Atlantic Physical Therapy and Rehabilitation

Patient History Form

Have you ever experienced or been diagnosed with any of the following (check all that apply):

High Blood Pressure _____
Headaches _____
Heart Trouble _____
Pacemaker _____
Rheumatic Disease _____
Circulation Problems _____
Seizures _____
Blood Clots _____
HIV/AIDS _____
Stroke _____
Cancer _____
Hepatitis _____
Breathing Problems _____
Mental Illness _____
Fractures _____
Fibromyalgia _____
Osteoporosis _____
Diabetes _____
Arthritis _____
Sudden Weight Loss/Gain _____
Hearing Change/Problems _____
Tuberculosis _____
Other_____
Current Pregnancy (women only) ____

Have you ever had Surgery? Yes No If yes, give date(s) and operation _____
_____

Current Medication (list all) _____
_____

List any Allergies you have_____
Have you ever had physical therapy treatments before? Yes No
If yes, indicate Where, when and for what problem _____
Do you smoke? Yes No Packs per day_____ Since_____
Do you drink? Yes No How many drinks per day_____ per week_____
Do you exercise? Yes No
How many days per week _____ How long per session _____

HIPAA 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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.
Your Rights: a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** This notice was published and becomes effective on/or before **April 14, 2003.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

Atlantic Physical Therapy & Rehabilitation will use and disclose your personal heal information to treat you. To receive payment for the care we provide, and for other health care operation. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Notice of Privacy Practices to help you better understand our policies about your personal health information. The terms of notice may change with time and we will always post the current notice.

Please Initial _____

MEDICARE AUTHORIZATION TO PERMIT PAYMENT OF MEDICARE BENEFITS

I certify that the information given by me in applying for the payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician organization to submit clams on my behalf.

Please Initial _____

PATIENT RIGHTS AND RESPONSIBILITIES

ALL PATIENTS HAVE THE RIGHT TO INFORMED CONSENT IN TREATMENT DECISIONS, TIMELY ACCESS TO SPECIALTY CARE, AND CONFIDENTIALITY PROTECTIONS.
Patients should be treated courteously with dignity and respect. Before consenting to specific care choices, they should receive complete and easily understood information about their condition and treatment options.
Patients should be entitled to: coverage for qualified second opinions; timely referral and access to needed specialty care and other services; confidentiality of their medical records and communications with providers; and, respect for their legal advanced directives or living wills.
ALL PATIENTS HAVE THE RIGHT TO CONCISE AND EASILY UNDERSTOOD INFORMATION ABOUT THEIR COVERAGE.
This information should include the range of covered benefits, required authorizations, and service restrictions or limitations (such as on the use of certain health care providers, prescription drugs, and "experimental" treatments). Plans should also be encouraged to provide information assistance through patient ombudsmen knowledgeable about coverage provisions and processes.
ALL PATIENTS HAVE THE RIGHT TO KNOW HOW COVERAGE PAYMENT DECISIONS ARE MADE AND HOW THEY CAN BE FAIRLY AND OPENLY APPEALED.
Patients are entitled to information about how coverage decisions are made, i.e., how "medically necessary" treatment is determined, and how quality assurance is conducted. Patients and their family caregivers should have access to an open, simple, and timely process to appeal negative coverage decisions on tests and treatments they believe to be necessary.
ALL PATIENTS HAVE THE RIGHT TO COMPLETE AND EASILY UNDERSTOOD INFORMATION ABOUT THE

COSTS OF THEIR COVERAGE AND CARE.

This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, copayments, and additional premiums), and any catastrophic cost limits. Upon request, patients should be informed of the costs of services they've been rendered and treatment options proposed.

ALL PATIENTS HAVE THE RIGHT TO A REASONABLE CHOICE OF PROVIDERS AND USEFUL INFORMATION ABOUT PROVIDER OPTIONS.

Patients are entitled to a reasonable choice of health care providers and the ability to change providers if dissatisfied with their care. Information should be available on provider credentials and facility accreditation reports, provider expertise relative to specific diseases and disorders, and the criteria used by provider networks to select and retain providers. The latter should include information about whether and how a patient can remain with a provider who leaves or is not part of a plan network.

ALL PATIENTS HAVE THE RIGHT TO KNOW WHAT PROVIDER INCENTIVES OR RESTRICTIONS MIGHT INFLUENCE PRACTICE PATTERNS.

Patients also have the right to know the basis for provider payments, any potential conflicts of interest that may exist, and any financial incentives and clinical rules (e.g., quality assurance procedures, treatment protocols or practice guidelines, and utilization review requirements) which could affect provider practice patterns.

ALL PATIENTS, TO THE EXTENT CAPABLE, HAVE THE RESPONSIBILITY TO:(It is recognized that patients may suffer significant physical and/or mental conditions which may limit their ability to fulfill these responsibilities.)

PURSUE HEALTHY LIFESTYLES.

Patients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.

BECOME KNOWLEDGEABLE ABOUT THEIR HEALTH PLANS.

Patients should read and become familiar with the terms, coverage provisions, rules, and restrictions of their health plans. They should not be hesitant to inquire with appropriate sources when additional information or clarification is needed about these matters.

ACTIVELY PARTICIPATE IN DECISIONS ABOUT THEIR HEALTH CARE.

Patients should seek, when recommended for their age group, an annual medical examination and be present at all other scheduled health care appointments. They should provide accurate information to providers regarding their medical and personal histories, and current symptoms and conditions. They should ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives. Where appropriate, this should include information about the availability and accessibility of experimental treatments and clinical trials. Additionally, patients should also seek and read literature about their conditions and weigh all pertinent factors in making informed decisions about their care.

COOPERATE ON MUTUALLY ACCEPTED COURSES OF TREATMENT.

Patients should cooperate fully with providers in complying with mutually accepted treatment regimens and regularly reporting on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they are pursuing simultaneously.

1 National Health Council Board of Directors. "Principles of Patients Rights' and Responsibilities," (National Health Council Principle, 1995) Washington D.C.

A patient shall be fully informed of their rights and responsibilities and of all procedures governing patient conduct and responsibilities. The undersigned certifies that he/she has read the above and fully completed all requested information.

Please Initial _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Atlantic Physical Therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. Any patient that is referred for treatment in our clinic is still under the care of his/her physician, as well as, the physical/occupation therapy for the treatment of his/her condition. The patient consents to any treatment necessary as prescribed by his/her physician. The patient also recognizes that all therapists that consult and furnish services ordered by the referring physician are privileged to provide such services. We (Atlantic Physical Therapy) are not liable if the patient does not follow the instruction of his/her attending physician/therapist during the course of outpatient therapy.

Please Initial _____

LIABILITY: I know and agree that Atlantic Physical Therapy is not responsible for loss or damage to personal valuables.

Please Initial _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Atlantic Physical Therapy, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

The clinic may disclose all or any part of the patient's medical record to any person or corporation that is liable for the clinic's charge including, but not limited to insurance companies, medical service companies, review agencies, workman's compensation carriers/attorneys, automobile insurance/attorneys, welfare funds and other government insurance companies. This release is strictly for the reimbursement purposes to the clinic for services rendered.

The clinic may disclose all or any part of the patient's medical record for this admission to the referring physician, social worker, claims adjuster, treating physician, or family physician or other treatment agencies to aid in the continuing once discharged from the clinic. Authorization must be signed by the patient or, in the case of a minor when a patient is physically or mentally incompetent by the nearest relative or legal guardian.

Signature (If not Patient, indicate relationship (Parent, Guardian, Other) Date

_____ _____

* Any reference to "clinic" is known as Atlantic Physical Therapy and Rehabilitation and its employees.

FINANCIAL AGREEMENT

The undersigned agrees to direct payment to the clinic of any insurance benefit otherwise payable to or on behalf of the patient for outpatient services rendered. In the event that your insurance plan or carrier does not reimburse the clinic for charges and associated expenses incurred by the patient or if the benefits from such insurance plans cease while the patient continues outpatient therapy, the undersigned agrees to pay all charges and associated expenses not covered by those insurance plans for whatever period the patient continues outpatient treatment at the clinic. I understand that I am responsible for any and all amounts due that are not paid by my insurance company for any reason, along with any and all collection and legal fees incurred by this office in order to ensure payment on my account in full in a timely manner. I hereby authorize Atlantic Physical Therapy and Rehabilitation and all of its employees to furnish any necessary information to my insurance carriers and legal council concerning my treatment, and I hereby assign all payment for medical services rendered to me or my dependents to the clinic, physical therapist, and occupational therapist. Payment plans can be arranged at the clinic business office if deemed necessary. If your insurance plan changes or ceases during the course of treatment, it is **your responsibility** to notify the business office **immediately**.

I authorize the release of any medical information necessary to process insurance claims. Payment is to be made directly to the clinic for services rendered. I understand I am responsible for any amount not covered by the insurance. I understand any bill unpaid after 30 days is outstanding and will be charged at a rate of 1.5% per month and 18% annually. Auto and Worker's Compensation have additional billing/financial agreements.

WORKER'S COMPENSATION AND MOTOR VEHICLE ACCIDENT: It is your responsibility to provide us with the name and address of the insurance carrier along with your claim number. If we do not have verifiable billing information before your second appointment, your therapy will continue either on a cash basis until we receive the necessary billing information pertaining to your injury, or we obtain private insurance information. If, for any reason, your claim is denied, we will attempt to bill your private healthcare insurance, but please understand that ultimately you are responsible for full payment. Any attorney "letter of protection" for claims being disputed or in litigation will be discussed on a patient -by- patient basis and will not always be an acceptable form of payment guarantee. If that is the case we will need alternate insurance information or transfer your account to a cash pay basis. If your claim is in a "deferred" status we will need to have private insurance information on file in the event your claim is denied or pending litigation.

Please Initial _____

GUARANTEE OF PAYMENT

If the undersigned fail(s) to make any payments due hereunder, clinic may at anytime, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise(s) to pay all cost of collection including, but not limited to, attorney's fees equal to fifteen percent (15%) of any amount due and owing to the clinic, and any other collection fees which are incurred by or on behalf of the clinic in enforcing payment after default. The undersigned expressly agree(s) and stipulate(s) that if, in the sole discretion of the clinic, its representatives or its attorneys, litigation or court process is necessary to enforce payment hereunder, that the venue for any such litigation or court process shall be the court of common pleas of Philadelphia County, Pennsylvania ant the undersigned hereby expressly waive)s) any right of venue or trial in any county or jurisdiction other than Philadelphia, PA.

Signature: _____ Date: _____

ATLANTIC PHYSICAL THERAPY

PATIENT MISSED APPOINTMENT POLICY

At Atlantic Physical Therapy Rehabilitation and Sports Medicine, Inc., we are committed to providing you with excellent service. As a part of this service, we reserve specific appointments for you with your physical therapist. We understand that appointments may need to be changed and/or canceled from time to time. In the event that you need to cancel an appointment we request that a minimum **24-hour notice** be given so that we can offer that appointment to other patients on our wait list.

A service fee of **$50.00** will be charged for appointments missed without proper notice. Any individual who does not show up for three appointments and does not cancel prior to that appointment will be charged and we will inform your physician of non-compliance with the prescribed rehabilitation order. The first two missed appointment will go with a warning, the third and any that follow will be charged.

I HAVE READ THE ABOVE CANCELLATION AND MISSED APPOINTMENT POLICY AND AGREE TO THE TERMS OF THIS POLICY.

Patient Signature :_____