3474 Alaiedon Parkway
Suite #700
Okemos, MI 48864
Phone: (517)657-7790
Fax: (517)657-7793

PHYSICAL THERAPY AS IT SHOULD BE

## PATIENT INFORMATION

**Patient Name:**_____________________________________________ **Birth Date:**____/____/______
Last First MI

**Address:**______________________________ **City**__________________ **State**_______ **Zip**_______

**Phone:** (____)______-__________ Check one: Cell Home Work Other (____)______-_________ Check one: Cell Home Work Other
Primary Secondary

_____ I give permission to be contacted at the above phone numbers

**Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced **Sex:** ☐ Male ☐ Female

**Occupation:**____________________________________ **Employer:**_________________________

**E-Mail Address:**__________________________________@___________________
(For appointment reminders, updates, event notices)

**Emergency Contact:**________________________________________ **Phone:** (____)_____-________

**Referring Physician:**________________________________________ **Phone:** (____)_____-________

**Who referred you to Wertz Orthopedic Physical Therapy?**

☐ **Family/Friend** ☐ **Website** ☐ **Physician** ☐ **Returning Patient** ☐ **Other**___________

**For Minors:** ☐ **N/A**

**Name of Guarantor:** ________________________**Relation to Patient:**____________________

☐ **Information is the Same as Above** (if not, please fill in below)

**Address:**____________________________ **City**______________ **State**_______ **Zip**_______

**Phone:** (____)______-__________ **E-Mail Address:**_______________________@____________
Primary

## INSURANCE INFORMATION & AUTHORIZATION TO BILL

**Primary Insurance:**_______________________________________________________________

Subscriber Name:__________________________________ Subscriber D.O.B.:_____/_____/_____

**Secondary Insurance:** ☐ N/A (if Applicable)____________________________________________

Subscriber Name:__________________________________ Subscriber D.O.B.:_____/_____/_____

______ I hereby authorize Wertz Orthopedic Physical Therapy permission to submit claims to the above listed insurance carrier on my behalf. I further understand and agree to allow Wertz Orthopedic Physical Therapy to release medical information needed to process my claim.

For office use only:

| Co-Pay per Visit $______ | Deductible $_______<br>Deductible Remaining $________ | Auth # __________ (if Applicable) | Limitations (Visit #, ect...) | Patient Initials/Date<br>________________ |
|---|---|---|---|---|

## MEDICAL RELEASE

I authorize the following individual to receive medical information regarding myself:

____________________/____________ ____________________/____________ ____________________/____________
Name / Relationship to patient Name / Relationship to patient Name / Relationship to patient

## INFORMATION REGARDING YOUR INJURY

**Was your current condition related to any of the following?**

☐ Auto accident ☐ Work related accident ☐ Slip and fall accident

Are there any lawsuits associated with this condition? ☐ Yes ☐ No

**If applicable to any of the above, please provide the following information:**

Injury Date:____/____/______ Claim #:_______________________

Contact Person:______________________________ Contact Phone #: (____)_____-________

**Auto Claims Only: Is this a Coordinated Benefit? ☐ Yes ☐ No ☐ Not Sure**

*A Coordinated benefit is an agreement between your medical insurance and your Auto insurance whereas, even though your injuries were sustained in an auto accident, your medical coverage is to be billed first, and the remaining amount due is paid by your Auto insurance.

## TREATMENT AUTHORIZATION

______ I authorize Wertz Orthopedic Physical Therapy to treat the patient listed above. Such services may involve bodily contact including the use of hands on examination and treatment procedures that can be sensitive in nature. I understand I have the right to refuse any treatment I may not be comfortable with at any time.

## NOTICE OF PRIVACY PRACTICE

______ I acknowledge receipt of Wertz Orthopedic Physical Therapy Notice of Privacy Practice.

## FINANCIAL POLICY

Please indicate billing preference: ____ Paper Statement ____ Email Statement

______ We make every effort to verify your insurance coverage and obtain your co-pay and deductible amounts for you. However, this is not a guarantee of payment and it is your responsibility to check the information given to us regarding your insurance. You are still responsible for any payment owed to the company regardless of the information gathered here.

______ We require a 24 hour notice for all canceled appointments. ***A $35 charge may be charged to your account if you fail to comply with this policy.*** This is not payed for by your insurance.

______ We accept cash, credit card and paper checks for payments. ***There will be a $35 fee for all NSF/returned checks.***

## AUTHORIZATION/ASSIGNMENT OF BENEFITS

______ I hereby assign all medical benefits of which I am entitled to Wertz Orthopedic Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance.

## WAIVER AND RELEASE

______ I hereby release Wertz Orthopedic Physical Therapy and its employees of any and all liability, claim, damage, or loss of any kind due to my refusal to accept emergency medical services including but not limited to ambulance/urgent care services, physician services and emergent medical attention.

## PATIENT CERTIFICATION AND SIGNATURE

I certify that I understand all the above information, and that the information provided is true to the best of my knowledge

________________________________________________ _____/_____/_______
**Circle one:** Patient signature / Parent or legal guardian signature Todays Date

WERTZ ORTHOPEDIC PHYSICAL THERAPY

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**Physical Therapy As It Should Be**

Patient Name__________________________________ Age______ Height______ Weight______

Please briefly describe what problem(s) you are being evaluated and treated for today?

____________________________________________________________________________

Approximately how long ago did your present symptoms start? _________________

Was there an event that initially caused your symptoms? ☐ Yes ☐ No

If yes, please briefly describe: __________________________________________________

Which statement is the most true regarding your current condition (choose all that apply):

☐ My pain is constant      My symptoms are getting: ☐ Better ☐ Worse ☐ Not changing

☐ My pain is intermittent      ☐ My symptoms are aggravated by specific movement / position / activity

Have you received any treatment for your current condition? ☐ Yes ☐ No

If yes: ☐ **Physical Therapy** ☐ **Chiropractic** ☐ **Injection(s)** ☐ **Surgery**

☐ **Other**:____________________________________________________________

Have you had any imaging or testing for your current condition: ☐ Yes ☐ No

If yes: ☐ **X-Ray(s)** ☐ **MRI** ☐ **CT Scan** ☐ **Bone Scan** ☐ **EMG**

☐ **Other**:____________________________________________________________

Does your current condition become aggravated by work related tasks? ☐ Yes ☐ No

If yes: ☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Lifting** ☐ **Bending** ☐ **Twisting**

☐ **Other**:____________________________________________________________

Are you currently taking any medications: ☐ Yes ☐ No

If yes, please list: ________________________________________________________
You may use the back of this form if needed

________________________________________________________________________

Do you have any allergies to medications or otherwise? ☐ Yes ☐ No

If yes, please list: ________________________________________________________
You may use the back of this form if needed

________________________________________________________________________

Do you, or have you ever had the following?

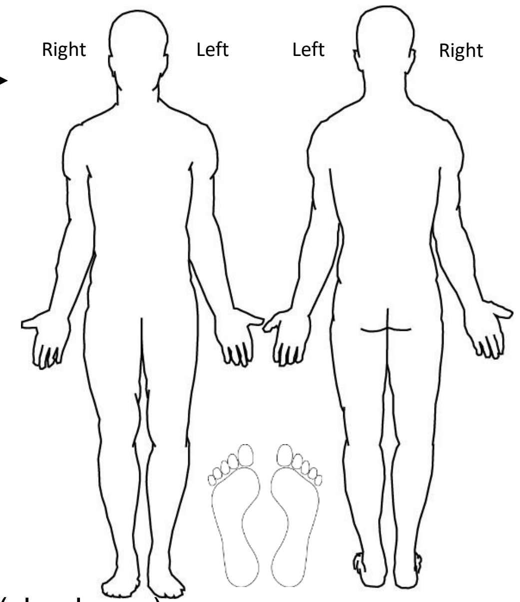
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Anemia** | Yes | No | **Hepatitis** | Yes | No | **Recent Weight Loss / Gain** | Yes | No |
| **Arthritis** (Type:____________) | Yes | No | **Hernia** | Yes | No | **Recurrent Infections** | Yes | No |
| **Asthma** | Yes | No | **High Blood Pressure** | Yes | No | **Seizures/Epilepsy** | Yes | No |
| **Cancer/Tumor** | Yes | No | **HIV/Aids** | Yes | No | **Shortness of Breath** | Yes | No |
| **Chronic Cough** | Yes | No | **Hypersensitive to Heat/Cold** | Yes | No | **Stroke** | Yes | No |
| **Deep Vein Thrombosis (DVT)** | Yes | No | **Kidney/Bladder Problems** | Yes | No | **Swelling in Ankles** | Yes | No |
| **Diabetes** | Yes | No | **Metal in Body/Surgical Implants** | Yes | No | **Thyroid Problems** | Yes | No |
| **Dizziness/Lightheaded** | Yes | No | **Nausea/Vomiting** | Yes | No | **Tuberculosis** | Yes | No |
| **Fatigue/Weakness** | Yes | No | **Numbness/Tingling** | Yes | No | **Vascular Disease** | Yes | No |
| **Fever/Chills** | Yes | No | **Osteoporosis** | Yes | No | **Anxiety** | Yes | No |
| **Head Injury/ Concussion** | Yes | No | **Pacemaker** | Yes | No | **Depression** | Yes | No |
| **Headaches** | Yes | No | **Previous Fractures** | Yes | No | **Smoking** | Yes | No |
| **Heart Disease / Heart Attack** | Yes | No | **Previous Surgeries** | Yes | No | **Substance Abuse** | Yes | No |

**Other**:_______________________________________________________________________________

**If you answered yes to any of the above questions, please explain**:______________________________________________

_______________________________________________________________________________

**On the Diagram, please indicate the location of your pain:** ⟶




Please describe your pain (check all that apply):

| | | | |
|---|---|---|---|
| Aching | Icy Coolness | Pressure | Tearing |
| Burning | Intermittent | Sharp | Tenderness |
| Crawling | Numbness | Shooting | Throbbing |
| Crushing | Piercing | Sore | Tightness |
| Heaviness | Pounding | Stabbing | Tingling |

Please rate your **CURRENT** level of pain level on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your **BEST** level of pain in the last week or so on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your **WORST** level of pain in the last week or so on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

Any additional information you feel necessary to report regarding your pain: ____________________

_______________________________________________________________________________

By signing below, I acknowledge that the above information is true to the best of my knowledge:

_______________________________________________________________ _____/_____/_______

**Circle one:** Patient signature / Parent or legal guardian signature Todays Date

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**Physical Therapy As It Should Be**

## NOTICE OF PRIVACY PRACTICES

In compliance with a newly enacted Federal Law, the **Health Insurance Portability and Accountability Act (HIPAA)**, Wertz Orthopedic Physical Therapy is informing you of your privacy rights. Please review the information below:

**What is HIPAA?** HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's **Personal Health Information** (PHI). PHI is confidential information about a patient, including demographic information.

**What are my rights under HIPAA?** Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

**You have a right to inspect and obtain a copy of your PHI.** We will respond to your request within 30 days. In most cases your request will be honored and a copy of your PHI will be mailed to you.

**You have a right to request an amendment of PHI**. If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.

**You have the right to know what disclosure(s) of your PHI have been made**. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/correctional facilities, or disclosures made prior to April 14, 2003.

**You have a right to request confidential communications of PHI.** We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.

**You have a right to request restrictions on the use and disclosure of PHI**, however we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.

**You have a right to receive a hard copy of this notice**.

**How will Wertz Orthopedic Physical Therapy Use and Disclose PHI under HIPAA?** HIPAA allows us to use and disclose your PHI for the purposes of **Treatment, Payment and Healthcare Operations**. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of **Treatment, Payment and Healthcare Operations**. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

• **Disclosure to those Involved in the Individual's Care** – when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.

• **Uses and Disclosures Required by Law** – as required by law we are required to use and disclose PHI for the following reasons:

1. Uses and Disclosure of Health Oversight Activities – we may use and release PHI to be used for audits, investigations, licensure issues, etc.
2. Disclosure for Judicial and Administrative Proceedings – we may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.
3. Disclosure for Law Enforcement Purposes – we may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
4. Uses and Disclosures Related to Decedents – we may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
5. Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations – we may use and release PHI in order to facilitate organ, eye or tissue donations.
6. Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations – we may use and release PHI in order to facilitate organ, eye or tissue donations.
7. Uses and Disclosures to Avert a Serious Threat to Health or Safety – we may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
8. Uses and Disclosures for Specialized Government Functions – we may use and release PHI for military/veterans activities and national security/intelligence activities.
9. Use and Disclosure of PHI in Emergency Situations - in the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.

- **Uses and Disclosures of PHI for Marketing Purposes** – Wertz Orthopedic Physical Therapy will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
- **Uses and Disclosures of PHI for Research Purposes** – we do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
- **Uses and Disclosures requiring the Patients Authorization** - we must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

**What does HIPAA require of Wertz Orthopedic Physical Therapy?** Wertz Orthopedic must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

**Where can I file a privacy complaint?** If you feel your privacy rights have been violated, contact Wertz Orthopedics Privacy Officer, Nathan Wertz at 517-657-7790. Or contact the regional Department of Health and Human Services at 312-886-2359 or www.hhs.gov.