

Welcome to Arvada Wheat Ridge Physical Therapy

<u>For office use only</u>	Patient Information:
CALL DATE	Name: Last _____ First _____ MI _____ Date _____
SCHEDULE DATE	Current Address: _____ City: _____ State: _____ Zip: _____ Phone: (h) _____ (w) _____
ACC Type	Date of Birth: Month _____ Day _____ Year _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Student <input type="checkbox"/> Single <input type="checkbox"/> Married
RX Code	Emergency Contact: _____ (relationship to patient) _____ Primary phone # : _____ Other phone #: _____
PT/Provider	Permanent Address (if different from above) _____ City: _____ State: _____ Zip: _____ Have you had physical therapy within the past 12 months? _____ Insurance: _____ Referring Doctor: _____ Family Doctor _____ Description of Problem: _____ Surgery? Y / N Date: _____ Was there an Accident? <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other Claim # _____ Date of Injury: _____ Adjuster: _____ Phone # _____
Primary Cardholder Information: (Who is responsible for the account)	
Name: Last _____ First _____ MI _____	
Relationship to Patient: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Insurance ID #: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Date of Birth: Month _____ Day _____ Year _____	
Employer: _____ Occupation: _____	

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

Assignment of Benefits: I hereby assign payment directly to Arvada Wheat Ridge PT. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge \$40 for missed appointments. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions or concerns.

Signature: _____ Date: _____

Arvada Wheat Ridge Physical Therapy Clinic

Notice of Health Information Practices

This notice describes how information about patients may be used and disclosed and how patients can get access to this information.

Introduction

Arvada Wheat Ridge Physical Therapy (AWRPT) uses personal health information about all our patients responsibly. How and when we collect and use this information is explained in this notice. With regard to personal health information, patient's rights are also explained here. This notice is consistent with all federal regulations.

Understanding Health Records/Information

All patient visits are documented in a chart. Details of each visit including patients' comprehensive medical history and subjective information, objective findings and assessment, diagnostic information and future plan of care. Verbal and written communication with other health care practitioners is also documented in this medical chart. This information can possibly serve as a:

- Means of communication between health care providers, who share in the care,
- Basis for planning care and treatment,
- Legal document describing the care received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

This information should help you, the patient, to understand who, what, when, and why others may access your information. Also, you can make informed decisions when authorizing disclosure to others.

Your Health Information Rights

Your medical records are the physical property of AWRPT, however, the information in it belongs to you.

You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy the health record (we ask for a 24 hour request)
- Obtain a list of the disclosures of your health information and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

AWRPT is required to:

- Maintain the privacy of the health information,
- Provide patients with this notice as to our legal duties and privacy practices with respect to information that we collect and maintain,
- Abide by the terms of this notice,
- Notify the patients if we are unable to agree to a requested restriction.

We reserve the right to change our practices in order to maintain compliancy with updated federal guidelines. These changes will be made available to each patient when returning for a follow up visit.

We will not use or disclose health information without authorization, except as described in this notice. We will also discontinue to use or disclose health information after we have received revocation of the authorization.

We will provide health information without authorization when necessary for treatment, payment or healthcare operations.

Appointment Notification: We may contact you on the telephone or by mail to provide appointment reminders and to follow-up with you after treatment in our facility.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Correctional institution: Should a patient eventually become an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for healthcare and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena (e.g. child protection, etc.)

Federal law makes provision for health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information of to Report a Problem

If you feel your privacy rights have been violated or you would like more information, you can contact our Privacy Officer, or the Office for Civil Rights, U.S. Department of Health and Human Services.

Office for Civil Rights
U.S. Dept of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Bldg
Washington, D.C. 20201

I, _____, have read and understand the Notice of Health Information Practices.

Please include a list of others' who you are authorizing to have access to your medical information:

- 1.
- 2.
- 3.
- 4.
- 5.

We call to remind you of upcoming appointments. Please indicate your preference... We will call your home number unless otherwise specified.

Yes _____

No _____

Other _____



ARVADA - WHEAT RIDGE
PHYSICAL THERAPY
CLINIC

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

DIABETES	YES ___ NO ___	ALLERGIES	YES ___ NO ___
HIGH BLOOD PRESSURE	YES ___ NO ___	DERMATITIS	YES ___ NO ___
HEART DISEASE	YES ___ NO ___	PREV. SURGERY	YES ___ NO ___
HEART ATTACK	YES ___ NO ___	HERNIA	YES ___ NO ___
PACEMAKER	YES ___ NO ___	SEIZURES	YES ___ NO ___
HEADACHES	YES ___ NO ___	METAL OR OTHER	YES ___ NO ___
KIDNEY PROBLEMS	YES ___ NO ___	IMPLANTS	
NERVOUS DISORDERS	YES ___ NO ___	NUMBNESS	YES ___ NO ___
BLOOD DISORDERS	YES ___ NO ___	CANCER	YES ___ NO ___
FIBROMYALGIA	YES ___ NO ___	OSTEOPOROSIS	YES ___ NO ___
RHEUMATOID	YES ___ NO ___	OSTEOPENIA	YES ___ NO ___
ARTHRITIS		DO YOU SMOKE?:	YES ___ NO ___
ARTHRITIS	YES ___ NO ___		
FEMALE PATIENTS ONLY:		ARE YOU PREGNANT?	YES ___ NO ___

ARE YOU PRESENTLY TAKING MEDICATIONS? IF SO, LIST THE MEDICATION AND THE FREQUENCY AT WHICH IT IS TAKEN: _____

PLEASE LIST ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW ABOUT YOUR MEDICAL HISTORY SO THAT WE MAY HAVE A MORE COMPLETE UNDERSTANDING OF YOUR PROBLEM:

WHAT OTHER PRIMARY HEALTH CARE PROFESSIONALS HAVE YOU SEEN IN THE LAST YEAR? (FAMILY PRACTITIONERS, INTERNISTS, OB-GYN, CHIROPRACTORS, ETC...)

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _____ PATIENT: _____