



# Northwest Physical Therapy

*Changing lives... One step at a time*

## PATIENT INFORMATION FORM

Please print and complete ALL items. They are REQUIRED to complete your medical record. If an item does not apply, put N/A.

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex: Female / Male Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Employment Status (please circle): Full-time / Part-time / Retired / Not employed / Student (part/full time)

Patient Employer: \_\_\_\_\_  
(Name) (Address) (Phone)

Marital Status (please circle): Single / Married / Divorced / Widowed

If Married: Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_  
(Employer Name) (Address) (Phone)

Patient's Primary Insurance: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Insurance Name) (Name of insured) (Policy holder)

Patient's Secondary Insurance: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Insurance Name) (Name of Insured) (Policy holder)

### Person to notify in case of an emergency (someone *OUTSIDE* of your household):

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Have you been a patient of NWPT before? YES / NO

Were you involved in a Motor Vehicle Accident? YES / NO

Are you presently receiving Home Health services such as nursing, IV therapy, etc? Yes / No

Have you received any other therapy in the past 12 months? Yes / No If YES, how many? \_\_\_\_\_

Have you had any chiropractor visits in the past 12 months? Yes / No If YES, how many? \_\_\_\_\_

How did you **FIRST** hear about NWPT? (Please circle) Doctor recommended / Family or Friend recommended / Radio or newspaper ad / School or trainer / Other (please explain) \_\_\_\_\_

Would you like to receive information from NWPT in the future? YES / NO

Email Address: \_\_\_\_\_ (Our Monthly E-Newsletter has great wellness tips and clinic news.)

### **For Office Use only:**

For Returning Patients:

Patient has reviewed the above information and the information is correct. \_\_\_\_\_  
NWPT Office Initials Date



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## Outpatient Screening Form

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Are you presently being seen in your home by a Home Health Agency? \_\_\_\_\_

If yes, which Home Health Agency? \_\_\_\_\_

**Have you received therapy or any other treatment for this condition in the past year, such as a different therapy provider or chiropractor? Yes \_\_\_\_\_ No \_\_\_\_\_**

Please place a checkmark by the ones that apply:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Smoker/Tobacco      | <input type="checkbox"/> Varicose Veins          | <input type="checkbox"/> Pacemaker     |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Metal Implants      | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Broken Bones  |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Surgeries        | (Fractures)                            |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Leak urine/incontinence |  |

How would you rate your overall health? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Was there an accident or injury involved? \_\_\_\_\_ When \_\_\_\_\_,  
Where \_\_\_\_\_, and How \_\_\_\_\_.

Please list any medications you are presently on: \_\_\_\_\_

Are you allergic to any types of medications or do you have any skin allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, which ones? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you have an Advance Directive/Living Will/DNR Instructions? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type? \_\_\_\_\_ (We will need a copy on file)

Would you like to receive information about Advance Directives? Yes \_\_\_\_\_ No \_\_\_\_\_

FEMALES ONLY: Is there a chance you may be pregnant at this time? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Patient Signature or Guardian

I have reviewed the above health history.

\_\_\_\_\_  
Therapist Signature



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## **CONSENT FOR TREATMENT**

I hereby authorize and consent to treatment at Northwest Physical Therapy, Inc. (NWPT), pursuant to a prescription from my physician and/or per Ohio Revised Code outlining the practice acts of Physical/Occupational/Speech Therapy and Athletic Training.

## **NOTICE OF PRIVACY PRACTICES**

My signature below acknowledges that I was given a copy of this offices privacy practices regarding my Protected Health Information.

## **NO SHOW-CANCELLATION POLICY**

NWPT requires a 24-hour notice for cancellation of appointments or any appointment changes. You can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a \$25.00 charge for a missed appointment without notification to the office.

## **INSURANCE / PAYMENT POLICY**

As a courtesy, NWPT will call your primary and/or secondary insurance company to verify your coverage for therapy. It is also your responsibility to contact your insurance company if required prior to or immediately after your first therapy visit to verify your therapy benefit coverage.

- **Verification of insurance benefits made by NWPT, by you or the responsible party is not a guarantee of payment by an insurance company.**
- **All copays, coinsurance, or deductibles are to be paid at each visit, in an effort to stay current with your account.**

NWPT determines a patient payment is required after an Explanation of Benefits (EOB) is received from your insurance company or after verification of your insurance benefits determines that you have a financial responsibility at the time therapy services are rendered. ALL FEES THAT ARE

DETERMINED TO BE PAID IN FULL BY YOU MAY NOT BE WAIVED AND MUST BE PAID ON THE DATE OF THERAPY SERVICE. See Financial Policy for further details.

I authorize payment directly to NWPT and release information necessary to file a claim with my insurance company. I understand that I am financially responsible for any balance not covered by my insurance company, regardless of any reason for denial of coverage. IF WE DO NOT HAVE CURRENT INSURANCE INFORMATION, WE WILL CONSIDER YOU AS SELF PAY.

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If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

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Patient Signature

Date

---

NWPT Employee Signature

Date



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## NOTICE OF PRIVACY PRACTICES

Effective April 13, 2003

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

Each time you visit NWPT, we make a record of the information gathered during your visit. This information is used for a number of purposes. These uses are set forth below. You have certain rights regarding this information. Your rights regarding this information are set forth below. Finally, we have certain responsibilities regarding our use of your information. Our responsibilities are set forth below.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We are permitted by law to use your health information to provide treatment to you. For example, we will provide your physician and our other clinicians involved in your care and treatment with the information in our records to assist the physician in providing proper care to you. We will also provide this information to subsequent health care providers. These individuals may create additional information related to the care and treatment they provide you.

We are permitted by law to use your health information to obtain payment for our services. For example, we may send your insurance company or other payor a bill that may include your health information.

We are permitted by law to use your health information to perform our regular health care operations. For example, we may use your health information to assess the quality of care we provide in order to maintain our standards.

In addition to these uses and disclosures, we may use your information to contact you to provide appointment reminders to you or to advise you of treatment alternatives available to you.

We are permitted, and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

- to public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse, and other public health issues;

- to health oversight agencies, such as governmental auditors, the Ohio Department of Health, and other agencies when required;

- to any individual when ordered by a court or other legal process to do so;

- to law enforcement officials when necessary for law enforcement purposes and required by law;

- to a coroner or medical examiner when necessary to enable them to perform their duties;

- to organ procurement organizations, to enable them to make suitability determinations;

- in cases of emergency;

- to researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy;

We will not use your information for any other purpose without your written authorization. You have the right to revoke any authorization you provide us.

#### YOUR INDIVIDUAL RIGHTS

You have certain rights regarding your health information. These rights include:

the right to obtain a paper copy of this notice;

the right to inspect and copy your health information (copies are available for a reasonable fee);

the right to request amendments to your health information you believe to be inaccurate;

the right to obtain an accounting of our uses and disclosures of your health information, subject to certain exceptions;

the right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request);

the right to request that communications regarding your health information be sent by alternative means or at alternative locations.

#### OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your information in accordance with this notice. We are also required to provide you with this notice explaining our duties and practices regarding your health information. We are required to abide by the terms of this notice.

We reserve the right to change the content of this notice and to make new provisions regarding your protected health information. We will provide you a revised notice during your first visit after the revisions are effective.

If you have any questions regarding this notice or wish to exercise any of your rights as described herein, you may contact Karyn Kamphaus at 419-523-9003, ext. 510. Any complaints regarding your rights or our practices can also be directed to Karyn Kamphaus. In addition, you can file a complaint with the Privacy Officer of NWPT. Finally, you can submit a complaint to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.