Premier Physical Therapy
"Feel Free to Move"

Patient Name: ____ **DOB**: _______________________________

Sex: Male / Female **Marital Status**: S / M / D / W **SSN:** _______________________________

Address: ____

City: ____ **State**: _____________________ **Zip**: ________________

Primary #: ________________________________ **Secondary #:**____________________________________

Email: ____

Emergency Contact: ____________________________________ **Emergency Contact #:** _________________

Date of Accident/Injury: ______________________ **State of Accident**: ________________________________

Accident Related to: ( ) Work ( ) Automobile ( ) Other **Is an attorney involved?** Yes / No

If so, what is the name and number of your attorney? ____

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Insurance Information:

Primary Insurance Co: __________________________________ **Subscriber:** ___________________________

Policy ID: ____ **Group #:** _____________________________

Secondary Insurance Co: _________________________________ **Subscriber:** __________________________

Policy ID: ____ **Group #:** _____________________________

I authorize that payment by insurance will be made directly to Premier Physical Therapy on my behalf for any services furnished to me. I authorize the release of any medical information about me to Health Care Financing Administrator and its agents to determine the benefits payable for related services. I further recognize that if payment is made directly to me by the insurance company, the amount received is the property of Premier Physical Therapy and should be paid to them immediately. I hereby authorize Premier Physical Therapy and its agents to render me treatment as deemed appropriate and as prescribed by my physician. I understand that I am fully responsible for any unpaid charges and if, for any reason, the account should become delinquent, I will be responsible for any/all collection agency fees (33.3%), attorney fees, and/or court cost, if such be necessary. You agree, in order for us to service your account or to collect monies you may owe, Premier Physical Therapy and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Signature: ____ ***Date***: ______________________

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HIPAA Information

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, a progress report will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage, or from the credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Premier Physical Therapy. For example, information on the treatment you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use & disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition & treatment.
- The right to inspect & obtain a copy of your protected health information.
- The right to amend and submit corrections of your protected health information.
- The right to receive information of how and to whom your health information has been disclosed.
- The right to receive a printed copy of this notice.
- **Effective Date:** This notice is effective on or after December 9, 2011. By signing below, I acknowledge that I have received and read the Privacy Notice of Premier Physical Therapy.

Signature: ____ ***Date***: ___________________________

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Medical History Screening Form

Please circle yes or no and list where appropriate.

Have you or any immediate family member ever been told you have or are you aware of symptoms related to:

	Patient	**Family**
Cancer?	Yes / No	Yes / No
Diabetes?	Yes / No	Yes / No
High Blood Pressure?	Yes / No	Yes/ No
Heart Disease/Heart Attack?	Yes / No	Yes / No
Stroke?	Yes / No	Yes / No
Osteoporosis/Osteopenia?	Yes / No	Yes / No
Osteoarthritis?	Yes / No	Yes / No
Rheumatoid Arthritis?	Yes / No	Yes / No
Other?	Yes / No	Yes / No

Do you have history of:

Allergies?	Yes / No	Headaches?	Yes / No
Bronchitis?	Yes / No	Kidney Disease?	Yes / No
Rheumatic Fever?	Yes / No	Ulcers?	Yes / No
Seizures?	Yes / No	Nervous Disorder?	Yes / No
Hernia?	Yes / No	Hernia?	Yes / No
Metal Implants?	Yes / No	Pacemaker?	Yes / No
Dizziness?	Yes / No	Balance Problems?	Yes / No
Are you pregnant?	Yes / No	Sensitive to Heat?	Yes / No
Are you stressed?	Yes / No	Sensitive to Ice?	Yes / No

Are your symptoms getting: Worse / Same / Improving
Do you have a problem with: Vision / Hearing / Speech

In the past three months, have you experienced any of the following:

A change in your health?	Yes / No	Nausea/Vomiting?	Yes / No
Fever/chills/sweats?	Yes / No	Weight Change?	Yes / No
Numbness or tingling?	Yes / No	Changes in appetite?	Yes / No
Difficulty Swallowing?	Yes / No	Shortness of Breath?	Yes / No
Dizziness?	Yes / No	Bladder Dysfunction?	Yes / No
Bowel Dysfunction?	Yes / No		

Signature: ____ ***Date***: ___________________________

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Medication List

Please list all medications including herbal, OTC, and vitamins/supplements.

Medications	What is your dosage and how often do you take it?	In what form is your medication? Pill, liquid, etc?

Signature: ____ *Date*: ____________________