River Valley Physical Therapy

White Cloud Physical Therapy

Phone: 231.689.5800
Fax: 231.689.5802

Patient Information (please answer every question)

Last Name:_____ First Name:_____

Mailing Address:_____

City:_____ State:___ Zip Code:__ Date of Birth:_____/__

_____ / Age:___ Sex: M F Marital StatUS: M D W S

Home Phone: (_____ Cell Phone: _____

Email Address:_____

Physician Who Ordered PT:_____ Primary Care Physician: _____

Health **Information**

Have you ever been diagnosed with and/or treated for:

- ☐ Stroke
- ☐ Heart Attack
- Pacemaker
- Pregnancy
- ☐ H1V/AIDS
- ☐ Other _____
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Recent Weight Change
- Falls (How many in the past year?
- ☐ Hepatitis A B C (irelc, if applicable)
- ☐ Heart Problems
- Open Wounds
- ☐ Allergies _____

« Are you currently receiving in-home healthcare (i.e., nursing or therapy)? NO YES

« Reason(s) for seeking therapy? _____

_____

« How long have you had these symptoms? _____

» Is your condition or injury due to any of the following accidents (circle one)?
Auto Work/Employment School/Sport Accident Not at Home

- Date of Accident or Injury (or best estimate): _____
- « Location of Accident or Injury: _____
- Claim Number: _____
- Insurance and Name & Phone of Adju5tor/Case Manager:

_____

« If not due to accident/injury, what do you feel brought the symptoms on? _____

_____

» Have you had any physical or occupational therapy or chiropractic care this year?
YES NO

- When (approximately)? Number of visits?_____

_____

Thank you for choosing us!

6 Hands Physical Therapy & Wellness proudly provides services at these

White Cloud Physical Therapy River Valley Physical Therapy

Patient Name: _____

I/rank you fot f» oviding tltis information. Your therapist iri/f discuss your respoii.see trills *you Stir ing the evaltialion.*

PERSONAL IN **FORMATION**

I am (circle one): Employed Employed w/ restrictions On Medical Leave Unemployed Retired

Employer:_____ Occupation: _____

Interests/Hobbies/Exercise:_____

- Is there nnyone who can assist you with doing home exercises or activities, if needed? Yes No
- Might you have any problems attending therapy sessions? Yes No
- Are there circumstances that may prevent you from arriving on time for therapy sessions? Yes No

Next scheduled doctor appointment: Date_____Physician_____

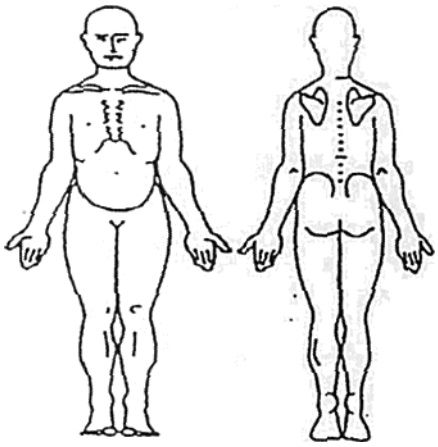
xrv tjucsTIONS **ABOUT YOUR CONDITION**

What is your main complaint?

_____

_____

On the picture below, place an "X" on the area(s) you are having problems:



Right Left 1.efl Right

- Pain level when at rest (mark on the following scale):

(No Pain) 1----2----3----4----5----6----7----8----9--- 10 (Worst Pain Imaginable)

- Pain level with activity (mark on the following scale):

(No Pain) l----2----3----4----5----6----7----8----9 --- 10 (Worst Pain imaginable)

GENERAL HEALTH

Are you experiencing any of the following?

- Trouble Sleeping: Yes No
- how cnergy or frequent fatigue: Yes No
- lncrcased perspiration: Yes No
- I lushing: Yes No
- Increased nc ₐtive feelings about injury or future: Yes No
- Unexplained Weight loss (10 lbs. or more): Yes No
- Uncomfortable with or avoiding people: Yes No

With whom, if anybody (other than your physician), may we discuss your treatment and contact in case of an emergency?

Name	Relationship to Patient	Phone

ACKNOWLEDGEMENTS

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_____white *Cloud Phy.vicul Therapy mill document medical & other iiformcition related In my* fi'enrm«nf. 7 *tinclei stanJ such infoi-iitaiion will be used in the course of my treatment. I authoriz-e Mite Cloud Physical Therap) to conlcict itiy phy.vician or other healthcaFe professional that may have information related to my ć onclilion(s) & ti calmest.*

Please ask if you have any questions related to Ihis information, and we will be happy to elaborate.

J ver/iJ *that I huve renJ, uncler8lund anal agi ee to the statements in this document.*

Patient (or Legal Guardian/Caregiver)	**Date**

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Physical Therapy

NO SHOW AND CANCELLATION POLICY

Please notify our office 1-2 days in advance of any cancellation or potential inability to come to your appointment. This gives us a chance to schedule another patient.

We are committed to providing outstanding patient care and satisfaction. When we reserve time for you and you fail to show up or give prior notice, it takes time away from other patients.

We do realize that life happens, and sometimes cancels are unavoidable. However, we cannot help you with your pain or condition if you don't come to appointments regularly. Three **cancels** and/or no-shows may result in your discharge from therapy. Please note: late **arrivals** may result in us having to reschedule or shorten your appointment.

Please sign to indicate your understanding of this policy.

Signature:_____Date:_____

Thank you! We feel privileged and grateful to be part of your health care team, and we look forward to working with *and getting to know you!*

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Physical Therapy

BILLING & INSURANCE

We are committed to honest & accurate billing practices. In order to ensure your insurance is properly billed and covers therapy according to their contract with you, please acknowledge the following:

- « My insurance may determine that some of the charges are my responsibility (for example, copay, deductible, coinsurance, uncovered procedures).
- I understand I may be responsible for charges not covered by my insurance.
- I agree to let White Cloud Physical Therapy know if there is a change to my insurance policy.
- I authorize White Cloud Physical Therapy and 6 Hands Physical Therapy & Wellness to file claims for reimbursement by my insurance policy and to provide them with any information requested regarding my present condition & treatment.

Signature:_____Date:_____

IF YOU DO NOT KNOW WHAT WILL BE COVERED, ASK THESE QUESTIONS OF YOUR INSURANCE COMPANY:

Is Physical Therapy a covered benefit? YES NO
Will I have any out-of-pocket costs associated with my therapy? YES NO
I Will I have a co-pay for each PT visit? YES NO $_____/visit
Must I pay a co-insurance for PT (a portion of the total charges)? YES NO_____%
Is there a limit to how much PT I can have each year (such as a dollar amount or maximum number of visits)? _____
I Are there any conditions or therapy treatments that are not covered by my insurance plan? _____
_____

If you have questions about your bill or concerns about any out-of-pocket costs, please contact us at (231) 689-5800 or via email at mswinehart@whi eclniidat.com.
We will do our very hest to answer your questions or work with you on a payment plan for any Charges you may be responsible for.

Notice of Privacy Practices

This Notice describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and oontrol your PHI. PHI about you is maintained as a written and/or electronic record. Specifically, it individually identifies you and relates to your past, present, or future payment for your healthcare.

Ws are required by law to maintain the privacy of your health infomation and provide yoM with a œpy of this notœ. We are required to abide by the terms of this notice. We reserve the right to change the terms of this no8œ, and make the revised or changed notice effective for all heaîth information that we maintain. Any changes to this notice will be posted in our facility and on our website.

HOW WE MAY USE AND DISCLOSE PROTECTED **HEALTH** INFORAMTION ABOUT YOU:

- For Treatment. We may use PHI about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care.
- For Payment. We may use and disclose PHI, as needed, about you so the treatment and servk:es you reœive may be bilted and payment collected from you, an insurance company or a third party. For example, this may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we æcommend for you, such as making a determination of eligibility or coverage of health benefîts.
- Healthcare Operations. We may use or disclose, as needed, your PHI for our day-to-day health cara aperations to ensuæ that you and other patients receive quality care. For example, we may use or disclose PMI relating to the evaluation of patient care, business management activities, quality assessment and improvement, employee reviews, legal services, and auditing functions. Disctosures of your PHI will be limited to the minimum necessary.

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

+ **Special** Notices. We may œntact you at the address and phone number you provide (including leasing a voice message) about scheduled or a cancelled appointrnents, billing and/or payment matters.
- Required by Law. We may use or disclose your PHI when æquired to do so by federal or stats law. We must also disdose your PHI when required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with requirements under the Privacy Ru]e.
- Public **Health Risks.** We may release your health information for public health activîties. For example, disclosures related to the quality, safety or effectiveness of a product, preventîon or disease control, to coroners, mediœl examiners and funeral directors as needed to perform their duties as required by law, and organ procurement organisations for the purpose of facilitating organ, eye or tissue dona8on or transplantation.
- **Victims** of Abuse, Neglect or Violence. We may discfœe your infôrmation to a govemment authority authorized by law to receive reports of abuse, negtect or viotenœ relatîng to children or the eldeñy.
- Health Oversight **Activities.** We may disclose your PHI to health agencies authorîzed by law to conduct audits, investigations, inspections, licensure and other proceedings ælated to oversight of govemment regulatory programs.
- Judlcial and **Administraflve Proceedings.** We may disclose your fiealth information in the course of an administrative or judicial proceeding in response to a œurt order. Under most circumsÏances, when the request is made through a subpoena, a discovery request, or involves another type of administrative order, your authorîzation will be obtained before disclosure is permitted.
- Law **Enforcement.** We may disclose your PHI for law enforœment purposes.
- **Research.** Your heaïth information may be usod for research purposes in certain ôrcumstanœs with your permission, or after we receive approval from a special review board whose me/nbers review and approve the research project.
- To Avert **A Serious Threat to Health** or Safety. We may disclose your PMI when neœssary to present a serious threat to your health and safety, or the health and safety of a particular person or the general pub1ic.
- **Speciaïized Govemment** Functions. We may disclose PHI for military/veterans' afféirs, or national security and intelligence activities.
- **Worker's Compensation.** Both sate and federal law allow, without your authorization, the disclosure of your PHI that is reasonably related to a worker's oompensation injury. Thase programs may provide benefits for work-related injuries or illness.
- **Others** Involved in Your Healthcaæ. Unless you object, we may disclose to a family member, relative or close friend your PHI that directly relates to that person's involvement in your care. If you have a personal rapresentative, such as a legal guardian (or an executor or administrator of your ststate after your death), we will treat that person as if that person is you with respect to disclosures of PHI.
- Business Associates. We may disclose PHI to our business associates who perform functions on our behalf Or provide us services if the PHI is necessary for those functions or servioes. For example, we may use a billing company for billing/payment purposes. To protect your health information, we require the business associate to appropriately safeguard your information.
- Information Not Personally Identifiable. We may use PHI about you in a yyay that does not personally identify you.
- Non-Custodial Parent. We may disclose PHI about a minor equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.

USES AND DISCLOSURES THAT **REQUIRE** YOUR AUTHORIZATIOX:

jf you *do* authorize us to use and disclose your PHI for another purpose, you may revoke your authorization in writing at any time. Your decision to revoke authorization will not affect or reverse any use or disclosure that occurred before you notified us of your decision.