PATIENT INFORMATION AND FINANCIAL AGREEMENT (PLEASE PRINT)

Foothills Physical Therapy Center

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

Legal Name: First_____ MI___ Last_____ SSN:_____

Nickname_____ Occupation _____

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.

- 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 health insurance subscriber is someone other than you, please supply the following information:

Subscriber 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 ☐ _____Prev Patient ☐

Other_____

For Workers Compensation Claims only:

Employer: _____BusinessPhone:_____Supervisor_____

Case Manager's Name**:** _____ Phone_____

Patient Health Questionnaire

Name_____Age_____Occupation _____

If you are a student are you employed: ☐ full time ☐ Part-time Job ☐ Not employed

Job Duties_____

Describe the problem(s) for which you seek treatment_____

_____

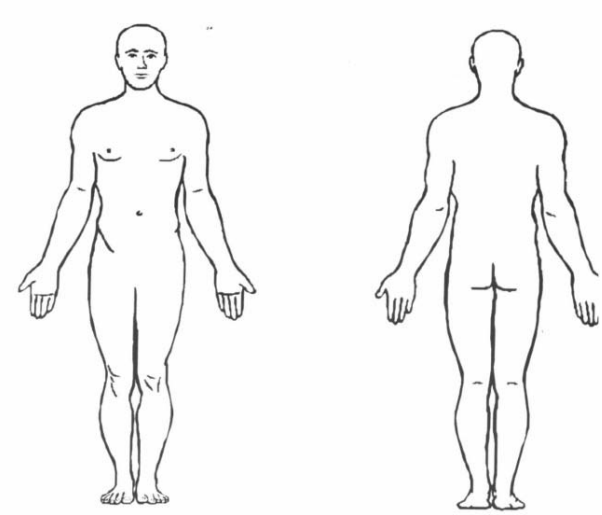
How did your symptoms begin_____

When did your symptoms start?_____

What describes the nature of your symptoms?

☐ Sharp ☐ Shooting
☐ Dull ache ☐ Burning
☐ Numb ☐ Tingling

Indicate where you have pain or other symptoms



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)

Indicate the average intensity of your symptoms:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 0

Have you ever had this problem before? _____

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		Yes	No	
		Heart Disease:			
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Valvular Disease
☐	☐	High Blood Pressure	☐	☐	Stents
☐	☐	Heart Attack	☐	☐	Arrhythmia
☐	☐	Atherosclerotic Disease	☐	☐	Coronary Artery Bypass
☐	☐	Angioplasty	☐	☐	Angina
☐	☐	Do you have a Pacemaker?			
		Vascular Disease:			
☐	☐	Chronic Obstructive Pulmonary Disease (COPD)	☐	☐	Respiratory Distress Syndrome
☐	☐	Emphysema	☐	☐	Recent Pneumonia
☐	☐	Peripheral Artery Disease	☐	☐	Stroke/TIA
☐	☐	Blood Pressure Meds	☐	☐	Chronic Bronchitis
☐	☐	Diabetes	☐	☐	Hypertension
☐	☐	Asthma			
		General Medical Conditions:			
☐	☐	Arthritis (rheumatoid/osteoarthritis)	☐	☐	Osteoporosis
☐	☐	Allergies	☐	☐	Anxiety or Panic Disorders
☐	☐	Neurological Disease (such as MS or Parkinson's)	☐	☐	Kidney, Bladder, Prostate or Urination Problems
☐	☐	Headaches	☐	☐	Previous Accidents
☐	☐	GI Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	☐	☐	Visual Impairment (cataracts, glaucoma, macular degeneration)
☐	☐	Depression	☐	☐	Incontinence
☐	☐	Back Pain (neck pain, low back pain, degenerative disc disease	☐	☐	Hearing Impairment
☐	☐	Hepatitis/AIDS	☐	☐	Sleep Dysfunction
☐	☐	Prior Surgery	☐	☐	Prosthesis/Implants
☐	☐	Cancer			

Explain_____

_____

Other Disorders_____

In Case of Emergency Contact:

_____Relationship:_____

Home Phone:_____ Work Phone _____Cell:_____

Signed_____ Date_____

General Information:

Welcome to Foothills Physical Therapy Center!! We are committed to providing you with the best possible care and we are pleased to discuss your physical therapy treatment with you at any time.

Our clinical staff includes:

- Teresa Johnston, Licensed Physical Therapist, Certified Athletic Trainer and Owner
- Amy Gregory Myers, Licensed Doctor of Physical Therapy
- Caitlin Quinn, Licensed Doctor of Physical Therapy
- LaDawn Wolfe, Licensed Physical Therapy Assistant and Certified Athletic Trainer

While your care may primarily be with one of the individuals listed above, it is possible that all may be involved in your physical therapy treatment. We also have part-time physical therapists, physical therapy assistants and rotating physical therapy students that may assist in your care under the supervision of the physical therapists.
For your comfort, please dress in loose, comfortable clothing. You may be required to change into a clinical gown, depending upon what treatments you are to receive.

Please arrive for your therapy appointments promptly. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment. A courtesy call could possibly avoid a rescheduling necessity.

Cancellation Policy:

Please cancel appointments that you will be unable to keep by phone. Consistent attendance of all therapy sessions is very important for your rehabilitation. Cancellations/no shows are highly discouraged. If you must cancel or reschedule an appointment**, PLEASE GIVE 24 HOURS NOTICE OR YOU WILL BE CHARGED A $20.00 ADMINSTRATIVE FEE.** When you do not keep a scheduled appointment, 3 people are hurt:

- **You-**Because you are not getting the treatment you need.
- **The Therapist-**Who has an open space in the schedule which was reserved exclusively for you.
- **Another Patient-**That could have been scheduled if you would have given our office proper notice of your cancellation.

Please feel free to discuss your treatments or any concerns with your physical therapist. You have the right to refuse any treatment. For the protection of everyone, we ask that if you bring family members or friends with you, please ask them to wait in the lobby. If it necessary for someone to attend your treatments with you, please discuss this with your physical therapist.

We appreciate your questions and comments. We also encourage feedback and input concerning your treatments. Our goal is to return you to the highest level of function possible.

_____ _____

Individual/Parent/Guardian/Next of Kin 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 & Sports Medicine 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 & Sports Medicine 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'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 & Sports Medicine 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

Foothills Physical Therapy Center

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:_____

COMMUNICATION PREFERENCES

Please check ✓ how you would prefer to receive the following information:

Type of Communication	Text/E mail	Cell Ph	Home Ph	OK to leave a voice message?
Appointment Reminders				
Insurance/Payment Issues				
Clinical Information				

Please list applicable contact information for above:

Cell/Text Phone #_____-_____-_____ Provider (Verizon, AT&T, etc)_____

Home Phone # _____-_____-_____ Email_____

Note that e-mail and text are not secure. Others may intercept information sent on unsecured e-mail. Please do not e-mail any information concerning your medical condition, billing, or any other information that you may not want someone other than us to read.

_____

Name

_____ _____

Signature **Date**