bodymechanix physical therapy

163 Main Street Wakefield, RI 02879 |tel| 401.782.4049 |fax| 401.782.0890

PATIENT INFORMATION

Name: _____

Date of Birth: _____ **SS#:** _____

Address: _____

City: _____ **State:** _____

Zip Code: _____ **Gender:** _____**M** _____**F**

Primary Care Dr Name: _____

Referring Dr Name: _____

Appointment Reminders **EMAIL only. Please provide us with your email**_____

***Phone*:**
Home:_____

Mobile:_____

Work:_____

***Is this a work related injury: Yes__ No __ Date of Injury_____**

***Is this related to a Motor Vehicle Accident:___ Yes ___ No____**

If related to a Motor Vehicle Accident fill out info on right side of Demographic sheet.

Have you received any home care within the last six months? If yes, what agency? _____

Have you received any physical therapy at another facility prior to this visit?

AUTHORIZATION TO PAY BENEFITS TO PHYSICAL THERAPIST: I hereby authorize payment directly to the above named physical therapist of medical benefits, if any, otherwise payable to me for his/her services.

Patient's Signature (Parent or guardian if the patient is a minor)
_____

Date: _____

PRIMARY INSURANCE

Carrier Name: _____

Address: _____

City, State, Zip: _____

Subscriber Name _____

Subscriber Date of Birth:_____

Insured ID No: _____

Group No _____

Patient Relationship to Subscriber? Self Spouse Child

SECONDARY INSURANCE

Carrier Name: _____

Address: _____

City, State, Zip: _____

Subscriber Name: _____

Subscriber Date of Birth:_____

Insured ID No: _____

Group No: _____

Patient Relationship to Subscriber? Self Spouse Child

GUARANTOR (Responsible Party)

_____Same as Patient

Name: _____

Address:_____

City, State, Zip: _____

Phone: _____

***Motor Vehicle Accident Information**

Date of Injury:_____

Auto Insurance: _____

Address: _____

City, State, Zip: _____

Contact Name/Phone: _____

Claim No: _____

MEDICAL SCREENING FORM

Please circle YES or NO…

Have you or any immediate family member ever been told you have:	**Self**		**Family**	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
Angina/chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No

In the past 3 months have you had or do you experience:

A change in <u>your</u> health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No
Do you have a pacemaker?	Yes	No

Do you have a history of:

Allergies/Asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney disease?	Yes	No
Rheumatic fever?	Yes	No
Ulcers?	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?	Yes	No

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

Name: _____

Have you seen anyone for your symptoms?
Yes ___ No____
If yes, who? _____
Have you had similar symptoms in the past?
Yes _____ No_____
If yes, please explain:
_____
_____

Are your symptoms: (please circle)
Getting worse Same Improving

How are you able to sleep at night? (please circle)
Fine Moderate difficulty Only with medication

Have you fallen in the past 12 months?
If so, how many times? _____
Fall with injury? Yes___ No___

Please check all that apply…

Do you have a problem with…
___ Hearing ___ Vision
___ Speech ___ Communication

Do you or have you in the past smoked tobacco?
YES NO
If yes, ____Packs X _____Years.
Last tobacco use _____

Do you drink alcoholic beverages? YES NO
If yes, how many drinks do you routinely have per week? _____/week

Current list of medications:
_____
_____
_____
_____

What is your occupation?
_____

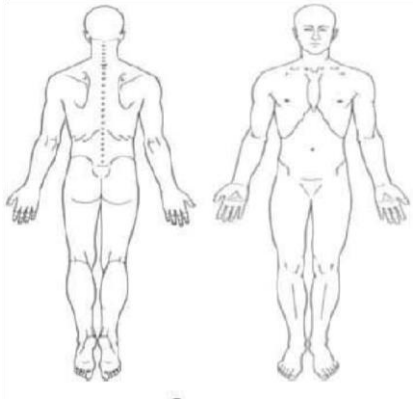
Date: _____

Patient Summary Form

Name: _____

Symptoms began on: | | | |

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms: _____

_____

2. How did your symptoms start? _____

_____

3. Average pain intensity:

Last 24 hours: no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **worst pain**

Past week: no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **worst pain**

4. How often do you experience your symptoms:

① **Constantly (76%-100% of the time)** ② **Frequently (51%-75% of the time)** ③**Occasionally (26%-50% of the time)** ④**Intermittently (0%-25% of the time)**

5. How much have your symptoms interfered with your usual daily activities? (including both work outside and the home and housework)

① **Not at all** ② **A little bit** ③ **Moderately** ④ **Quite a bit** ⑤ **Extremely**

6. How is your condition changing, since care began at *this* facility?

⓪ **N/A-This is the initial visit** ① **Much Worse** ② **Worse** ③ **A little worse** ④ **No change** ⑤ **A little better** ⑥ **Better** ⑦ **Much better**

7. In general, would you say your overall health right now is…

① **Excellent** ② **Very Good** ③ **Good** ④ **Fair** ⑤ **Poor**

Patient Signature _____ **Date:** _____

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Important Company Policies

We strive to provide the best personalized care available. To make this possible, we adhere to a set of very important policies. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

☐ **Late Policy "10-minutes"…** Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee…** If you wish to change or cancel an appointment we require a minimum *24 hour notice*. Missed appointments will result in a $50.00 no-show fee that you are responsible to pay. Our expenses are still incurred whether or not you keep your scheduled appointment. We do NOT make a profit with this charge, but try to deter last minute changes. Advance notice allows us to fill the appointment slot with someone else who needs the time and may be on our "wait" list or may call in urgent need. Please be courteous and responsible. Thank you.

☐ **Co-pays are due upon arrival…** Co-pays are due on the date of service provided, unless other arrangements have been pre-approved. If you have any questions with regard to your copay call your insurance carrier. As a patient, you are responsible to know how much of a deductible you have and you need to pay it in a timely manner. We do not get paid by your insurance when your deductible is due… it is your responsibility to pay us directly.

☐ **Important Notice from the Federal Government…** It is unlawful to routinely avoid paying your ***copay, deductible or coinsurance payments***. You are responsible for the contracted portion for medical care as outlined in your insurance plan. Upon non-payment you will turned over to collections, ***you will be responsible for any collections fees, if your account is left unpaid.*** If you are having a financial hardship please talk to someone in the office as we may be able to set up a payment plan that meets your needs.

Patient Signature_____ Date_____

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Notice of Privacy Policies

I. 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. If you have questions about this notice, please contact our Privacy Officer at 401.782.4049. You may also send written questions or complaints to the Secretary, U.S. Department of Human Health Services, 200 Independence Avenue S.W., Washington, D.C. 20201.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). Body Mechanix Physical Therapy (BMPT) is dedicated to maintaining the privacy of your medical information. In conducting our business, we will create records regarding you and your treatment and services provided to you. These records are our property. However, we are required by law to protect you PHI and to follow the privacy policies described in this notice. PHI includes information that we create or receive about your past, present, or future health condition, the provision of health care to you, or the payment for health care provided to you. We are required by law: 1) to maintain the confidentiality of your medical information.

2) to provide you with this notice of our legal duties and privacy practices concerning your medical information.
3) to follow the terms of our privacy practices in effect at the time of the notice. We will post a copy of our current notice in a prominent location in our main reception area in our clinic. We may change the terms of this notice and our privacy policies at any time. Any change will apply to the PHI we already have. When we change our policies, we will promptly change this notice and post it in our main reception area.

III. HOW WE MAY USE AND SHARE YOUR PHI.

We use and share your PHI for Treatment, Payment or Health Care Operations.

Treatment: BMPT may use and share your PHI to treat you, for example, information obtained from you physician will be used to assist our therapists in their assessment and treatment of you. We will record information regarding your treatment in a private health record. We may disclose your medical information to others that may assist in your care, such as other physicians, therapists, spouse, children, or parents.

Payment: BMPT may use and share your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share your PHI with your health plan, to get paid for the rehabilitation services provided to you by our therapists. We may also share your PHI with collection agencies and companies that process our health care claims.

Health Care Operations: BMPT may use and share you PHI in order to operate this facility. For example, we may use PHI in order to evaluate the quality of health care services that you receive, or to evaluate the health care professionals who provide health care services to you. We may also use your medical information to conduct cost-management and business planning activities for our organization. This information will be used in an effort to continually improve the quality and effectiveness of the health care service we provide. We may also share PHI with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

Additional conditions in which we may use or share you PHI

We will use of share your PHI when:

1. Required applicable law such as information required by government agencies and law enforcement about victims of abuse, neglect, or domestic violence, or when required in a legal proceeding.
2. Public Health agents require information for public health activities related to disease control, injury or disability and/or the maintenance of vital records such as births or deaths.
3. Health oversight agents investigate or inspect a health care provider or organization.
4. Serious threats to health or safety require that we disclose only the information necessary to help prevent the threat.
5. Other government functions such as military or veteran's activities, national security or intelligence activities or protective services for the President of the United States or correctional facilities require your information.
6. Worker's Compensation laws require release of your information to be in compliance with federal and state laws.
7. We give you appointment reminders or health related benefit or service information about treatment choices or other health care services or benefits.

IV. YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding the medical information that we maintain about you:

Our use of your PHI requires your prior written authorization for any other use of your PHI not described in section III. If you authorize us to use your PHI, you can later remove the authorization and stop any future of your PHI. You can remove an authorization by written request to the Privacy Officer at:

Body Mechanix Physical Therapy, Inc.
163 Main Street
Wakefield, RI 02879

Requesting Restrictions:
You have the right to request a restriction in our use of your medical information for treatment, payment of health care individuals involved in your care or the payment of your care, such as family members, friends, or others. We will consider your request to limit how we share your PHI but we are legally not required to agree to it. If we agree with your request, we will follow your limits, except in emergency situations. You cannot limit the uses and reports that we are legally required or allowed to make.

Confidential Communication:
You have the right to request that BMPT communicate with you about your health and related issues in a particular manner, or at a certain location. In order to request a confidential type of communication, you must make a written request to our Privacy Officer at Body Mechanix Physical Therapy. Your request must specify the requested method of contact or location where you wish to be contacted. You do not need to give a reason for your request. BMPT will accommodate reasonable requests.

Inspection and Copies:
You have the right to inspect and obtain a copy of your PHI (except for mental health notes). Your request must be in writing. If we do not have your PHI, but know who does, we will tell you how to get it. We will reply to your request within 30 days of receipt of your request. If we deny your request, we will tell you in writing our reasons for the denial. You will have the right to have the denial reviewed. If your request a copy of your PHI, we may charge a fee.

Report Rights:
You have a right to get a list of the parties to whom we have reported your PHI. This list will not include reports for treatment, payment or health care operations; reports that you have previously authorized; reports made directly to you or your family; reports from our facility; reports made for national security purposes; reports to corrections or law enforcement personnel; or reports made before April 14, 2003. Your written request must be submitted to the Privacy Officer at BMPT. We will respond to you within 60 days. We will not charge for your list. Second requests within the same year will be provided for a fee.

Amendment:
You have the right to ask us to amend PHI if you believe it is incorrect or incomplete. You must submit this request in writing to the Privacy Officer at BMPT. You must provide a reason that supports your request. BMPT will deny requests for amendment when information on record is accurate and complete, not part of medical information created by BMPT, or not part of the medical information you are permitted to inspect. We will respond within 60 days of your request. You can ask us for a copy of this notice at any time. The effective date of this notice is April 14, 2003.

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Notice of Privacy Practices
and
Patient Acknowledgment Form

Body Mechanix Physical Therapy is required by a federal law known as "The Health Insurance Portability and Accountability Act" (HIPAA) as well as by Rhode Island state law to maintain the privacy of your medical and health information, also referred to as "Protected Health Information" (PHI).

Our notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the notice (or any other Notice in effect at the time of the use/or the disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree with this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your signature below constitutes your acknowledgment that you have received a copy of our Notice of Privacy Rights and Practices, and your consent under federal and state laws to the kinds of uses and disclosures of Protected Health Information mentioned in our notice.

A copy of our notice of Privacy Rights and Practices will be give upon request.

_____ _____
Patient's Signature Date

_____ _____
Personal Representative or Guardian Signature Date

_____
Relationship to Patient