NEW EVALUATION
HEALTH QUESTIONNAIRE

Date: _____

Name: _____ DOB: ____ / ____ / _____ SS# _____ - ____ - _____

Home Phone # ( ) _____-_____ Cell # ( ) _____-_____ Work # ( ) _____-_____

Street: _____ City_____ State ____ Zip _____

Email Address: (Please print neatly) _____

Occupation: _____ Referring Physician: _____

Do we have permission to contact you by E-Mail? Yes ___ No ___ If no selection is made, you will automatically entered. Email is for office use only, and will never be given or sold to third party.

Emergency Contact: _____ Phone # _____ Relationship_____

Insurance Cardholder's Name: _____ DOB: ____ / ____ / _____

Have you ever had or been told you had any of the following: (Check if yes)

___ Cardiovascular Disease
___ High Blood Pressure
___ Respiratory Disease
___ Cancer
___ Pelvic Floor Dysfunction (incontinence/pain)
___ Unexplained weight loss
___ Diabetes: Type I or Type II
___ Gastrointestinal Disease
___ Neurological Disorder
___ Rheumatoid arthritis
___ Depression
___ Osteoarthritis
___ Allergies
___ Kidney Disease
___ Other: _____

Explain if yes:

_____

_____

List all hospitalizations: Operations, serious illness, injuries, etc.

_____

_____

Your present weight: _____ Height: _____

Are you pregnant? _____ Do you currently have any illnesses? _____

Please describe your activity level prior to this injury/condition:

_____

_____

List all your current medications: Prescription, over the counter, vitamin & herbal.

NAME	DOSE	FREQUENCY

What is your reason for seeking therapy at this present time?

_____

_____

What type of diagnostic testing have you had for this condition? Examples: x-rays, MRI, etc

_____

_____

_____

Have you ever had therapy in the past for this injury/condition? If so, when?

_____

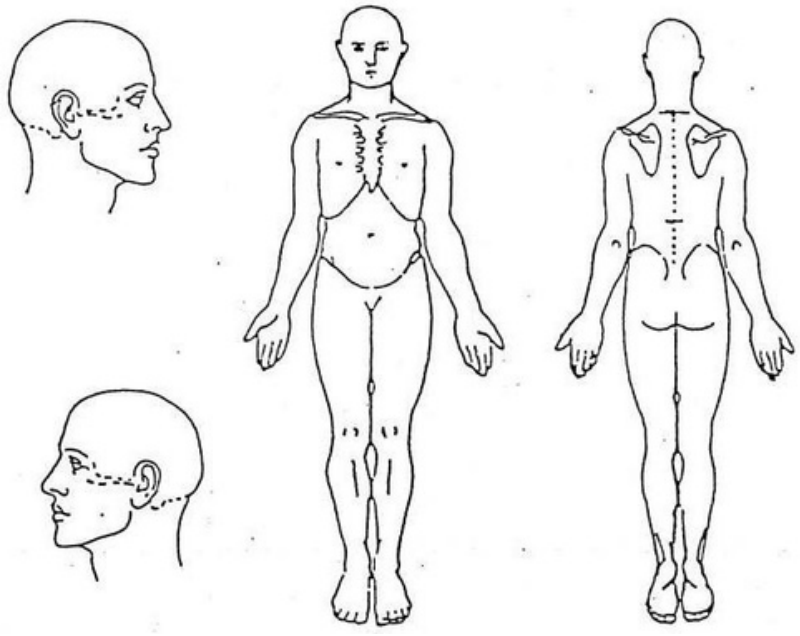
_____

Please rate your level of pain on a 0-10 scale.

Rate your pain:

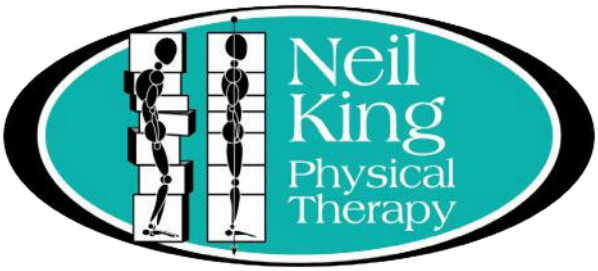
At worst: _____
At best: _____
Current: _____

Mark areas of pain on body diagram.



I certify that the above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

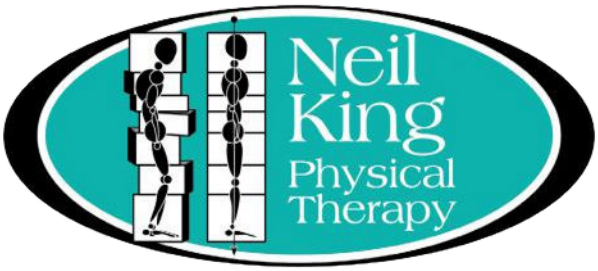
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. Before we shall begin any healthcare treatment we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this physical therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this physical therapy office to submit requested PHI to the health insurance company (or companies) provided to use by the patient for purpose of payment. Be assured this office will limit the release of all the PHI to the minimum needed for what the insurance companies require for payment.
2. We may use or disclose your health information to your attending and referring physician.
3. The patient has the right to examine and obtain a copy of his/her own records at any time and request corrections. The patient may request to know disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions
4. Patients have the right to receive a copy of their health record in electronic format if records are stored in electronic format. The request will be processed within 30 days, with a one-time 30-day extension, if required.
5. A patient's written consent needs to only be obtained one time for all subsequent care given in this office.
6. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for any care given prior to the request to revoke consent but would apply for any treatment given after the request has been received.
7. As stated in #3, we must disclose your health information to you. We may also disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only with your consent
8. Patient's 18 or older will be considered an adult and will be responsible for making their own decisions.
9. We may use or disclose your health information to provide you with an appointment reminder, such as voicemail messages or letters.

10. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in your office. We have taken all precautions that are know by this office to ensure your records are not readily available to those who do not need them.
11. The patient has the right to request information not to be sent to their health plan when the patient is paying out of pocket in full for the service(s) performed.
12. Patient's have the right to file a formal complaint with our privacy official about any possible violation of these policies and procedures.
13. If the patient refused to sign this consent for the purpose of treatment, payment and healthcare operations, the physical therapist has the right to refuse treatment.

I have read, and I understand how my patient health information will be used and agree to these policies and procedures.

SIGN X_____ DATE_____



PAYMENT PROVISIONS AUTHORIZATION

THE TERM "HEALTHCARE BENEFITS" IN THE FOLLOWING PARAGRAPHS MEANS MEDICARE, MEDICAID, MATERNAL AND INFANT HEALTH BENEFITS, BCBS, COMMERCIAL HEALTH INSURANCE BENEFITS, HEALTH MAINTENANCE ORGANIZATION, PREFERRED PROVIDER ORGANIZATION, OR MANAGED CARE PLAN COVERAGE, IF APPLICABLE.

I REQUEST PAYMENT ON MY/THE PATIENT'S BEHALF OF ALL HEALTH CARE BENEFITS FOR SERVICES PROVIDED BY NEIL KING PT.

I ASSIGN AND TRANSFER TO NEIL KING PT ALL HEALTH CARE BENEFITS APPLICABLE TO MY/THE PATIENTS CARE. I AUTHORIZE AND DIRECT ALL SUCH HEALTH CARE BENEFITS BE PAID DIRECTLY TO NEIL KING PT.

I UNDERSTAND MY INSURANCE BENEFITS WERE VERIFIED WITH MY INSURANCE COMPANY AT THE BEGINNING OF MY TREATMENT, AND THE DEDUCTIBLE AMOUNT MAY CHANGE BASED ON WHAT WAS VERIFIED. I AM ALSO AWARE THAT DURING MY TREATMENT MY DEDUCTIBLE MAY RESET, AND MY ACCOUNT WILL BE ADJUSTED ACCORDINGLY, AND I WILL BE RESPONSIBLE FOR ANY, AND ALL CHARGES THAT MAY OCCUR.

I UNDERSTAND WHILE I AM BEING TREATED BY NEIL KING PHYSICAL THERAPY, IT IS MY RESPONSIBILITY TO NOTIFY THEM OF ANY CHANGES IN MY INSURANCE COVERAGE. ANY ADDITIONAL CHARGES (DEDUCTIBLE, CO-PAY, ETC.) WILL BE THE PATIENTS RESPOSIBILITY. IF A NEW INSURANCE REQUIRES PRIOR AUTHORIZATION & PATIENT DOES NOT NOTIFY US, THEN THE PATIENT WILL BE RESPONSIBLE FOR ALL THERAPY SESSIONS REJECTED BY THE INSURANCE COMPANY.

I AGREE TO PERSONALLY PAY FOR ANY PHYSICAL THERAPY CHARGES NOT COVERED BY, OR COLLECTED FROM, ANY APPLICABLE HEALTH CARE BENEFIT PROGRAM, INCLUDING ANY DEDUCTIBLES AND COINSURANCE AMOUNTS.

I CERTIFY I HAVE READ THIS FROM AND UNDERSTAND IT AND CONSENT TO IT. IF THE SIGNER IS NOT THE PATIENT, THE SIGNER CERTIFIES THAT HE OR SHE, IS THE PATIENTS DULY AUTHORIZED REPRESENTATIVE.

SIGNATURE X_____DATE_____

CANCELLATIONS AND NO-SHOWS

The following are our updated policies regarding cancellations and no-shows:

We take this subject very seriously as it can make a difference to the success of your treatment. Usually, your referring doctor and your therapist prescribe a set frequency of treatment. Attending appointments as scheduled is your most important job, along with following your therapist's instructions to help meet your treatment goals.

We require a **24-HOUR** notice in the event of a cancellation. It is your responsibility to call us with alternative times to reschedule; this will ensure you get your total prescribed number of treatments each week. In some cases, you may have sequential days of treatment.

Effective April 25th, 2024, cancellations without proper notice will incur a **$50** charge. Insurance does not cover cancellation charges, and payment will be your responsibility.

For our workers' compensation and personal injury patients, missed appointment documentation will be forwarded to your case manager and primary care physician, potentially jeopardizing your claim.

You may need to see a different therapist for a rescheduled appointment, but you will return to your primary team with your next regularly scheduled appointment. We assure you that our entire team of therapists are experienced, licensed professionals who will study your chart in advance.

Please understand that your pain will likely increase and decrease over the course of your treatment. This is not a reason to cancel your appointment.

Keep in mind:

- Feeling temporarily worse does not mean treatment is not working
- Feeling great is not a reason to cancel
- Come in even if you are in pain or not, as this could be an opportunity for greater education, or to begin making significant progress.

When you do not show up as scheduled, three people are hurt: yourself from missing a scheduled prescribed treatment, your therapist who now has a space in their schedule reserved for you, and other patients who could have been scheduled for treatment if proper notice was given.

Please cooperate with us in this regard. We are looking forward to working with you.

Signature: _____ Date: _____