NEW PATIENT INTAKE FORM

Date:

Last Name:	First Name:
Address:	Apt. or P.O. Box:
City:	State:
Zip Code:	Date of Birth:
Phone Numbers	
Home Phone: ( )	Email:
Work Phone: ( )	Social Security Number:
Cell Phone: ( )	

Emergency Contact

Last Name:	First Name:
Phone: ( )	
Relationship:	

Employer Information

Name of Employer:	
Address:	Suite or Office Number:
City:	State:
Zip Code:	

Problem/Condition

Description of Problem:	
Referred by:	
Referral Information:	
Date of Onset:	

Primary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

NEW PATIENT INTAKE FORM

Secondary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	

Have you ever been treated at Professional? Y/N. If yes, which location: _____.
Have you had physical therapy, occupational therapy or chiropractic treatment this year? Y/N. If yes, please indicate the type of treatment and the duration of treatment?_____.
Have you previously had treatment for this condition? Y/N. If yes, for how long?_____.
Have you ever had surgery? Y/N. If yes, please list all surgeries:_____.

For Medicare Patients Only:
Are you currently receiving home care services? **Y/N.** If yes, expected date of completion?_____.
Do you have a home care discharge letter? **Y/N.**

For Student Athletes Only:
What sport(s) does the student athlete play?_____.
Was the student athlete injured during the performance of the sport? **Y/N.** If yes, what date was the student athlete injured?_____.
Was the student athlete injured at school or in a league?_____.
Was any paperwork filed with the school or league? **Y/N.** If yes, please provide the name of the school or the league:_____.

Motor Vehicle Accident Injuries Only: If you are receiving care for injuries from a motor vehicle accident, in what state did the accident occur?_____.

Newsletter:
☐ I would like to receive Professional's Newsletter, which contains information about the company and its services.

CONSENT TO TREATMENT: I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

Signature of Patient or Legal Guardian: _____ **Date:**____/____/_____

NEW PATIENT INTAKE FORM

AUTHORIZATION TO USE RECORDING DEVICES: In conjunction with my care, I authorize the use of recording devices, including, without limitation, a camera and/or mobile device to record videos and/or images for the purposes of enhancing my care. In addition, I authorize the transmittal of such recording device videos and/or images to my rehabilitation provider and/or the treating physician through secure email and/or text message. I acknowledge that such videos and/or images will only be used or disclosed for treatment purposes, and that my rehabilitation provider will not further use or disclose such videos and/or images for any other purpose without my written authorization.

Signature of Patient or Legal Guardian: _____ **Date:**____/____/_____

FINANCIAL RESPONSIBILITY: I agree to pay my rehabilitation therapy provider ("Provider") all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney's fees.

Signature of Patient or Legal Guardian: _____ **Date:**____/____/_____

ATTENDANCE POLICY: I acknowledge that I read and understand the **Attendance Policy** and agree to abide by its terms and conditions.

Signature of Patient or Legal Guardian: _____ **Date:**____/____/_____

ELECTRICAL STIMULATION PAD POLICY: I acknowledge that I read and understand the **Electrical Stimulation Pad Policy** and agree to abide by its terms and conditions.

Signature of Patient or Legal Guardian: _____ **Date:**____/____/_____

DIRECT ACCESS LAW POLICY (This section only applies to Connecticut, Massachusetts, New Hampshire, and New Jersey patients receiving rehabilitation therapy without a referral): I confirm that I disclosed or affirmatively confirmed in writing the identity of my primary care provider, health care provider of record, licensed health care professional of record, or health care practitioner to my rehabilitation provider, and I acknowledge that I read and understand the **Direct Access Law Policy** in the state I am receiving rehabilitation therapy and agree to abide by its terms and conditions, and I consent to receive rehabilitation therapy and any supplementary services that are deemed medically necessary or appropriate by my therapist without a referral from an eligible practitioner.

Signature of Patient or Legal Guardian: _____ **Date:**____/____/_____

Get Going PRO ex Physical Therapy
An affiliate of Professional Physical Therapy

PATIENT MEDICAL HISTORY FORM

Name: _____Treating Physician: _____Primary Care Physician: _____
Date of 1st Doctors Visit for this Injury:_____Last Day Worked Due to this Injury (if applicable):_____
Date Returned to Work after Injury (if applicable):_____Have you retained an attorney as a result of your injury? YES NO
Referral Source: Surgeon Rehab MD Other:_____
Have you had Surgery for this Injury? YES NO Number of Surgeries:_____ Type of Surgery(ies):_____

Are you currently taking any medications (prescription and/or over the counter medicines):

Anti-Inflammatories	YES	NO	If YES, please specify:_____
Muscle Relaxers	YES	NO	If YES, please specify:_____
Pain Medication	YES	NO	If YES, please specify:_____
Other	YES	NO	If YES, please specify:_____

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode

	YES	NO		YES	NO
Chiropractor	____	____	General Practitioner	____	____
EMG/NCV	____	____	CT Scan	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room	____	____	X-Rays	____	____

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	High Blood Pressure	____	____
Anemia	____	____	Shortness of Breath/Chest Pain	____	____
Heart Attack or Surgery	____	____	Diabetes	____	____
Coronary Heart Disease or Angina	____	____	Thyroid Trouble/Goiter	____	____
Gout	____	____	Cancer/chemotherapy/Radiation	____	____
Dizziness or Fainting	____	____	Weakness	____	____
Emotional/Psychological Problems	____	____	Infectious Diseases	____	____
Hernia	____	____	Bowel or Bladder Problems	____	____
Numbness or Tingling	____	____	Allergies	____	____
Severe or Frequent Headaches	____	____	Elbow/Hand Injury	____	____
Osteoporosis	____	____	Vision or Hearing Difficulties	____	____
Neck Injury/Surgery	____	____	Stroke/TIA	____	____
Sleeping Problems/Difficulties	____	____	Back Injury/Surgery	____	____
Blood Clot/Emboli	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Knee Injury/Surgery	____	____	Epilepsy/Seizures	____	____
Do you have a Pacemaker?	____	____	Arthritis/Swollen Joints	____	____
Varicose Veins	____	____	Any Pins or Metal Implants?	____	____
Are You Pregnant?	____	____	Joint Replacement	____	____
Weight Loss/Energy Loss	____	____	Do You Smoke?	____	____

Please list any additional information that would assist us in providing care to you? _____

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

What are your expectations/goals? _____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: _____ **Date:** _____
Patient/Legal Guardian Name: _____
Therapist's Signature:_____ **Date:** _____

ATTENDANCE POLICY

We, as the provider of rehabilitation therapy, strive to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery.

While we are sensitive to the fact that an emergency may occur, cancellations, tardiness and absentees reduce our ability to accommodate the scheduling needs of our patients. As such, we request your full cooperation with the following company policy:

- If a patient is more than 30 minutes late for an appointment and fails to notify the clinic of the tardiness, treatment may be cancelled and a cancellation fee* charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a cancellation fee* may be charged for that appointment.
- Failure to show up for a scheduled appointment without providing the clinic advanced notification of your absence may result in a fee* being charged for that appointment. Furthermore, 2 consecutive absences without advanced notification may result in the cancellation of all your remaining scheduled appointments, as such failures may negatively impact your treatment plan.
- PATIENTS that cancel a scheduled appointment less than 24 hours in advance, are late to an appointment or absent from a scheduled appointment will be charged a $50.00 CANCELLATION FEE*. THE PATIENT IS RESPONSIBLE FOR THE CANCELLATION FEE*, NOT THE INSURANCE COMPANY OR THIRD PARTY PAYOR. Please note that a cancellation fee will not be charged if the missed appointment is rescheduled within a week of the tardiness, absence or late cancellation and another appointment was not previously scheduled.
- All cancellations and absences will be documented in your medical record and reported to your physician and insurance company or third party payor.
- Repeated failure to comply with this policy will result in your appointments being scheduled based on availability, which may require you to call for an appointment on the day you would like to receive therapy.

*except as otherwise restricted by government payors

Patient Notification Policy and Consent

Patient's Name:_____DOB:_____

In order to ensure that patients receive time-sensitive information and other informational healthcare messages, we, as the provider of rehabilitation therapy ("Provider", "we," or "our") send notifications to patients that opt-in to receive such notifications. If you (patient is referred to herein as "you," "I," "me," "my," "yourself," and "your") choose to sign this consent and opt-in to receive such notifications from Provider, Provider will not impose a separate charge for these notifications; however, depending on the terms and conditions of your wireless carrier contract and/or plan, fees and/or restrictions may be imposed upon you for receiving notifications from Provider. Please contact your wireless carrier about such fees and/or restrictions prior to providing your consent herein to such notifications from Provider.

It is important to note that certain communications, including, without limitation email and text message, which may contain your protected health information ("PHI"), are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), we are required by law to maintain the privacy and security of your PHI. In addition, pursuant to the HIPAA Privacy Rule and Provider's Notice of Privacy Practices, we will not use and/or disclose your PHI without your explicit written authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, when we are authorized and/or permitted to use and/or disclose your PHI, we will limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose of the use and/or disclosure of your PHI. If you choose to have Provider disclose your PHI to an individual or entity other than yourself, you must properly complete Provider's HIPAA Authorization Form, which is available at the front desk upon request.

You have the right to revoke this consent by providing written notice of revocation to the Privacy Officer at Provider. The revocation will become effective on the

day the Privacy Officer receives the revocation of the consent, and any prior notification from Provider will not be subject to such revocation of the consent.

I, the undersigned, hereby consent to receive notifications from Provider, which notifications may include my PHI, by the following methods of communication that I indicated below, with a full understanding of the risks involved with such notifications from Provider, and I agree to assume all responsibility for informing Provider in writing of any changes to any of the methods of communications that I indicated below and for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable, and I further agree that Provider shall not be held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication I authorized below or for any fees and/or restrictions that may be imposed upon me for receiving notifications from Provider:

☐ Mobile Device***:** (_____)_____

☐ Text Message***:** (_____)_____

Wireless Carrier:_____

☐ E-Mail**:** _____

☐ Opt-out of receiving text message and email communications from Provider

*****wireless carrier's standard message rates, data rates, and/or restrictions may apply, and by consenting to receive notifications from Provider you agree to be solely responsible for all fees that you incur from receiving notifications from Provider.

Patient/Legal Guardian Signature: _____ Date:_____

Patient/Legal Guardian Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, acknowledge
(insert name of patient)

receipt of a copy of Provider's **NOTICE OF PRIVACY PRACTICES**.

Date: _____

Patient or Legal Guardian Signature:_____

Legal Guardian Name:_____

Received by:

_____
(Print Name of Staff Member)

_____
(Signature of Staff Member)

*****This completed form must be scanned into the patient's EMR*****

Patient's Name: ______________________ Date: __________________

Please list all your medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements, and the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Injection ❑ Other:

By my signature below, I certify that the information I have provided above and/or on a separate document is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: ___________________________ Date ______________

Patient/Legal Guardian Name: ____

Reviewed by:_________________________________ Date: _________________________

PROEX PHYSICAL THERAPY
http://proexpt.com/

Privacy Officer
333 Earle Ovington Boulevard, Suite 225
Uniondale, New York 11553
Phone: (516) 321-2492
Email: JWells@ProfessionalPT.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: May 10, 2017

This Notice of Privacy Practices applies to the following organizations.

This notice applies to PROEX PHYSICAL THERAPY, LLC, which provides outpatient rehabilitation services in Connecticut, Massachusetts, and New Hampshire.

Jeffrey Wells, Privacy Officer
Phone: (516) 321-2492
Email: JWells@ProfessionalPT.com