Northwest Physical Therapy

Changing lives... One step at a time

PATIENT INFORMATION

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

Last Name:	First Name:	Middle Initial:	Date of Birth: / /	Age:

Is this your legal name? If not, what is your legal name? ☐ Yes ☐ No	Sex ☐ M ☐ F	Marital Status (Circle One) **Single / Married / Divorced / Widowed**

Address:	Home Phone:	Cell Phone:
City: State: ZIP Code:	SSN:	Email Address:

If Married: Spouse's Name:	Spouse's Phone Number:
If Employed: Employer Name:	Employer Phone Number:

Emergency Contact

Contact Name: (Other Than Spouse)	Phone Number:	Relationship to Patient:

Medical Information Release

Do you give your permission to discuss your medical condition with someone other than your healthcare providers? ☐ Yes ☐ No

If **YES**, Contact Name:	Phone Number:	Relationship to Patient:

Insurance Information

Primary Insurance:	Policy Holder (If not Patient):	Date of Birth (If not Patient): / /	Relationship to Patient:
Secondary Insurance:	Policy Holder (If not Patient):	Date of Birth (If not Patient): / /	Relationship to Patient:

Have you received any **other therapy** (PT/OT/Speech) within the last 12 months? ☐ Yes ☐ No How many visits?

Have you had any **chiropractor visits** within the last 12 months? ☐ Yes ☐ No How many visits?

Are you currently receiving Home Health Services, such as Nursing, IV Therapy, etc? ☐ Yes ☐ No What agency?

Why did you choose NWPT? (Circle One) Physician Suggested / Insurance / Internet Search / Friend / Employer / Social Media

Reminder Notifications

Would you like to receive Appointment Reminder Notifications? ☐ Yes ☐ No If **YES**, by: ☐ Text and/or ☐ Email

Would you like to receive additional information about NWPT in the future? ☐ Yes ☐ No

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

Additional Relevant Information:

Please Notify the Front Office of any changes in your personal information that occur throughout your therapy.

For Office Use Only:

Returning patients: Patient has reviewed the above information & the info. is correct: _____ (NWPT Office Initials & Date) _____ (Patient Initials & Date)

Created 04-2010, Updated 04-2013, Updated 03-2019, Updated 01-2025

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MEDICAL HISTORY FORM

Patient's Name _____ Date_____

Date of Birth:_____ Age: _____ Occupation: _____

Please place a checkmark by all that may apply:

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

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, Last 5 Years: Body Region? _____

When? (Month & Year) _____ Type? _____

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

_____

List any known allergies to any types of medications or causes of skin reactions/allergies:

_____

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?_____

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

_____ _____
Patient Signature (or Guardian) Date

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NOTICE OF PRIVACY PRACTICES

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 Jody Benda at 419-523-9003. Any complaints regarding your rights or our practices can also be directed to Jody Benda. 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

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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 office's 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 <u>not a guarantee</u> 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.

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