Functional Fitness
and Physical Therapy, LLC

Client Information and Health History Questionnaire

Client Information

Name:_____ Male/Female:____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Mobile Phone:_____ Home Phone:_____

Emergency Contact:_____ Phone:_____

Relationship of Emergency Contact:_____

Appointment Reminders by **Text** □ (mobile provider:_____) **Email** □ **Phone call** □

Email to be used for appointment reminders:_____

Currently Employed?: yes □ no □ Occupation:_____

Referral from Physician?: yes □ no □ Name of Physician:_____

Is this Injury or condition related to a work or motor vehicle accident (check one)?: yes □ no □

Are you using health insurance or self-payment for PT services?: Insurance □ Self-pay □

Health Insurance (if billing insurance)

Insurance Company:_____ ID#:_____

Primary Care Physician:_____ Phone:_____

Subscriber of Health Insurance:_____ Date of Birth:_____

Address of Subscriber (if different):_____

Relationship to Subscriber:_____ Phone (if different):_____

Current Condition

What is your reason for this visit?:_____

When did your pain/condition begin?:_____

Have you had any episodes of similar problem(s) in past, if so when?:_____

List any medical tests or procedures/surgery and/or and any Physical Therapy or other therapies performed for **this** condition:_____

Do you have any pain associated with **this** injury/condition? yes☐ no☐

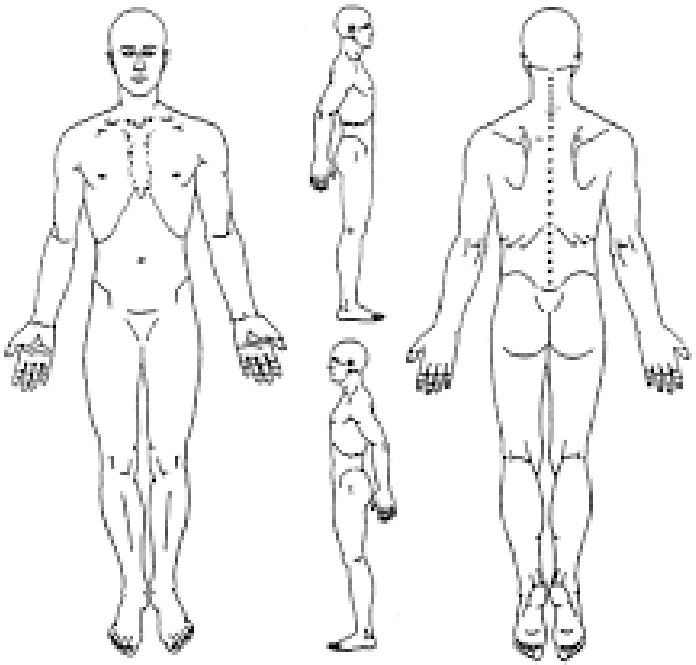
Pain at worst (circle): Pain Free- 0 1 2 3 4 5 6 7 8 9 10 -Severe

Pain at best (circle): Pain Free- 0 1 2 3 4 5 6 7 8 9 10 -Severe

Current pain (circle): Pain Free- 0 1 2 3 4 5 6 7 8 9 10 -Severe

Pain and/or symptom location chart (please indicate location of your current pain or symptoms)

Right side



Right Left Left side Left Right

My pain can be described as (circle all that apply): Burning Sharp Dull/Aching Throbbing Shooting Numbness/Tingling Constant Intermittent Worse in a.m. Worse in p.m.

Is there anything that makes your pain/condition better?:_____

Please circle any factors that increase your pain or make your condition worse?: Sitting Standing Walking Stairs-up Stair-down Getting up from chair Bending Lifting Sleeping Driving Reading House-work Yard-work Recreation Voiding Coughing/sneezing

Please indicate any other activities or positions that increase your pain or make your condition worse:

_____

List any prior regular activities that you are unable to perform now due to your current condition:

_____

Health History

Do you now or have you ever had any of the following?	Yes	No		Yes	No
Heart Attack or Surgery			Dizziness or Fainting		
High Blood Pressure			Anxiety or Depression		
Cancer/Chemotherapy/Radiation			Hernia		
Asthma, Bronchitis or Emphysema			Bowel or Bladder Problems		
Shortness of Breath/Chest Pain			Severe or Frequent Headaches		
Diabetes			Osteoporosis/Osteopenia		
Hearing Difficulties			Stroke/TIA		
Vision Difficulties			Allergies		
Thyroid Issues			Eating Disorder		
Smoking			Joint Replacement		
Joint Pain/Arthritis			Pacemaker/Internal Defibrillator		
Sleep Disorder			Endometriosis/Pelvic Problems		
Currently Pregnant			If Pregnant, due date:		

Allergies:_____

Medications (please list all current medications or include list):_____

_____

List any previous surgeries and date: _____

_____

Additional concerns or comments about your past medical history:_____

_____

What do you do for activity or exercise now? _____

What would you like to accomplish by coming to Physical Therapy? _____

How did you hear about Functional Fitness and Physical Therapy, LLC?_____

I agree that the above information is accurate and agree to inform my therapist of any changes to this information.

Client/Guardian Signature:_____Date:_____

Functional Fitness
and Physical Therapy, LLC

Attendance and Missed Visit Policy

Functional Fitness and Physical Therapy (FFPT) is proud to provide high quality individual appointment sessions with a licensed physical therapist. Only one client is scheduled at a time, allowing for one-on-one sessions with a specific physical therapist. This gives your therapist the ability to fully supervise, educate and perform hands-on treatment as needed. FFPT's unique approach allows exceptional results and a high rate of patient satisfaction, usually requiring less treatment visits than with traditional physical therapy practices. Missed appointments can slow your progress, recovery and are costly to the practice.

If you need to cancel an appointment, kindly notify the office at least **24 hours** prior to your scheduled appointment. Failure to do so will result in an office charge of **$25.00** per occurrence.

If you fail to show up ("No-Show") for a scheduled appointment, a **$25.00** no-show fee will be charged to you. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.

If you think you will be late for your appointment, please call and inform FFPT. All efforts will be made to accommodate you; however, your treatment session may need to be reduced because of time constraints due to the next scheduled patient. If you are more than 20 minutes late you may need to be rescheduled. If you are more than 30 minutes late and fail to notify the clinic, treatment may be cancelled and a **$25.00** fee charged for missing the appointment.

Your insurance company will not pay for any cancellation fees. Any fees accrued will be collected from you at your next scheduled appointment.

It is understood that unforeseen matters of sickness or emergencies occur that you cannot control, unfortunately you may still be charged for these missed appointments. These unfilled appointment slots will prohibit FFPT from offering this unique high level of individual care to patients. Thank you for your understanding and cooperation in this matter.

I have read and fully understand the Attendance and Missed Visit Policy of Functional Fitness and Physical Therapy, LLC and agree to these terms.

Signature of Patient/Guardian:_____ Date:_____

Functional Fitness
and Physical Therapy, LLC

Please initial the following:

___Consent for Treatment

I consent to services including a physical therapy evaluation and treatment and or fitness assessment and programming, by Functional Fitness and Physical Therapy, LLC (FFPT). I have been notified of my rights to refuse treatment at any time during the evaluation or treatment session(s). I have informed the Physical Therapist of any physical or medical conditions or medications and will keep the therapist updated with any changes. I will also notify the therapist of any changes in my health or reactions to treatment. I have the right to revoke this consent at any time by written request to my provider.

___Authorization to Release Information/HIPAA Release Form

I hereby authorize Functional Fitness and Physical Therapy, LLC to release my Protected Health Information relative to any Physical Therapy treatment to any third party payer(s) financially responsible for these services or to my referring and/or primary care physician. I am aware that Functional Fitness and Physical Therapy, LLC will use only the minimal amount of information necessary for my treatment and payment of my services in accordance with the The Health Insurance Portability and Accountability Act according to the U.S. Department of Justice.

___Payment Policy and Financial Agreement

Please check one:

- ☐ I am using my Health Insurance for Physical Therapy Services
- ☐ I am paying cash for Physical Therapy and or Fitness Services

___Health Insurance Payment Policy

If your insurance requires a co-payment, it will be due at the time of service. Payments can be made by cash, check or credit card. A $35 returned check fee will be charged for any returned checks. I agree to pay for equipment and supplies not covered by my insurance company. FFPT is not liable if your insurance does not cover your visits or reduces the amount paid because authorization was not obtained. Some insurance companies require authorization or a referral for physical therapy. Although FFPT will assist you in this matter, ultimately this is your responsibility to obtain. Some insurance plans involve a deductible. It is your responsibility to determine if you have already met your deductible; if you have not, you will be responsible for payment of your physical therapy session once FFPT receives an Explanation of Benefits statement (EOB) from your insurance carrier. I understand that I am solely responsible for the balance due on my account.

___Cash Payment Policy

I understand that I am paying cash for Physical Therapy and or Fitness Services and do not expect Functional Fitness and Physical Therapy, LLC to submit any claims to my health insurance carrier. I understand that I am legally responsible for payment of all services.

___HIPAA/Notice of Privacy

I, hereby attest that I have seen Functional Fitness and Physical Therapy's Notice of Privacy (see last page). I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

Please sign to indicate that you are in agreement with all of the above Policies.

Signature of Patient/Guardian:_____ Date:_____

Functional Fitness
and Physical Therapy, LLC

HIPAA Release Form

Patient Name:_____ Date of Birth:_____

Release of Information
⦻ I authorize the release of information including the diagnosis, records, examination and treatment rendered to me and claims information.

This information may be released to:
⦻ Spouse:_____
⦻ Child(ren):_____
⦻ Other:_____
⦻ Information is not to be released to anyone

Messages
Please call:
⦻ my home:_____
⦻ my work:_____
⦻ my cell number:_____

If unable to reach me:
⦻ you may leave a detailed message
⦻ please leave a message asking me to return your call
⦻ do not leave a message

This Release of Information will remain in effect until terminated by me in writing.

Signature of Patient/Guardian:_____ Date:_____

Functional Fitness
and Physical Therapy, LLC

NOTICE OF PRIVACY

This notice describes how medical and personal information about you may be used or disclosed and how you can obtain access to this information. Please review this form carefully.

OUR LEGAL DUTY

Functional Fitness and Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide notice about our information management practices, and follow the information protocols described.

USES AND DISCLOSURES OF HEALTH INFORMATION

Functional Fitness and Physical Therapy, LLC uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we provide. Your personal information will be used to contact you to arrange an appointment with us and to properly bill for the services we provide to you. In any other circumstances, Functional Fitness and Physical Therapy, LLC, will obtain your written permission and authorization before disclosing your personal health information. If you provide FFPT with a written authorization to release your information for any reason, you may later revoke that authorization to cease further disclosures at any time. If and when any changes are made in the privacy and confidentiality policies of FFPT, a new Notice of Privacy will be available. You may request a copy of the Notice of Privacy at any time. The HIPAA Compliance Officer for FFPT is Sarah Anestam. She can be reached at 508-682-0186.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that FFPT correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where FFPT disclosed your personal health information for reasons other than treatment, payment, or related administrative purposes. You may request in writing that FFPT not use or disclose your personal health information for reasons other than treatment, payment, or related administrative purposes except when specifically authorized by you, when required by law, or in an emergency.

CONCERNS AND COMPLAINTS

If you are concerned that Functional Fitness and Physical Therapy, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the HIPAA Compliance Officer for FFPT, Sarah Anestam, at the address and number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Functional Fitness and Physical Therapy, LLC
HIPAA Compliance Officer
Attention: Sarah Anestam
50 Oliver Street, W-2B
N. Easton, MA 02356
508-682-0186

Functional Fitness
and Physical Therapy, LLC

Credit Card Recurring Payment Authorization Form

(please fill out only if applicable)

I, _____(client), authorize Functional Fitness and Physical Therapy, LLC, to charge my credit card on a recurring basis after my Physical Therapy/Fitness sessions. I understand that my card information will be securely saved and charged within 24-48 hours of being seen for the above mentioned treatment session.

Last 4 digits of credit card: XXXX-XXXX-XXXX-_____

Exp date:_____

_____ _____

Client Signature Date