PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

HECTORPT REHABILITATION SERVICES PLLC
Patient Intake Sheet

This form may be completed online. Tab or move cursor to text field and type in text. For HIPPA Compliance reasons this form IS NOT TO BE SAVED with patient information. Selecting the PRINT button will clear all information.

Patient Information

Name: | Home Phone:

Street: | Work Phone:

City: | Cell Phone:

State: | Date of Birth: | Age:

Zip Code: | Weight: | Height:

Soc. Sec. No: | Today's Date:

Occupation: | Employer:

Email:

Emergency contact person: | Relationship:

Address:

Phone: | Cell: | Work:

Referring Physician: | Phone Number:

Who is your primary care physician? | Who is your Surgeon?

How did you hear about us? ☐ Internet ☐ TV ☐ Radio ☐ Insurance Co. ☐ Family ☐ Friend ☐ Other

Policy Holder Information

Name of Policy Holder: | Date of Birth:

Address: | Employer:

Social Security No. | Telephone:

Primary Insurance Information

Primary Insurance:

Address:

Group No. | Policy/I.D. No.

Treatment Authorization/referral number:

Secondary Insurance Information

Secondary Insurance:

Address:

Group No. | Policy/I.D. No.

Treatment Authorization/referral number:

Is your injury due to an accident? | Date of injury: | Claim #:

Is your injury work related? | Date of injury: | Claim #:

MEDICAL HISTORY

Medical History - Please check if you have or ever had:

☐ Arthritis ☐ Back pain ☐ Cancer ☐ Circulation/vascular problems ☐ Depression ☐ Diabetes ☐ Falls

☐ Fractures ☐ Head injury ☐ Headaches/migraines ☐ Heart problems ☐ High blood pressure

☐ Infectious diseases (i.e. TD, hepatitis) ☐ Joint replacements ☐ Lung problems ☐ Metal implants (i.e. Pace maker)

☐ Multiple sclerosis ☐ Muscular dystrophy ☐ Osteoporosis ☐ Parkinson's disease ☐ Sprain/strains

☐ Sports related injuries ☐ Seizures/epilepsy ☐ Skin diseases ☐ Stroke ☐ Other _____

Please list other diagnosis:

Have you ever had surgery? ☐ Yes ☐ No If yes, please list and give dates:

Do you suffer recurrent injuries? ☐ Yes ☐ No If yes, explain: _____

Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? _____

Did you sustain an injury when you fell and if so, please describe: _____

Allergies: _____

Medications: _____

RECENT MEDICAL TESTS RELATED TO YOUR SYMPTOMS

☐ Angiogram ☐ Arthroscopy ☐ Biopsy ☐ Blood scan ☐ CT scan ☐ Doppler ultrasound ☐ Echocardiogram

☐ EEG electroencephalogram ECG (electrocardiogram) ☐ EMG (electromyogram) ☐ Mammogram ☐ MRI

☐ Myelogram ☐ NCV (nerve conduction velocity) ☐ Pulmonary function test ☐ Spinal tap ☐ Stress test

☐ X-rays ☐ Blood test ☐ Other Please list: _____

SOCIAL HISTORY

SOCIAL HISTORY

Employment/Work (job/school/play): _____

☐ Working full time ☐ Working part time ☐ Retired ☐ Student ☐ Unemployed

Sports/Hobbies: _____

Are there cultural/religious practices that may affect your healthcare? ☐ Yes ☐ No

If Yes, please explain: _____

GENERAL HEALTH STATUS

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes during the past year? (e.g., new baby, job change, death of a family member)

☐ Yes ☐ No If yes, how many times? _____

SOCIAL HEALTH HABITS

Smoking: Currently smoke tobacco? ☐ Yes ☐ No # of packs per day _____

Smoked in past? ☐ Yes ☐ No Year quit: _____

Alcohol use: ☐ Yes ☐ No How much? _____

Illegal drug use: ☐ Yes ☐ No How much and when? _____

Have you ever abused narcotics or prescription medications? _____

EXERCISE

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No

If yes, please describe (including days per week and avg # of minutes _____

CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

Briefly describe the problem for which you seek physical therapy:

_____

How did your current episode begin? ☐ Suddenly ☐ Gradually

When did your current pain episode begin? _____

What caused your current pain episode? _____

Has the pain lessened, worsened or stayed the same? _____

PAIN SYMPTOMS

Type:

☐ Ache ☐ Burning ☐ Sharp Shooting ☐ Stabbing ☐ Tingling/Numbness

☐ Other _____

Location: _____

My pain/problem is slowly getting:

☐ Worse ☐ Better ☐ Staying the same

My pain bothers me:

☐ Constantly ☐ Occasionally ☐ Most of the time

Mark the effect of each of the following on your pain:

What makes the problem(s) better?

☐ Heat ☐ Ice ☐ Inactivity ☐ Lying Down ☐ Moving ☐ Sitting ☐ Standing ☐ Exercising ☐ Stretching ☐ Rest

☐ Other _____

What makes the problem(s) worse?

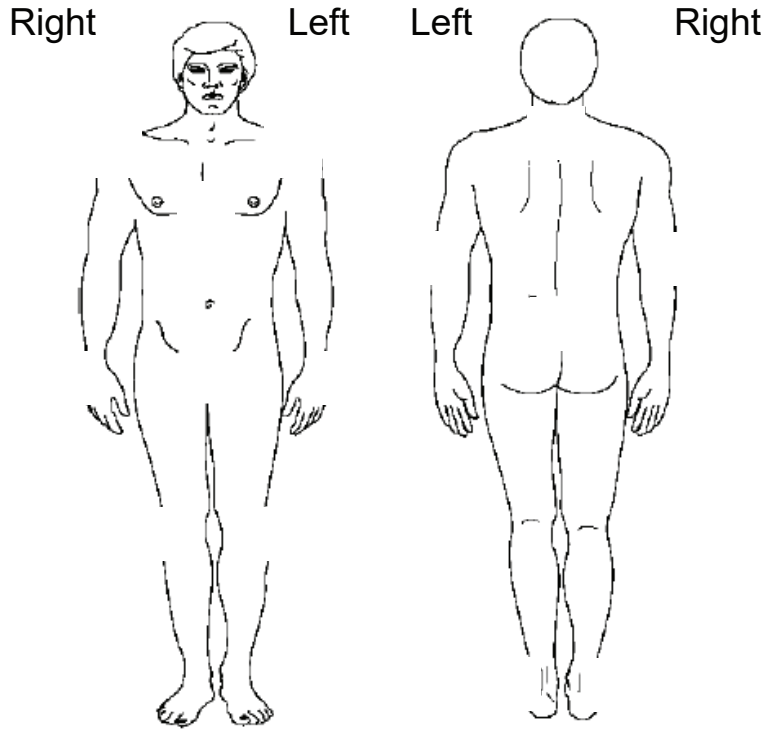
☐ Heat ☐ Ice ☐ Inactivity ☐ Lying Down ☐ Moving ☐ Sitting ☐ Standing ☐ Exercising ☐ Stretching ☐ Rest

☐ Other _____

Location of pain

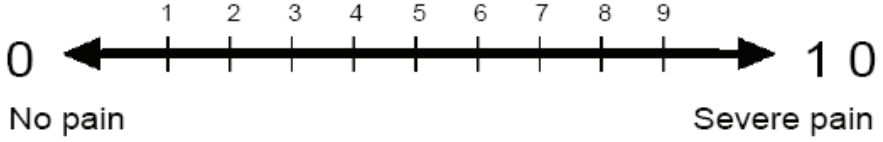
Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms.

"N" = numbness
"S" = stabbing pain
"B" = burning pain
"P" = pins and needles
"A" = aching pain



What is your pain level today?

Mark on the line where your pain is **today**



_____ Which number (0-10) describes your pain **right now?**

_____ Which number (0-10) is your worst pain?

_____ Which number (0-10) is your least pain?

_____ Which number (0-10) describes your average pain over the past week?

Please use the following scale to give us an estimate of your pain:

0	Pain free
1	Very minor annoyance, occasional minor twinges
2	Minor annoyance, occasional strong twinges
3	Annoying enough to be distracting
4	Can be ignored if you are really involved in your work, but still distracting
5	Can't be ignored for more than 30 minutes
6	Can't be ignored for any length of time, but you can still go to work and participate in social activities
7	Makes it difficult to concentrate, interferes with sleep, you can still function with effort
8	Physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors or pain
9	Unable to speak, crying or moaning uncontrollably, near delirium
10	Unconscious, pain makes you pass out

Treatment for your pain:

Please mark all of the following physicians or specialists you have consulted.
ONLY FOR PAIN RELIEF RELATED TO CURRENT PROBLEM, NOT FOR OTHER PROBLEMS

☐ Acupuncturist	☐ General Physician	☐ Pain Clinic
☐ Anesthesiologist	☐ Hypnotist	☐ Physical Therapist
☐ Chiropractor	☐ Internist	☐ Plastic Surgeon
☐ Dentist	☐ Neurologist	☐ Podiatrist
☐ ENT Physician	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Endocrinologist	☐ Opthalmologist	☐ Rheumatologist
☐ Faith Healer	☐ Orthopedic Surgeon	☐ Other

MY GOALS FOR PHYSICAL THERAPY ARE:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful response can affect my entire Plan of Care and overall health.

_____ _____
Patient/Guardian Signature Date

_____
Print Name

CONSENT FOR TREATMENT

I, or my guardian, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician or my physical therapist.

By signing I give consent for treatment and acknowledge that the above information is true.

_____ _____
Patient/Guardian Signature Date

_____
Print Name

This is an agreement between HectorPT Rehabilitation Services, PLLC (creditor) and the Patient/Guardian (debtor) named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient (debtor). The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us" and "our" refer to HECTORPT REHABILITATION SERVICES PLLC.

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments: Any co-payments or co-insurance required by an insurance company must be paid at the time of service. We shall have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible or coinsurance, you must pay that at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay and the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

Benefit Assignment: You assign all medical benefits to us including health insurance, Medicare, auto insurance, workers' compensation or other insurance plans. You also authorize HECTORPT REHABILITATION SERVICES PLLC, to release all information necessary (including photocopies of medical records) to secure payment (see Notice of Privacy Practices). You agree that if your insurance pays directly to you, that it is your responsibility to forward all payments to us.

Primary Insurance: As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days, the balance will become patient responsibility unless other arrangements are made with us. If possible, we will verify benefits and eligibility prior to your first appointment. It is the patient responsibility to be aware of your own benefits and eligibility. If your insurance company notifies us that they are waiting to receive the accident report form from you, the balance is automatically patient responsibility and we will begin Collection procedures.

Secondary Insurance: As a courtesy to you, we will bill your secondary insurance after your primary insurance has paid. If our office has not received payment from your secondary insurance after 120 days from the date first billed to your secondary insurance, the balance will become patient responsibility unless other arrangements are made.

Referrals/Prescription/Authorization: If your insurance company requires a referral, prescription or preauthorization, you are responsible for obtaining it. Failure to obtain the referral, prescription and/or pre-authorization may result in a lower payment, or no payment from the insurance company.

Workers' Compensation: If your claim is in deferred status, we will ask for private medical insurance to bill if your claim is denied. We require approval/authorization by workers' compensation carrier prior to your initial visit. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or Workers' Compensation carrier.

Personal Injury /Motor Vehicle Accidents (MVA): If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred in a personal injury case. If you have Personal Injury Protection (PIP) through your motor vehicle insurance policy, we will bill them as primary insurance and will bill your private health insurance when your PIP benefits are exhausted.

The Financial Policy continues on PAGE 2

Billing Information: It is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance of the account at the last date of service will be entirely your responsibility. We will not be responsible for rebilling, Appealing or other dealings with newly provided insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Methods of Payment: We accept VISA, MasterCard, personal checks and cash. There is a fee of $25 for any checks returned by your bank.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was paid by your insurance company or due by you. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve (12) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "past due balance" of your account. The "past due" balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. You understand that finance charges are not billable or payable by insurance.

Past Due Accounts: If your account becomes past due, we may need to take necessary steps to collect this debt. This may include contacting the person listed as the Emergency Contact on your patient data sheet. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we refer your account to a collection agency, we will add a surcharge of 30% to your balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Missed Appointment Fee: A $30 fee will be charged for missed appointments or appointments cancelled with less than 24 hours notice. This fee must be paid before a new appointment is scheduled or services provided. This fee is not billable or payable by insurance. Patients with more than two missed appointments will be discharged from therapy and referred back to their physician. We understand that emergencies do occur and will attempt to make reasonable accommodations for that.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form.

Patient Name: _____

Responsible Party (if not the patient): _____

_____ _____

Signature Date

HIPAA Privacy Notice

Notice of Privacy Practices for HECTORPT REHABILITATION SERVICES, PLLC.

At HECTORPT REHABILITAION SERVICES, PLLC we are dedicated to providing top–quality Physical Therapy treatment. Protecting your privacy is of paramount importance to us, and we have implemented procedures to safeguard the information included in your files. This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it carefully.

Your Personal and Protected Health Information:
We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

- We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
- We may disclose your PHI to any third party you designate in writing.
- We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
- We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
- We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
- We may disclose your PHI to a health oversight agency for activities authorized by law.
- We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
- We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
- Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
- We may use or disclose your PHI when required by law.
- We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about physical rehabilitation, or other related information that may be of interest to you.

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records upon written request.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have a right to receive all notices in writing.
5. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions in writing, the restriction is binding on us.

If you have any questions regarding your HIPAA Privacy Rights, please contact Hector Jasen at 518-371-5554 or hectorptsports@gmail.com.
This notice remains in effect until it is replaced or amended by changes in the law.

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide HECTORPT REHABILITATIION SERVICES PLLC, with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ **DOB:** _____
(Please Print)

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____