# Northwest Physical Therapy

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

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

## PATIENT INFORMATION

| Patient's last name: | First: | Middle Initial: | Marital status (Please circle one) Single / Married / Divorced / Widowed |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | Social Security no.: | Date of Birth: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Address: | Home phone: ( ) | Cell phone: ( ) |
|---|---|---|

| City: | State: | ZIP Code: | **Email address:** |
|---|---|---|---|

| Employment Status: ❑ Full-time ❑ Not employed ❑ Part-time ❑ Retired ❑ Student | Employer Name: | Employer phone: ( ) |
|---|---|---|
| | Address: | City, State, ZIP: |

| *If Married:* Spouse's Name: | Spouse's Contact Phone: ( ) |
|---|---|

Chose clinic because/Referred to clinic by (please check one box): ❑ Doctor recommended ❑ Insurance Plan ❑ Internet Search
❑ Family ❑ Friend ❑ Close to home/work ❑ Facebook ❑ School or trainer ❑ Other ______________________________

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT OFFICE)

| *Person responsible for bill:* | Birth date: / / | Address (if different): | Home phone: ( ) |
|---|---|---|---|

| **Primary insurance:** | | Subscriber's Name: | |
|---|---|---|---|
| Subscriber's Employer Name: | | Employer Phone: | |
| Address: | | Subscriber's DOB: / / | Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other__________ |
| City, State, ZIP: | | | |
| **Secondary insurance:** | | Subscriber's Name: | |
| Subscriber's Employer Name: | | Employer Phone: | |
| Address: | | Subscriber's DOB: / / | Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other__________ |
| City, State, ZIP: | | | |

| Have you been a patient of NWPT before? ❑ Yes ❑ No | Was this injury a result of a Motor Vehicle Accident? ❑ Yes ❑ No |
|---|---|

Have you received any other therapy (i.e. PT/OT/Speech) within the past 12 months? ❑ Yes ❑ No If YES, how many visits?__________

Have you had any chiropractor visits within the past 12 months? ❑ Yes ❑ No If YES, how many visits?__________

Are you presently receiving Home Health Services, such as nursing, IV therapy, etc? ❑ Yes ❑ No If YES, what agency?_____________

## REMINDER NOTIFICATIONS

Would you like to receive Appointment Reminder Notifications via: (Please select) ❑ Yes ❑ No If YES, by: ❑ Text and/or ❑ Email

Would you like to receive additional information from NWPT in the future? ❑ Yes ❑ No

Would you like messages left on your answering machine or voicemail regarding any appointments? ❑ Yes ❑ No

Do you give permission to discuss your medical condition with someone other than your healthcare providers? ❑ Yes ❑ No
If YES, you wish to designate (Give name & relation) ________________________________________ to discuss your medical condition.

## IN CASE OF EMERGENCY

| Name of relative or friend (NOT living at same address): | Relationship to patient: | Home phone: ( ) | Cell phone: ( ) |
|---|---|---|---|

| Address: | City: | State: | ZIP: |
|---|---|---|---|

***For Office Use Only:***
Returning patients: Patient has reviewed the above information & the info. is correct:______________________ ___________________
(NWPT Office Initials & Date) (Patient Initials & Date)

**Northwest Physical Therapy**

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# Medical History Form

Patient's Name ________________________________________ Date_________________________

Date of Birth:____________ Age: _______ What is your occupation? ____________________________

Please place a checkmark by all that may apply:

| | | |
|---|---|---|
| Allergies | Dizzy Spells | MRSA |
| Anemia | Emphysema/Bronchitis | Multiple Sclerosis |
| Anxiety | Fibromyalgia | Muscular Disease |
| Arthritis | Fractures | Osteoporosis |
| Asthma | Gallbladder Problems | Parkinsons |
| Autoimmune Disorder | Headaches | Rheumatoid Arthritis |
| Cancer | Hearing Impairment | Seizures |
| Cardiac Conditions | Hepatitis | Smoking |
| Cardiac Pacemaker | High Cholesterol | Speech Problems |
| Chemical Dependency | High/Low Blood Pressure | Strokes |
| Circulation Problems | HIV/AIDS | Thyroid Disease |
| Currently Pregnant | Incontinence | Tuberculosis |
| Depression | Kidney Problems | Vision Problems |
| Diabetes | Metal Implants | |

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

Was there an accident or injury involved? Yes No When? (Month & Year) __________________
Where? ____________________________ How? _____________________________________________

Recent Fall History: Injury as a result of a fall in the past year? Yes No
Two or more falls in the last year? Yes No

Surgical History: Body Region? ______________________________ When? (Month & Year) ____________
(Within past 5 years) Surgery Type? _____________________________________________________

Please list medications & dosages you are presently on. *(We can make a copy of any lists that you may have.)*

_____________________________________________________________________________________

_____________________________________________________________________________________

Are you allergic to any types of medications or do you have any skin allergies? Yes No
If so, which ones? __________________________________________________________________

Do you have any of the following: Advance Directive? Living Will? DNR Instructions?

*If YES - **Due to Medicare Guidelines - We will need a copy kept on file***

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

***Office Use only:*** Advanced Directive/Living Will/DNR copy obtained? Yes No If NO, why?______________

By signing this, I acknowledge the above information is correct & most current.

____________________________________ __________________

Patient Signature or Guardian Date

Revised 01/10, 05/10, 06/10, 07/10, 04/16

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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.

## APPOINTMENT REMINDERS

NWPT can notify you of your appointments via text messages on your cell phone or email. If you choose this option on your Patient Information Form, you are authorizing NWPT to send reminders via the selected form of communication (i.e., text or email). At any time you may cancel these notifications by informing the Front Office staff. NWPT is not responsible for any charges for these reminders.

## 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!

________________________________________ ________________________________________

Patient Signature Date NWPT Employee Signature Date

Created 07-08 / Updated 02-09, 01-10, 04-10

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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 Emily Risner at 419-523-9003, ext. 510. Any complaints regarding your rights or our practices can also be directed to Emily Risner. 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.

Cc Notice available to patient upon request/signed acknowledgment form obtained