HAYDEN physical therapy

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For Office Use Only

Date: ___/____/_____
Provider: _____
ICD-10: _____
Physician: _____
WC: YES NO
DOI: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Sex: M F

Soc. Sec. #	Date of Birth	Marital Status	Home Phone

Street	City	State	Zip

Employer	E-mail Address

Occupation	Bus. Phone	Cell Phone

Is your injury due to a car accident?	Is your injury work related?	Date of injury or accident: _____/_____/_____

How did you hear about us?

Policy Holder's Name (If different than above)	Soc. Sec. #	D.O.B.

Employer	Email Address

Occupation	Bus. Phone	Cell Phone

Medicare Patients: Have you had any Physical Therapy this Year? Yes No

If Patient Is A Minor Complete Next Section

Father	Soc. Sec.#	D.O.B.
Employer	Email Address	Phone
Mother	Soc. Sec. #	D.O.B.
Employer	Email Address	Phone

In Case of Emergency (if different than above)

Name	Address	Phone

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MEDICAL HISTORY

Family Physician
Referring Physician (If Different)

Have you had a history of any of the following: Please note the space for any answers that require clarification or any other information you think important. (CIRCLE THE APPROPRIATE ANSWER.)

Any Heart Problem: NO YES .....

Rheumatic Fever: NO YES .....

Nervous Problems: NO YES .....

Excessive Bleeding: NO YES .....

Allergy to Penicillin: NO YES .....

Asthma : NO YES .....

Diabetes: NO YES .....Type: .....

Hepatitis: NO YES .....

Cancer: NO YES .....

Lung Disease: NO YES .....

Are You Pregnant? NO YES .....

Abnormal. Blood Pressure NO YES .....(HIGH/LOW)……

Kidney Disease: NO YES .....

Arthritis: NO YES .....

Rheumatoid Arthritis: NO YES .....

Lupus: NO YES .....

Stroke: NO YES .....

Previous Surgreries: NO YES……

Allergies: NO YES……

Please list any medications you are currently taking.....

Signature of Parent or Patient: _____ Date:_____

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Informed Consent for Treatment and Assignment of Insurance Benefits

I hereby authorize therapists and staff at Hayden Physical Therapy to treat my condition as deemed appropriate. The therapists and staff will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my therapist or any staff of Hayden Physical Therapy responsible for any errors or omissions that I may have made in the completion of this form.

Physical Therapy, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While physical therapy treatment is considered to be extremely safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Physical therapy is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this clinic. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Physical Therapy

Soreness- Physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to physical therapy care. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort

Soft Tissue Injury- Occasionally physical therapy treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at Hayden Physical Therapy.

Other Problems- There are occasionally other types of side effects associated with physical therapy care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have physical therapy treatment administered.

_____

Patient Signature **Date**

_____

Parent/Legal Guardian Signature **Date**

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Hayden Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Patient/Responsible Party Signature:_____ Date_____

Hayden Physical Therapy

586 S. State Road 135, Suite E, Greenwood, IN 46142
Telephone (317) 881-0101

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2018 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the top of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you. I hereby authorize payment of all insurance benefits directly to Hayden Physical Therapy. I understand that I am fully financially responsible, whether I sign as an agent or as the patient, for the charges not paid by the insurance company. I also understand I will be responsible for payment of responsible collections fees, attorney fees and court costs required to collect these services for delinquent accounts.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practice to make reasonable inferences or your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms or health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Signed:_____ **Date:**_____

You may make follow-up calls to my home phone and/or leave additional information about this visit on my voice mail or answering machine. ___ YES _____NO