, and contact information of the liability insurance.

   Insurance Name:_____

   Address:_____

   City, State, Zip:_____

   Phone:_____Contact:_____

Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing Medicare.

☐ Check here if none of the above apply

_____ _____

Patient Signature Date

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Patient Bill of Rights

This Facility adopts and affirms as policy the following rights of patient/clients who receive services from our facility. This policy affords you, the patient/client, the right to:

- Treatment without discrimination as to age, race, color, religion, sex, national origin, political belief, or handicap. It is our intention to treat each patient as a unique individual in a manner that recognizes their basic human rights.
- Considerate and respectful care including consideration of psychosocial, spiritual, and cultural variables that influence the perceptions of illness.
- Receive, upon request, the names of the therapist directly participating in your care and of all personnel participating in your care.
- Obtain from the person responsible for your health care complete and current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information shall be made available to an appropriate person in your behalf.
- Receive information necessary to give informed consent prior to the start of any treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, and an explanation of other appropriate treatment methods, if any.
- The patient may elect to refuse treatment. In this event, the patient must be informed of the medical consequences of this action. In the case of a patient who is mentally incapable of making a rational decision, approval will be obtained from the guardian, next-of-kin, or other person legally entitled to give such approval. The facility will make every effort to inform the patient of alternative facilities for treatment if we are unable to provide the necessary treatment.
- Privacy to the extent consistent with adequate medical care. Case discussions, consultation, examination and treatment are confidential and should be conducted discreetly.
- Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third- party payment contract.
- A reasonable response to your request for services customarily rendered by the facility, and consistent with your treatment.
- Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
- The identity, upon request, of all health care personnel and health care institutions authorized to assist in your treatment.
- Upon patient request, examine and receive a detailed explanation of your bill including an itemized bill for services received, regardless of sources of payment.
- Know the facility's rules and regulations that apply to your conduct as a patient.
- Any unanswered concerns on the part of patients or family relative to ethical issues can, with enough notice, be referred to our Compliance Committee for advice.
- Complaints or criticisms will not serve to compromise future access to care at this facility. Staff will gladly advise you of procedures for registering complaints.
- Access and copy information in the medical record at any time during or after the course of treatment. If patient is incompetent, the record will be made available to his/her guardian.
- Expect to be cared for in a safe setting regarding patient environmental safety, infection control, security and freedom from abuse or harassment.
- Participate in the development, implementation, and revision of his/her care plan.

Signature: _____ Date:_____

HOME TEAM PHYSICAL THERAPY

CONSENT FOR TREATMENT | RELEASE OF INFORMATION
HIPPA PRIVACY NOTICE | FINANCIAL AGREEMENT

Patient Name: _____ Date: _____

CONSENT: I do hereby agree and give my consent for **Home Team PT** to furnish Therapy Treatment. _____(Please initial)

Northwest PT has my permission to allow students to observe my treatment and care. Yes ____NO ____(check yes or no)

RELEASE OF INFORMATION: I agree that **Home Team PT** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third-party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, worker's compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI and/or BILLING INFORMATION.

Name: _____ Relationship _____ PHI _____ Billing _____

Name: _____ Relationship _____ PHI _____ Billing _____

HIPAA PRIVACY NOTICE: I acknowledge that I have received the HIPAA Privacy Notice and have had the opportunity to review its content. _____ **(Please initial)**

FINANCIAL POLICY STATEMENT: As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Home Team Physical Therapy.**

The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

*******ARE YOU BEING TREATED AS A RESULT OF AN AUTO ACCIDENT: YES _____ NO_____**
(*If yes, have you supplied Home Team Physical Therapy with your claim information?)*

*******ARE YOU BEING TREATED AS A RESULT OF A WORKERS COMP ACCIDENT: YES _____ NO _____**
(If yes, have you supplied Home Team Physical Therapy with your claim information?)

*******ARE YOU BEING TREATED AS A RESULT OF AN ACCIDENT OF ANY KIND: YES _____ NO _____**

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party **Date**

_____ _____
Employee **Date**

HOME TEAM PHYSICAL THERAPY

Patient Health Information

Name _____ Date _____/_____/_____

Please describe your current complaint or limitation:

_____

_____

Please tells us when/how your problem began:

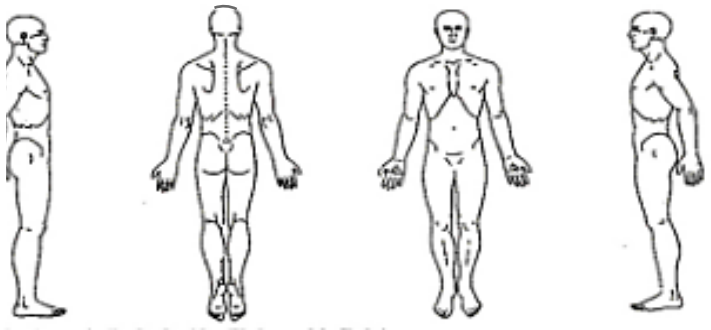
_____

Did you have surgery? **No** **Yes** Date___/___/____

Surgery Type: _____

Please circle the area of your pain on the body chart and check nature of below:

☐	Sharp pain	☐	Tingling
☐	Dull (pain) Ache	☐	Constant (76-100%)
☐	Throbbing	☐	Frequent (51-75%)
☐	Shooting	☐	Occasional (26-50%)
☐	Burning	☐	Intermittent (25- or less)



Indicate the intensity of your pain at worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Indicate the intensity of your pain currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Indicate the intensity of your pain at best: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Since this condition began your symptoms have: **decreased** **not changed** **increased**

Your symptoms are worse *(circle one)* **morning -- afternoon -- night --- increased during the day--- same all day**

In the past have you been treated for this problem: **Yes** **No**

If yes, who did you see for this condition? **MD** **PT** **OT** **Chiropractor** **Other**_____

When and what treatment did you receive? _____

Occupation: _____ Has your work status changed because of this condition: **Yes or No**

The information you provide concerning past & present conditions and diseases assists your therapist in more thoroughly understanding your state of health

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Jaw Pain/TMJ
☐	☐	Heart Condition
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Nervous System Disease
☐	☐	Cancer location:_____date____
☐	☐	Tumor
☐	☐	Hepatitis
☐	☐	Epilepsy/Seizure
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Tobacco packs/day_____
☐	☐	Other_____

Hospitalizations/Surgical Procedures/Previous Injuries (if not elsewhere stated)_____

_____

_____

I have reviewed contradictions with the patient prior to initiating evaluation and treatment. The following contradictions were identified:

I have reviewed with the patient their rehabilitation potential prior to initiating treatment.

Patient/Guardian Signature **Date**

Therapist Signature **Date**

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PATIENT MEDICATION LIST

Name: _____

Medication:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ Please check here if no medication at this time.

_____ _____

Signature **Date**