New Patient Intake Paperwork

NAME:_____
Last First Middle

DATE OF BIRTH: _____ SEX: M / F

ADDRESS:_____
Street City State Zip

PHONE:_____MOBILE:_____

EMAIL ADDRESS:_____

EMPLOYER NAME: _____ PHONE: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT:_____PHONE:_____

PRIMARY CARE PHYSICIAN:_____PHONE: _____

REFERRING PHYSICIAN (If Different):_____

DATE OF NEXT DOCTOR FOLLOW UP FOR THIS INJURY:_____

HOW DID YOU HEAR ABOUT SOUL PT? (CIRCLE): **FRIEND/FAMILY DOCTOR WEBSITE MAILING OTHER**

IF "OTHER", PLEASE DESCRIBE:_____

WOULD YOU LIKE TO RECEIVE INFORMATION REGARDING YOUR APPOINTMENTS, BILLING, AND HEALTH UPDATES VIA:

EMAIL (CIRCLE): Y / N

TEXT (CIRCLE): Y / N

SOUL PHYSICAL THERAPY INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE:

HEALTH INSURANCE CARRIER: _____

POLICY/ID#: _____SUBSCRIBER: _____ DOB:_____

SECONDARY HEALTH INSURANCE (If applicable):

HEALTH INSURANCE CARRIER:_____

POLICY/ID#:_____SUBSCRIBER: _____RELATION: _____

********** Please fill out this section ONLY if you were in an accident or have filed a WC Claim**********

AUTO INSURANCE:
(List YOUR automotive insurance carrier, regardless of fault, if injury is due to a motor vehicle accident)

INSURANCE CARRIER NAME: _____CLAIM #:_____

ADJUSTER'S NAME: _____PHONE:_____

INJURY DATE: _____

WORKER'S COMPENSATION:

INSURANCE CARRIER NAME:_____CLAIM #:_____

ADJUSTER'S NAME:_____PHONE:_____

INJURY DATE:_____

ATTORNEY INFORMATION (If obtained for injury you are seeking treatment for):

NAME:_____

PHONE:_____FAX:_____

MEDICAL HISTORY FORM

Do you now have, or have EVER had the following? Please put an X next to all that apply:

Latex Allergy ( )	Cardiac Disorders ( )	AIDS / HIV ( )	Mental Illness ( )
Arthritis OA / RA ( )	Pacemaker ( )	Hepatitis A B C ( )	Asthma ( )
Cancer / Tumors ( )	Stroke ( )	Seizures / Epilepsy ( )	Fracture ( )
Diabetes ( )	High/Low Blood Pressure ( )	Bowel/Bladder Disorder ( )	Artificial Joint ( )
Sudden Weight Loss ( )	Alcohol/Drug Abuse ( )	Osteoporosis ( )	Other: ( )

PAST MEDICAL HISTORY:
Please list previous surgical procedures and provide the date for each:

_____

_____

Please list any other significant ailments or problems that have required medical treatment in the past:

_____

_____

Please list any medications you are currently taking:

_____

_____

Have you received **PHYSICAL THERAPY** for this or any other injury over the last **12 Months**? **YES or NO**

Females: Are you currently, or is there a possibility that you may be pregnant? **YES or NO**

PAIN ASSESSMENT

Please Circle the Areas of Pain You are experiencing on the diagram below

SOUL PT AUTHORIZATION AND POLICIES

CONSENT FOR TREATMENT:
I, the undersigned, voluntarily give consent to Soul Physical Therapy, LLC, to perform physical therapy evaluations, assessments, and treatments for the injury(s) I was referred to this facility for or referred myself for. I further understand that no guarantee or promise has been made to me concerning the results of treatment received.

ASSIGNMENT OF BENEFITS:
I, the undersigned, authorize direct payment by my insurance company and/or my attorney if out of settlement, for all physical therapy services rendered to Soul Physical Therapy, LLC.

F**INANCIAL POLICY:**
I, the undersigned, understand that although Soul Physical Therapy, LLC will verify my insurance benefits as a courtesy, it is my responsibility to know and understand my own insurance benefits. I understand that I am responsible for paying Soul Physical Therapy directly for any applicable deductible, co-insurance, and/or co-payment required by **MY OWN** health insurance policy. This is a mandatory requirement when receiving healthcare services. Failure to meet your financial obligations is a violation of the agreement between you and your health insurance carrier. Please note that the carrier may take additional action when financial obligations are not met. **Soul Physical Therapy requires payment at time of service.**

ACKNOWLEDGEMENT AND UNDERSTANDING:
It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition or certain physical therapy treatment options be such that it is not covered by my health insurance policy, or if, for any reason, the insurance carrier and/or my attorney refused to pay my balance to this office.

AUTHORIZATION TO RELEASE INFORMATION:
I, the undersigned, authorize Soul Physical Therapy to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

PATIENT REQUEST FOR RECORDS:
I, the undersigned, authorize the release of all medical, hospital, or surgical records **pertinent to my case** for the purpose of assisting with physical therapy diagnosis, treatment options and improving the overall quality of care received at Soul Physical Therapy, including but not limited to, exams, special tests, OR reports, X-rays, MRI's, CT scans or lab results to this office.

CANCELLATION / NO-SHOW POLICY:
We at Soul Physical Therapy work hard at providing you with the best care possible so that you reach your health and recovery goals. Your commitment to your physical therapy program is critical to your success and ability to reach these goals. Soul Physical Therapy expects that you keep each scheduled appointment. If you do have to cancel an appointment, we require a courtesy of a **12 hour notice** and ask that you reschedule your cancelled appointment within the same week in order to maintain the prescribed plan of care set by your therapist. **Soul Physical Therapy reserves the right to charge you, NOT your insurance carrier, a fee of $50.00 for any appointment cancelled with a less than 12 hour notice or if NO call is made and you "no-show" for an appointment. This fee is due at the time of your next scheduled appointment.** We understand that emergencies due happen and thus you **will NOT be charged** for the first offense to the above stated policy. Soul Physical Therapy reserves the right to close your case and discharge you from our care if **3** or more appointments are missed. **We want to help those patients who have a true desire to improve their health.**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. **PLEASE READ IT CAREFULLY**

As Required by the Privacy Regulations Created as Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Soul Physical Therapy must maintain the privacy of your health information that is protected by the rule, and must provide you with notice of our legal duties and privacy practices with respect to our protected health care information.

USES AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION [45 CFR 164.506]

Treatment:
Generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

For example:
While undergoing physical therapy evaluations and treatments, medical information will be obtained by the therapist and will be recorded in your patient record. These records may be shared with your health care team so that they know how you are responding to treatment and may be shared with other providers participating in your care to assist them in treating your if referred to them for additional services.

Payment:
Encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

For example:
A bill, which may contain information which identifies you, treatments provided, and your diagnosis, may be submitted to you or a third-party payer such as your health insurer. We may contact your health insurance carrier in order to determine eligibility. We may also disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

Heath Care Operations:
Refer to certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities which are limited to the activities listed in the definition of "health care operations at 45 CFR 164.501.

For example:
Conducting quality assessment and improvement activities, conducting activities relating to improving health or reducing health care cost, arranging for medical, legal, and auditing services, including fraud and abuse detection and compliance programs, underwriting and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits.

USES AND DISCLOSURE FOR OTHER PURPOSES

Business Associates:
We may disclose protected health information to our business associates and allow them to create and receive protected health information on our behalf.

For example:
We may share information with a durable medical equipment provider to acquire the appropriate prescribed piece of equipment.

Notification:
We may disclose information to notify or assist in notifying a family member, a person responsible for your care, regarding your location or general condition.

Law Enforcement Purposes:
When required by federal, state, or local law, we may disclose protected health information in response to a court order subpoena.

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

PATIENT PRIVACY RIGHTS

Below is a list of your privacy rights. If you chose to request (in writing) how your private health information is used or disclosed, understand that Soul PT is not required to agree to your requested restrictions. However, if agreed to, Soul PT is bound to abide by such restrictions [45 CFR 164.522(a)]. Privacy rights are as follows:

- You have the right to request that we further restrict use and disclosure of your protected health information.
- You have the right to request that we communicate your health information to you by certain means or at a certain location, for example you might request that we may only contact you at work.
- You have the right to obtain, upon request, an accounting of certain disclosures of your protected health information by us.
- You have the right to inspect and obtain a copy of your protected health information.
- You have the right to receive a paper copy of our Notice of Privacy Practices.
- You have the right to revoke this consent (in writing) at any time, except to the extent that action has already been taken.

OUR DUTIES

We are required by law to maintain the privacy of your health information and are also required to provide you with this notice of your legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect.

We reserve the right to reserve the right to change the terms of our privacy notices. If we make a change to our privacy notice, we will notify you in writing when you arrive for your next treatment.

If you believe we have violated your privacy rights, you can file a complaint with the secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create a contractual or other rights independent of those created in the federal privacy rule.

EFFECTIVE DATE: Dec 1, 2014

I have read and understand this notice and that I may request a written copy at any time.

By signing below, I certify that I have read, fully understand, and agree to all policies and procedures stated above and on the previous pages of this intake paperwork.

Name (print) _____ Date of birth _____

Signature _____ Date _____
(Parental Signature Required for Children under 18)

Waiver and Release of Liability

In agreeing to receive care provided by Soul Physical Therapy LLC ("Soul Physical Therapy ") and to use the facilities provided therefore by Beverly Racquet & Fitness Club Inc. doing business as Beverly Athletic Club ("Beverly Athletic Club") located at 7 Reservoir Road Beverly MA 01915, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Soul Physical Therapy and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Soul Physical Therapy , Beverly Athletic Club, Soul Real Estate Holdings, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Soul Physical Therapy, Beverly Athletic Club or Soul Real Estate Holdings LLC, or by any other person.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Soul Physical Therapy LLC, Beverly Athletic Club, Soul Real Estate Holdings LLC and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Soul Physical Therapy, Beverly Athletic Club or Soul Real Estate Holdings LLC.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE SOUL PHYSICAL THERAPY, BEVERLY ATHLETIC CLUB AND SOUL REAL ESTATE HOLDINGS LLC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Name (print) _____ Date of birth _____

Signature _____ Date _____

(Parental Signature Required for Children under 18)