PROPEL
PHYSICAL THERAPY AND ATHLETIC PERFORMANCE

New Patient Medical Health Form

Name: _____ Referring Physician: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Gender: Female ❒ Male ❒

Describe your reason for today's visit _____

Date of Injury / onset of symptoms: _____ _____ Was the onset: Gradual ❒ Sudden ❒

Have you ever had this pain or injury before? Yes ❒ No ❒

If yes, explain: _____

Please list any current prescription medications you are taking: _____

_____

Have you taken any over-the-counter medications in the past 2 weeks? *(Please circle Yes or No)*

Yes No Anti-inflammatory Yes No Decongestant Yes No Vitamins / Supplements

Yes No Antihistamine Yes No Pain Killer Yes No Other

Have you had any diagnostic testing (X-Rays, MRI's, Bone Scan, EMG, etc?)_____

_____

Do you: Smoke Yes or No Number of packs / day _____ Drink alcohol Yes or No How often? _____

What are your goals for physical therapy? _____

_____

Please list any previous surgeries or any other condition for which you have been hospitalized:

Date (approximate) Surgery / Reason for hospitalization

_____ _____

_____ _____

_____ _____

Have you had physical therapy previously? Yes No **If yes, please provide the following:**

Date (approximate) Injury

_____ _____

_____ _____

_____ _____

Do you have a history of the following (Please circle Yes or No):

Cancer: Yes No
If yes, what type? _____

Heart Disease / Heart Attack: Yes No

If yes, describe _____

Allergies: Yes No
If yes, list _____

Chemical Dependency (ex: alcoholism): Yes No
If yes, describe _____

Angina / Chest Pain	Yes	No	Kidney Disease	Yes	No
High Blood Pressure	Yes	No	Depression	Yes	No
Circulation Problems	Yes	No	Asthma	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No
Stroke	Yes	No	Rheumatoid Arthritis	Yes	No
Tuberculosis	Yes	No	Hepatitis	Yes	No
Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Pace Maker	Yes	No	Osteoporosis	Yes	No
HIV / AIDS	Yes	No			

In the past 3 months, have you experienced any of the following?

A change in your health	Yes	No	Nausea / Vomiting	Yes	No
Fever / Chills / Sweats	Yes	No	Fatigue	Yes	No
Unexplained weight change	Yes	No	Shortness of Breath	Yes	No
Numbness or Tingling	Yes	No	Changes in appetite	Yes	No
Changes in bowel or bladder function	Yes	No	Difficulty swallowing	Yes	No
Dizziness / Lightheadedness	Yes	No			

For WOMEN:

Are you pregnant?	Yes	No
Are you taking fertility drugs?	Yes	No

Date of last physical examination: _____

_____ _____
Patient Signature Date

_____ _____
Parent Signature for Minor Date

PROPEL STAFF ONLY – Treating PT has review medical history with patient

_____ _____
Physical Therapist Signature & License Number **Date**

Propel Physical Therapy and Athletic Performance
New Patient Registration Form

Thank you for choosing our practice. In order to serve you properly, we need the following information. Completing this information now will help us start your first visit without delay. All information will be confidential.

Date: _____Patient Name: _____ Date of Birth: _____

Street Address: _____

City / State / Zip: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Gender: Male or Female *(Circle One)* Marital Status: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

How did you hear about us? _____

Referring Physician: _____ Primary Care Physician: _____

Is this injury the result of an accident? YES or NO (Circle one) *If no, please skip to next section

What type of accident? AUTO WORK SCHOOL OTHER Date of accident: _____

City & State where accident occurred: _____ Is an attorney involved in your case? YES or NO

Attorney's Name: _____ Phone: _____

Address: _____

Primary Insurance Company:_____ Secondary Insurance Company:_____

- I consent to treatment necessary for the care of the above patient.
- I authorize release of all medical records, copies of this authorization and any information necessary for my treatment or claim to my health care providers and their billing agents as needed.
- I understand payments of charges is due at time of service, unless other financial arrangements are made prior to treatment and I accept full financial responsibility.
- I authorize payments of medical benefits to Propel Physical Therapy and Athletic Performance, from my insurance carrier.
- I have read and fully understand the above consent for treatment, release of medical information, insurance authorization and my financial responsibility.

_____ _____

Patient Signature Date

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Consent for Care

I, the undersigned, consent the physical therapy treatment as ordered by physician prescriptions and administered by Propel Physical Therapy and Athletic Performance (Propel PTAP).

Consent for Use and Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information by Propel Physical Therapy and Athletic Performance for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Propel PTAP is not required to agree to the restrictions that I may request. However, if Propel PTAP agrees to a restriction that I request, the restriction is binding on Propel PTAP. Your request must be in writing and it must state the specific restriction requested and to whom you want the restriction to apply.

I have the right to revoke this consent, in writing, at any time, except to the extent that Propel PTAP has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical therapy or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Propel PTAP's Notice of Privacy Practices prior to signing this document. Propel PTAP's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care operations of Propel PTAP. This Notice of Privacy Practices also describes my rights and Propel PTAP duties with respect to my protected health information. Propel PTAP reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please be advised that Propel PTAP practices in an open gym environment. This means that if your treating provider is discussing your private health information with you, someone in close proximity may overhear the conversation. If you had concerns with this, please bring this to the attention of your therapist.

_____

Patient Signature (or parent if minor) Date

PROPEL
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General Patient Policies

Dear Patient,

Welcome to Propel Physical Therapy and Athletic Performance. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss any problems. Together we will work through the most appropriate solution. To ensure this, we are providing some simple guidelines to follow:

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a $25.00 charge for a no show or cancellation without proper notice. This charge will probably not be covered by your insurance company. Therefore it will have to be paid by you personally.
- Please be prompt with your scheduled appointment so we can maximize your treatment. If you are arriving late, your treatment time may be limited.
- Co-payments are due at the time of service. We accept payments by credit card, cash or check.
- For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist prepares a report for your doctor.
- Please bring or wear proper clothing to make your body part(s) accessible for treatment.
- Please be compliant with your home exercise program. This will help to accelerate your recovery time.
- In case of inclement weather, please call ahead of time to confirm your appointment.
- Most importantly, please communicate with your therapist! The more information that is known, the better we can conquer your problem.

By following these simple guidelines, together we can reach your goal in the shortest amount of time. Thank you again for choosing us as your rehabilitation provider.

Please sign to acknowledge that you have read and understood the guidelines.

_____ _____
Patient Signature Date

_____ _____
Signature of Legal Guardian, Health Care Agent or other Personal Representative Date

PROPEL
PHYSICAL THERAPY AND ATHLETIC PERFORMANCE

Notice of Privacy
Practices & Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and therapists continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment or payment of health care operations.

If you have any questions, comments or objectives to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies:

Patient Name: _____ Signature: _____

Date: _____

If minor, signature of parent or guardian: _____

For Office Use Only

A "good faith effort" was made to get a signature from the patient. Signature was not attained due to the following:

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To our valued PROPEL patients:

Please be advised that your insurance carrier may elect to mail payments (checks) directly to you for treatment at our facility. If this should occur, simply endorse the back of the check and bring it to our office so we may apply the payment to your account.

_____ _____

Patient Signature Date

_____ _____

Signature of Legal Guardian, Health Care Agent or other Personal Representative

Date