Acknowledgment of Receipt of Notice of Privacy Practices

A copy of the Notice of Privacy Practices for Access Physical Therapy & Wellness was given or made available to me. Access Physical Therapy & Wellness reserves the right to modify the privacy practices outlined in the notice.

_____ _____

Signature of Patient Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Patient Representative to Patient

Request for Non-Disclosure

Information involving you may be released to a family member, other relative or close friend if we believe it is for your best interest. We will use only health information that is relevant to that person's involvement in your care. If in the event we need to discuss your care with a family member, other relative or close friend, is there anyone you object this information being disclosed to?

DO NOT release any medical information about my care to the following family members or close friends:

_____

_____

_____

_____ _____

Signature of Patient Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Patient Representative to Patient

Name: _____

Authorization for Treatment

I hereby authorize Access Physical Therapy & Wellness to release information on my therapy treatment and services to myself or above-named individual. I also authorize the release of such information that may be necessary for my care via mail, electronic or facsimile transmission.

Release and Assignment of Benefits

I hereby authorize Access Physical Therapy & Wellness (APTW) to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to APTW. I authorize APTW to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-payment or co-insurance, and any charges not reimbursed by my insurance carrier. I understand that some insurance carriers require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

_____ _____

Signature of Patient or Responsible Party Date

Emergency Contact Information:

Emergency Contact: _____ Relation: _____

Phone Number: _____ Other Phone: _____

Text/E-Mail Reminders & Satisfaction Surveys

We are excited to offer text and e-mail reminders of your appointments, as well as surveys to help make sure we provide an outstanding patient experience. Keeping your information secure is important to us so we want you to be aware that email and texts are not considered secure means of communications. These communications contain minimal information and therefore are low risk; however please consider this when electing this service. Please choose your preferred options.

☐ Please send me e-mail reminders of my appointments.

My E-mail address is: _____

☐ Please send me text reminders of my appointments.

My cell phone number is: _____

☐ Please send me the survey **via text** to provide my feedback on my experience at Access. (Survey will be sent by email if you choose to opt out of text surveys.)

_____ _____

Signature of Patient or Responsible Party Date

12/21/17

No Show and Cancellation Policy

Scheduled appointment times are very important at ACCESS PT & Wellness. It is our policy to make sure you are not waiting more than 5 minutes for your scheduled appointment. In return, we ask that you make every effort to be on time for your appointment. If you are unable to keep an appointment, we ask that you give us at least 24 hours' notice. The following no show and cancellation policy is in effect:

No Show Policy: If an appointment is missed without a notifying phone call with 24 hours' notice, we reserve the right to charge a $50 fee (this is **not** covered by your insurance). If this occurs a second time, not only will a fee be incurred, but we reserve the right to place you on our "call the day of" list or discharge you from our services.

Cancellation Policy: If an appointment is cancelled with less than 24 hours notice given, we reserve the right to charge a $50 fee (this is **not** covered by your insurance). If this appointment is **rescheduled** for another time that day or another time that week the fee will not be incurred. If 3 cancellations occur, you will be placed on our "call the day of" list or you may be discharged from our services.

**We understand emergencies can happen. The therapist will use their discretion to accommodate these unforeseen circumstances.*

If you know your personal or work schedule will cause you to cancel several appointments with short notice and you do not want to incur fees, you have the following options:

- **Schedule appointments for full plan of care** so that you can reserve the time that is most convenient for you and your schedule.
- **Reschedule** your appointment for another time that day or that week. We will do our utmost best to accommodate your desired time.
- **"Call the day of"** If you know on a particular day that you will be able to make an appointment, you can call first thing in the morning and see what we have available that day.

I, _____, have read and understand the cancellation policy.

_____ _____

Signature Date

ACCESSPT™

FOR INTERNAL USE ONLY:

Height: _____ Weight: _____

BMI: _____

Date: _____ Initials: _____

Patient Health Questionnaire

Name: _____ Date of Birth: _____

Referring MD: _____ Next MD Appointment: _____

Would you like a copy of your reports sent to your Primary MD? ☐ Yes ☐ No

If yes: Primary MD Name: _____ Fax: _____

Current complaint or limitation: _____

Date of Injury/Onset: _____ ☐ Work Related ☐ Auto Accident ☐ School Injury

If your injury is the result of an accident, in what State did the accident occur? _____

If your injury is the result of an accident, is there currently any legal action being pursued? ☐ Yes ☐ No

Occupation: _____ Present work status: _____

Please list any surgeries and dates below: _____

_____

What is your goal for therapy? _____

Do you have any other aches and pains we should know about? ☐ Yes ☐ No

If "Yes" please describe: _____

Past Medical History - Please check all that are applicable:

☐ High Blood Pressure	☐ Stroke	☐ Hepatitis	☐ Heart Attack
☐ HIV/AIDS	☐ Systemic Lupus	☐ Asthma	☐ Depression
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Pacemaker	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Tuberculosis	☐ Latex Allergy	☐ Currently Pregnant
☐ Osteoarthritis	☐ Angina	☐ Osteoporosis	Other: _____

☐ Cancer - Location(s) and Date(s): _____

Please list below any current medications, including dosage and route, you are presently taking (including prescription, over-the-counter, herbals, vitamins/minerals/dietary or nutritional supplements).

☐ Please see attached copy of medication list provided ☐ Not taking any medication.

Name of Medication	**Dosage**	**Route (by mouth, patch, injection, etc.)**

Please list any X-rays, CT scans, or MRI tests performed and the results: _____

_____

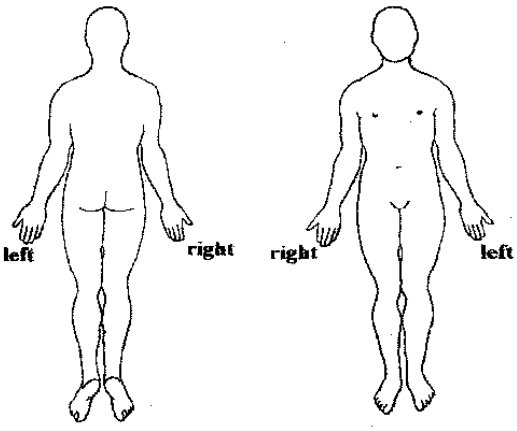
Name: _____

Please indicate the intensity of your pain at its worst:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Please indicate the intensity of your pain at its best:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Please circle the description of your pain (any that apply):
Sharp Dull Throbbing Numbness
Shooting Burning Tingling
Constant (>76%) Frequent (51-75%)
Occasional (25-50%) Intermittent (<25%)

On the diagram to the right, mark the location(s) of your pain.



What increases the pain? _____

What decreases the pain? _____

Have you had physical therapy in the past for this same problem? ☐ Yes ☐ No

Have you had any physical/occupational/speech therapy or chiropractic visits this year? ☐ Yes ☐ No
Number of therapy visits received this year for: PT _____ OT _____ Speech _____

Were you in a hospital or skilled nursing facility within the past 30 days? ☐ Yes ☐ No
If yes, reason for stay _____
Dates of stay: From: _____ To: _____

Have you recently received any type of home care services? ☐ Yes ☐ No
What was the last date anyone came into your home for services? _____

Over the past 12 months, have you fallen 2 or more times? ☐ Yes ☐ No

Over the past 12 months, have you had 1 or more falls that resulted in injury? ☐ Yes ☐ No

Do you smoke or use smokeless tobacco products?
☐ No, I do not use tobacco products ☐ Yes, I smoke _____ packs per day
☐ Yes, I use smokeless tobacco products _____ times per day

Do you drink alcoholic beverages? ☐ No ☐ Yes
How many alcoholic drinks per day? _____ How many alcoholic drinks per week? _____

Please let us know how you heard about our facility:
☐ Sign out front ☐ Mailing ☐ Insurance Directory ☐ I was a previous patient
☐ A previous patient (please specify) _____ ☐ Newspaper ad
☐ Dr. _____ ☐ Phone book (please specify) _____
☐ Friend/Family (please specify) _____ ☐ Other: _____

Is there someone specific we may thank for referring you to us? ☐ Yes: _____ ☐ No

I am signing this form attesting to the best of my knowledge the information is accurate and reliable. I will notify the provider if any information changes.

Patient or Authorized Representative Signature: _____ Date: _____

Therapist Signature: _____ Date:_____