PATIENT INTAKE & CONSENT FORM

Patient Name: _____

Birth Date: _____ Social Security #: _____

Gender: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Insured Address (if not self): _____

City: _____ State: _____ Zip Code: _____

Insured Birth Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

By providing us with your landline or cell phone number(s), you give consent for us, our agents, and our collection agents, to contact you at these numbers, or at any number that is later acquired for you, and to leave live or pre-recorded messages regarding any accounts or services. You are also giving consent for us to deliver these calls by an automatic dialer. Providing us a telephone number or cell phone number is not a condition of receiving our services however.

Email address: _____

**Email for internal use only*

Employer Name (of patient or parent): _____

Prior Therapy (chiropractic, home care, etc.) this year? ◯ Yes ◯ No # of Visits: _____

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This release of information will remain in effect until terminated by me in writing. This information is released to:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ Do NOT release information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

RENUE PHYSICAL THERAPY | there is a DIFFERENCE.™

CANCELLATIONS AND NO SHOWS

Cancellations and no shows affect a person's ability to succeed in treatment. The physician and therapist prescribe a set frequency of treatment. The patient's role is to appear for appointments and follow the therapist's instructions so we will be able to help you achieve your goals in treatment. To encourage regular attendance:

1. We require a 24-hour notice in the event of a cancellation.
2. A $25.00 charge will be assessed for a cancellation without proper notice and a $50.00 charge for a no-show. These charges are not covered by your insurance, and are due at the next scheduled visit.
3. Renue Physical Therapy feels that the continuity of care is the most important part of a treatment plan. Because of this Renue Physical Therapy reserves the right to terminate treatment if a patient is not compliant with their plan of care due to canceling and/or missing scheduled appointments.

CO-PAYS/DEDUCTIBLES

As a courtesy, Renue Physical Therapy will call your insurance company to check your benefits. Co-pays are expected at time of service and deductibles will be billed to the patient after we hear from your insurance company. Patients are encouraged to contact their insurance company and verify their coverage/benefits.

NOTICE OF PRIVACY PRACTICES

I have read and understand the HIPAA Notice of Privacy Practices that was provided to me on this day. (upon request)

WORKER'S COMP/AUTO CLAIMS

Documentation of any missed appointments will be forwarded to your Case Manager/Adjustor and Primary Care Physician. This could jeopardize your claim.

FINANCIAL AGREEMENT/TREATMENT CONSENT/ASSIGNMENT

In consideration for services rendered, I hereby authorize payment to Renue Physical Therapy. In addition, I authorize the release of any medical information necessary to process this claim. The undersigned agrees, as patient or agent of patients, that the patient is accepting financial responsibility for services rendered and is obligated to pay their balance due at time of service and all balances that may be denied by your insurance company after we file a claim. I recognize that therapy may involve the touching of my body by the therapy staff for "hands on" examination and treatment procedures that may be sensitive in nature and that partial disrobing may be required to facilitate such care. No treatment for any condition or disease is without side effects and risks and therapy is no exception. Fortunately, with the hands-on techniques and therapeutic exercises utilized by the therapist, any unwanted side effects are usually minor and limited. By signing below you indicate you are aware of, and accept the risks of therapy treatment, and give your full consent for the therapists at Renue Physical Therapy to provide such treatment.

*Medicare patients receiving home health services of any kind are NOT eligible for outpatient therapy services.

Patient Signature: _____ **Date:** _____

Parent/Guardian: _____ **Relationship:** _____
(If patient under 18 years old)

Witness Signature: _____ **Date:** _____

RENUE PHYSICAL THERAPY | there is a DIFFERENCE.™

MEDICAL HISTORY

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Next Doctor's Appt: _____ Date Problem Began: _____

Please mark Yes/No for the following conditions with descriptions as appropriate

Yes __ No __ Heart Attack _____

Yes __ No __ Stroke/TIA _____

Yes __ No __ High Blood Pressure _____

Yes __ No __ Pacemaker/Defibrillator _____

Yes __ No __ Other Cardiac Issues _____

Yes __ No __ Diabetes _____

Yes __ No __ Multiple Sclerosis _____

Yes __ No __ Parkinson's _____

Yes __ No __ Seizures _____

Yes __ No __ Concussion ___ _____

Yes __ No __ Traumatic Brain Injury _____

Yes __ No __ Cognitive/Memory Changes _____

Yes __ No __ Cancer _____

Yes __ No __ Anxiety/Depression _____

Yes __ No __ Autoimmune Conditions _____

Yes __ No __ Osteoporosis _____

Yes __ No __Fibromyalgia _____

Yes __ No __ Change in Bowel/Bladder _____

Yes __ No __ Numbness Tingling _____

Yes __ No __ Currently Pregnant _____

Yes __ No __ Falls in the past year? If yes, how many in the past year? _____

Please explain if answered "Yes" to any of the above: _____

_____

_____

_____

Please list any infectious diseases you have (ex: Hepatitis, HIV/AIDS, MRSA, C-Diff, Chicken Pox, Staph, Influenza, etc.): _____

Please list any skin conditions you have (ex: Ring Worm, Scabies, Dermatitis, Psoriasis, etc.): _____

_____

Please list any surgeries and approximate dates, including any metal/plastic implants: _____

_____

_____

Diagnostic Testing (X-ray, MRI, CT scan, EMG, etc.): _____

Current Medications (or provide list): _____

_____

Allergies: _____

Other Concerns: _____

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Director, Clinic Development & Compliance at this practice.

Who will follow this notice? Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. billing service), site and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How we may use and disclose medical information about you? The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For treatment – We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For payment – We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, and insurance company, or third party. Example: We may need to send your protected medical information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For health care operations – We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other uses or disclosures that can be made without consent or authorization:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other health care providers treatment activities
- Other covered entities providers payment activities
- Other covered entities and providers operations activities (to the extent permitted under HIPPA)
- Users and disclosures required by law
- Users and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and disclosures of protected health information requiring your written authorization – 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 authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter 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 authorization, and that we are required to retain our records of

NOTICE OF PRIVACY PRACTICES

Your individual rights regarding your medical information/Complaints – If you believe your privacy has been violated, you may file a complaint with the Director, Clinic Development & Compliance at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against or filing a complaint.

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 healthcare operations or to someone who is involved in your care or the payment for your care. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Director, Clinic Development & Compliance at this practice. In your request, you must specify what information you want to limit.

Right to request confidential communications – You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Director, Clinic Development & Compliance at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to inspect and copy – You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Director, Clinic Development & Compliance at this practice. If you request a copy of the information, we reserve the right to charge a fee for the cost of copying, mailing or other supplies associated with your requests. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to amend – If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and be submitted to the Director, Clinic Development & Compliance at this practice. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information not kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an accounting of non-standard disclosures – You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Director, Clinic Development & Compliance at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before October 3, 2011. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we reserve the right to charge you the cost of providing the list.

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. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. A copy of the current Notice with the effective date will be posted.

RENUE PHYSICAL THERAPY | there is a DIFFERENCE.™