EAGLE
PHYSICAL THERAPY & WELLNESS

PATIENT INFORMATION

NAME_____ DATE OF BIRTH_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____SOCIAL SECURITY#_____

OCCUPATION_____E-MAIL ADDRESS_____

WORK ADDRESS_____CITY_____STATE_____ZIP_____

WORK PHONE_____ EMPLOYER_____

CELL PHONE #_____ REFERRING MD_____

PRIMARY CARE PHYSICIAN _____HOW DID YOU HEAR ABOUT US?_____

EMERGENCY DATA

IN CASE OF EMERGENCY CONTACT:

NAME_____ PHONE NUMBER_____

ADDRESS_____ CITY_____STATE_____ ZIP_____

RELATIONSHIP_____

INSURANCE DATA

NAME OF INSURANCE COMPANY_____

POLICY NUMBER_____SUBSCRIBERS NAME_____DOB_____

WAS INJURY DUE TO AN AUTO OR WORKERS COMP ACCIDENT?
IF YES, PLEASE FURNISH THE FOLLOWING.

DATE OF INJURY_____ FILE CLAIM NUMBER_____

INSURANCE COMPANY_____

ADDRESS TO SEND BILLS_____CITY_____STATE_____ZIP_____

CLAIMS ADJUSTERS NAME_____PHONE NUMBER_____

PRE-CERT CO._____PHONE NUMBER_____

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO EAGLE PHYSICAL THERAPY, FOR SERVICES RENDERED.
I HEREBY AUTHORIZE EAGLE PHYSICAL THERAPY TO RELEASE (OR OBTAIN) INFORMATION REGARDING MY PHYSICAL THERAPY EVALUATION AND TREATMENT AND RELATING BILLING INFORMATION TO (FROM) MY ATTORNEY, OR INSURANCE CARRIER FOR PURPOSES OF PROCESSING THIS CLAIM. **WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED WITHOUT 24HR NOTICE.**

SIGNATURE_____DATE_____

PATIENT MEDICAL HISTORY FORM

Name:_____ DOB:_____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY: (Please check any conditions that apply to you. Items not checked are understood to be negative.)

___High Blood Pressure	___Abnormal Bleeding	___Bowel or Bladder Problems
___Heart Problem	___Asthma	___Autoimmune Disorder
___Abnormal Heart Rate	___Emphysema	___Recent and Sudden Weight Loss/Gain
___Pacemaker	___Chronic Lung Problem	___Thyroid Problem (Hyper or Hypo)
___Heart Palpitations	___Chronic Heartburn	___Diabetes (Medication Dependent? YES/NO)
___Angina (Chest Pain)	___History of Ulcers	___Cancer/Tumors (Where?_____)
___Shortness of Breath	___High Cholesterol	___Seizures/Epilepsy
___Osteoporosis	___Night Sweats	___Arthritis
___Dizziness	___Hearing Problems	

Other:

_____

Do you have a history of fractures? YES NO Where? _____

Do you have a history of back/neck pain? YES NO When? _____

Do you have any metal implants? YES NO Where? _____

Do you smoke? YES NO How much per day? _____

Do you exercise regularly? YES NO How often? _____

Do you have any known allergies? YES NO Please list _____

Are you allergic to latex? YES NO

Are you pregnant or suspect pregnancy? YES NO

MEDICATIONS: Please check if you are taking any of the following **(Please list name/dose of medications)**

___Blood Pressure Medication ___Heart Medication ___Anti-coagulants (blood thinners)

_____ _____ _____

___Muscle Relaxants ___Pain Killers ___ Diabetes Medication (i.e.Insulin)

_____ _____ _____

___Steroids (Cortisone) ___ Anti-inflammatories ___Other Medications

_____ _____ _____

SURGERIES: Please list all surgeries, including date:

_____

DIAGNOSTIC TESTS: Please check test(s) for current problem only.

( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density ( )Blood Chemistry ( )Ultrasound
( )Other (please specify)_____

Have you seen anyone else for your current problem?

( )Physician/MD ( )Chiropractor ( )Podiatrist ( )Orthopedic Surgeon ( )Dentist ( )Neurologist/Neurosurgeon
( )Osteopath/DO ( )Physical Therapist Date:_____

SYMPTOMS: In regards to your current condition:

How long have you been experiencing your symptoms:

_____

_____

How did your symptoms begin:

_____

_____

Have you had this problem before? YES NO

CHIEF COMPLAINT/ CURRENT CONDITIONS: Please describe:_____

_____

Please rate your on a scale of 0-10. (0 no pain, 10 worst pain)

0 1 2 3 4 5 6 7 8 9 10

Do you have any “pins and needles” or numbness in your extremities? YES NO

Do you have any weakness in your arms or legs? YES NO

Do you have any coordination or balance problems? YES NO

Do you have difficulty walking? YES NO

Do you experience dizziness or vertigo with a change in position? YES NO

Have you experienced headaches as a result of your condition? YES NO

I believe all information to be true and complete:

Signature_____ Date:_____

Patient Authorization Record

Initial here	
	<u>Authorization for Treatment</u> ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by *Georgia* Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	<u>Authorization for Release of Information</u> ➢ I agree that Eagle Physical Therapy & Wellness may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Eagle Physical Therapy & Wellness for services rendered. ➢ I agree that Eagle Physical Therapy & Wellness may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	<u>Authorization for Release of Payment</u> ➢ I authorize that direct payment of any benefits available to me be released to Eagle Physical Therapy & Wellness for services rendered.
	<u>Patient Agreement</u> ➢ I agree to pay *Eagle Physical Therapy & Wellness* charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Eagle Physical Therapy & Wellness collections costs including attorney and court fees.
	<u>Medicare, Medicaid, and Similar Benefits</u>

	➢ I agree that the information given to *Eagle Physical Therapy & Wellness* in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *Eagle Physical Therapy & Wellness* may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to *Eagle Physical Therapy & Wellness* in applying for benefits under Workers Compensation is complete and accurate. I agree that *Eagle Physical Therapy & Wellness* may give intermediary's information necessary to process claims.

_____

Patient signature Date

_____

Printed patient name Witness Signature Date

_____

Signature of Legal Representative/POA

NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where and why others may access your health information.

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for treatment, Payment, and Health Operations

We will use your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiates the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

We will use your health information for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality & effectiveness of the healthcare and service we provide.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for you care, of your location and general condition.

Family communication. After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, transplantation of organs for the purpose of tissue donation and the transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents there of health information necessary for your health and the health and safety of other individuals.

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

EFFECTIVE DATE _____

I acknowledge receipt of a copy of this Notice _____