

Foothills Physical Therapy Center

4011 Chapman Hwy Suite J Knoxville TN 37920 Phone 865-573-6458

PATIENT INFORMATION (PLEASE PRINT)

Legal Name: First _____ MI _____ Last _____

Nickname _____ **SSN:** _____ - _____ - _____

Birth Date (mm/dd/yyyy): ____/____/____ Sex: M[] F[] Marital Status: Married [] Single [] Other: _____

Address: _____ City: _____ State: ____ Zip Code: _____

email _____ Home Ph _____ Work Ph _____ Cell: _____

Permanent Billing Address: First _____ MI _____ Last _____ Ph _____

Address: _____ City: _____ State: ____ Zip Code: _____

What is the date that your injury or condition began? We must have a specific date for your claims (mm/dd/yyyy) ____/____/____

Referring MD (who sent you here): _____ Primary Care MD _____ Ph _____

Would you like for us to send your Physical Therapy Evaluation to your Primary Care MD? [] Yes [] No

Date of your Last visit to your referring physician (mm/dd/yyyy) ____/____/____ Date of your Next MD scheduled visit: ____/____/____

Have you seen a chiropractor, or a speech, occupational or physical therapist in the last 12 months? [] Yes [] No.

o If yes, how many visits? []. Some insurance policies limit the maximum of visits covered per year.

Is the condition or injury that you seek treatment for related to?

Employment [] Yes [] No Auto accident [] Yes [] No Other accident [] Yes [] No _____

Would you like for us to submit your claims to your: Health Insurance [] Workers Compensation [] Medicare Part B []

Auto Insurance [] Attorney [] Other: _____

If the primary subscriber on your insurance is someone other than you, please supply the following information:

Subscriber's Name: First _____ MI _____ Last _____ Relationship _____

DOB (mm/dd/yyyy): ____/____/____ If Legal Guardian, SSN _____ - _____ - _____ If Tricare, Sponsor ID#: _____ - _____ - _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Ph: _____ Work Ph _____ Cell _____

How Did You Hear About Us?

Physician [] Insurance Co[] Website[] Phone book[] Friend/ Family[] _____ Other _____

For Workers Compensation Claims only:

Employer: _____ BusinessPhone: _____ Supervisor _____

Case Manager's Name: _____ Phone _____

PATIENT HEALTH QUESTIONNAIRE

Name _____ Age _____ Occupation _____

Are you employed: Full time Part-time Job Not employed

Job Duties _____

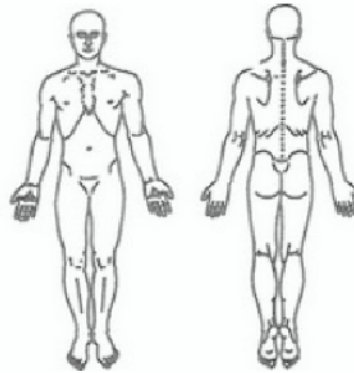
Describe the problem(s) for which you seek treatment _____

How did your symptoms begin _____

When did your symptoms start? _____

What describes the nature of your symptoms?

- | | |
|-----------|----------|
| Sharp | Shooting |
| Dull ache | Burning |
| Numb | Tingling |



How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

None

Unbearable

Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

Have you ever had this problem before? Yes ___ No ___. If yes, did it get better? Yes ___ No ___.

Briefly state previous treatment, if any: _____

Have you had any X-rays, CAT scans, MRIs, or other diagnostic tests for your recent injury? Yes ___ No ___. If yes, please explain the findings, as you understand them: _____

Please give us a complete list all the medicines that you currently or regularly take: _____

Current activity level (hobbies, sports, recreation, etc): _____

Activities wishing to return to: _____

Is there anything else you think I should know about your general health? Please explain and, if necessary, we can talk about it. _____

PAST MEDICAL HISTORY

Have you experienced any of the following?

Yes No

Orthopedic Surgery _____

Yes No

Heart Disease

Congestive Heart Failure (CHF)
High Blood Pressure
Heart Attack (Myocardial Infarction)(MI)
Atherosclerotic Disease (CAD)
Pace Maker

Yes No

Valvular Disease
Stents
Arrhythmia
Coronary Artery Bypass
Angina

Lung Disease

Chronic Obstructive Pulmonary Disease (COPD)
Emphysema

Asthma
Recent Pneumonia

Vascular Disease

Peripheral Arterial Disease
Acquired Respiratory Distress Syndrome (ARDS)
Diabetes
Taking Blood Pressure Meds

Stroke/TIA
Chronic Bronchitis
Hypertension

General Medical Conditions

Arthritis (rheumatoid/osteoarthritis)
Allergies
Neurological Disease (such as MS or Parkinson's)
Headaches
Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
Visual Impairment (such as cataracts, glaucoma, macular degeneration)
Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
Hepatitis/AIDS
Prior Surgery(s)

Osteoporosis
Anxiety or Panic Disorders
Depression
Previous Accidents
Kidney, Bladder, Prostrate or Urination Problems
Incontinence
Hearing Impairment

Sleep Dysfunction
Prosthesis/Implants
Cancer

Explain _____

Other Disorders _____

In Case of Emergency Contact:

Relationship: _____
Home Phone: _____ Work Phone _____ Cell: _____

Signed _____

Date _____

FINANCIAL POLICIES

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. A clear understanding of our Financial Policy and your responsibilities is important to our professional relationship.

When you arrive for your first visit, we will need to make a copy of your insurance card and a photo ID.

Medical Insurance Coverage

Insurance is a contract between you and your insurance company. As a courtesy to you, we will send your claims for physical therapy treatments to your insurance company. We will accept assignment of your insurance.

However, your copay / coinsurance, any unpaid deductible, and any charges for services not covered by your insurance plan, are due at the time of service. Patient balances that are more than 30 days overdue may be referred to an outside collections company.

We will help you receive maximum benefits by providing factual information as necessary.

If we are not in your insurance company's network, acceptance of your insurance will be at our discretion.

If it is acceptable, we will bill your insurance. Other arrangements may be worked out at our discretion.

If your insurance company has not paid their portion of your treatment charges within 60 days, you then may be billed. You will then have 30 days to pay the balance.

Worker's Compensation

We will file worker's compensation claims and accept assignment of their payments. However, if your claim is denied by your worker's compensation carrier, you will be personally responsible for any and all charges. In that case, we will send you a statement and you will have 30 days to pay the balance in your account.

Cancellations

Please call us in advance to cancel and reschedule any appointments that you are unable to keep.

IF WE DO NOT RECEIVE NOTIFICATION, YOU WILL BE CHARGED A \$20.00 FEE.

I do hereby give my consent to and authorize Foothills Physical Therapy Center to release to my insurance company such information from my medical records as may be necessary for the completion and processing of my claim. Foothills Physical therapy Center is authorized to furnish this information even though the confidentiality of the information may be protected by Federal and State Laws and Regulations. Foothills Physical Therapy Center is hereby released and discharged of any liability.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment of my account for any professional services rendered. In the event that this account is referred to an outside collection agency, Credit Bureau, or attorney for collection I agree to pay the expenses incurred, according to the 1989 Statutes of the State of Tennessee.

I understand the above Financial Policies and agree to the terms herein.

Individual responsible for payment of charges

Date

Foothills Physical Therapy Center

NOTICE OF PATIENT INFORMATION PRACTICES Effective 06/28/2004

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Foothills Physical Therapy Center's Legal Duty

Foothills Physical Therapy Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Foothills Physical Therapy Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, for treatment, we may use your personal health information to send medical information to the referring physician; for payment, we may send your chart notes to the insurance company; for healthcare operations, we may send charts to our physical therapy network for quality assurance review. Foothills Physical Therapy Center may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you.

Foothills Physical Therapy Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or for emergencies. We also provide information when required by law.

In any other situation, Foothills Physical Therapy Center's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Foothills Physical Therapy Center may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

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 we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Foothills Physical Therapy Center will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Foothills Physical Therapy Center 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 our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Foothills Physical Therapy Center's health information practices or if you have a complaint, please contact the following person:

Rod Johnston

4011 Chapman Highway Suite J, Knoxville, TN 37920

Telephone: 865-573-6458 Fax: 865-577-8147

Foothills Physical Therapy Center

PATIENT INFORMATION ACKNOWLEDGEMENT FORM Effective Date 06/28/04

I have read and fully understand Foothills Physical Therapy Center's Notice of Information Practices. I understand that Foothills Physical Therapy Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Foothills Physical Therapy Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Foothills Physical Therapy Center's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date