

HANDS ON PHYSICAL THERAPY

NEW PATIENT FORM

Circle Location: Fuquay Varina Cary Clayton Zebulon

PLEASE PRINT CLEARLY

DATE: _____

Name (First) _____ (Last) _____ (M.I.) _____

Home Address _____

Email Address _____ Marital Status: M S W D

City _____ State _____ Zip _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Social Security _____ DOB _____ Age _____ Sex: M / F

Employer _____ Occupation _____

Employer Address _____

Emergency Contact _____ Telephone # _____

Reason for your visit _____

Injury Type Work Auto Home Other _____ Injury Date _____

Referring Physician _____ Telephone # _____

Referring Dr. Address _____

Attorney Involved Yes / No Attorney Name _____

Address _____ Telephone _____

Primary Insurance _____

I.D. # _____ Group # _____

Subscriber Name _____ Social Sec. # _____ DOB _____

Secondary Insurance _____

I.D. # _____ Group # _____

Subscriber Name _____ Social Sec. # _____ DOB _____

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.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect & Copy: To inspect and receive a copy of your medical information, you must submit your request in writing. We have the option to deny your request, in limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request.** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient/Legal Guardian Signature

Date

HANDS ON PHYSICAL THERAPY

OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Hands On Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

Parent / Guardian Signature _____ **Date** _____

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by an examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for **Hands On Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Hands On Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Medicare Members: Hands On Physical Therapy is a Medicare provider. The member is responsible for co-payments and any non-covered services or supplies deemed necessary by the physical therapist for your treatment.

WORKERS' COMPENSATION CLAIMS: All workman's compensation claims must be verified in writing by the employer. If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION & NO-SHOW POLICY: **Hands On Physical Therapy** requires 24 hours notice in the event of a cancellation. The charge for canceling an appointment without proper notice or no showing is \$25. This charge is solely the patient's responsibility and will not be covered by insurance.

Absences: Three absences for any reason will result in immediate discharge from the program. (Cancellations made within 24 hours of your appointment are not considered an absence.) Discharge due to multiple absences will be reported to the referring physician and/or insurance adjuster, which may result in a loss of Worker's Compensation benefits.

FINANCIAL POLICY: If you have health insurance, we will help you receive maximum benefits. Hands On Physical Therapy will be glad to file claims to your insurance company provided we are in-network with them. The patient is responsible for paying the individual co-payment/deductible at the time services are rendered.

If have no insurance, you are expected to pay in-full at the time services are rendered.

Hands On Physical Therapy is committed to providing you the best possible care and we will be happy to discuss our professional fees with you at any time.

I have read the above policies and understand my responsibility for payment of my account.

Patient/ Responsible Party Signature _____

Date _____

PATIENT MEDICAL HISTORY

Name _____ Date _____

Age _____ Occupation _____

Type of Work; e.g. lifting heavy objects, prolonged sitting, standing, etc. _____

Past Medical History

Do you have any previous history of:

High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Strokes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other	_____

Have you been admitted to the hospital or undergone any surgical procedures during the past 5 years? Yes No

What was the condition? _____

Is this condition related to your visit to Hands On Physical Therapy? Yes No

Have you received Physical Therapy or Chiropractic treatments during the past 5 years? Yes No

If yes, for what condition and was the treatment effective? _____

What did the treatment consist of? _____

Have you had any other previous medical or orthopaedic problems? Yes No

If yes, please explain _____

Are you currently taking medications? Yes No

Please list medications here _____

Are you pregnant? Yes No

Exercise/activity level: 0 days/week 1-2 days/week 3-5 days/week 6-7 days/week

What types of activities? _____

Name and Location of Primary Care Doctor: _____

Name and Location of Orthopaedic Doctor: _____

Patient Signature

Date

Physical Therapist Signature

Date

HANDS ON PHYSICAL THERAPY

□ 1439 N. Main Street
Fuquay-Varina, NC 27526
(919)557-2111 FAX (919) 557-5543

□ 21-105 Anna Place
Clayton, NC 27520
(919)359-2222 FAX (919)359-2922

□ 530 West Gannon Ave.
Wedgewood Shopping Center
Zebulon, NC 27597
(919)269-0107 FAX (919)269-0207

□ 590 New Waverly Place #220
Cary, NC 27518
(919)851-0711 FAX (919)851-4848

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Hands On Physical Therapy's Notice of Information Practices. I understand that Hands On Physical Therapy may use or disclose my personal health information for 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 disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Hands On Physical Therapy will consider 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 Hands On Physical Therapy's Notice of Information Practices. In addition, I hereby consent to my image being recorded by video and/or camera for administrative & security purposes. Such recorded images will be kept in accordance with pertinent HIPPA regulations.

Patient Name (please print)

Signature

Date of Birth

Date