VIP THERAPY - Patient Information / Medical History Form

GENERAL INFORMATION (Please enter your information in every box)

Patient Name: Telephone #: Cell #:

Social Security #: Marital Status: (circle) M S D W D.O.B.: / /

Patient Local Address: Zip:

Other Address: Zip:

Place of Employment: Work Tel #:

E-Mail Address: Primary Care Doctor:

How did you hear about our office: O Referred by physician O Family/Friend O Phone Book O Website O Newspaper Ad O Sign Outside

What is the problem that brings you to therapy?

Is your condition due to: O Auto Accident O Fall O Work Injury O Other: _____

When did your problem start? / / Recent flare up? O Yes O No

What goal(s) would you like to achieve?

Height : **Weight:**

MEDICAL / SURGICAL HISTORY

	Yes	No	Comments		Yes	No	Comments
Asthma				**Intestinal Trauma**			
Arthritis				**Joint Replacement**			
Bladder Control				**Kidney/Urinary**			
Cancer				**Osteoporosis**			
Circulation/Vascular				**Pregnancy**			
Depression				**Pacemaker**			
Diabetes			**Type:**	**Psychiatric History**			
Dizziness				**Respiratory (COPD)**			
Epilepsy/Seizures				**Skin Problems**			
Headaches				**Stroke**			
Heart Disease				**Tuberculosis**			
Hypertension (HBP)				**Other**			
Hypotension (LBP)				**Other**			

Have you had any falls in the last two years? O No O Yes

Major surgical procedures within the last 60 day's: O No O Yes:

Have you received home health since your surgery / injury? O No O Yes:

If yes, have you been discharged from home health? O No O Yes: O Not Sure:

Signature: Date: / /

CONSENT FOR TREATMENT
VIP Therapy

I, (Patient's name)_____, at the recommendation of my primary or another referring physician, hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed at **VIP THERAPY** I hereby assign all medical benefits to be paid directly to **VIP THERAPY**.

I understand that **VIP THERAPY** requires payment at the time of service for office visits, and that **VIP THERAPY** will submit charges for services to my insurance company unless I make other arrangements. In consideration for this convenience to me, I am aware that **VIP THERAPY** expects payment of my balance within 7–10 days of receiving a statement.

I acknowledge responsibility for all charges incurred regardless of payment by my insurance company for which **VIP THERAPY** has signed a contract with as a participating provider. Any charges not paid by my insurance company will become my responsibility within 60 days.

X_____ _____

Patient or Guardian's SIGNATURE **Date**

_____ _____

Parent/Guardian's PRINTED NAME (if patient under 18) **Social Security Number**

PREVIOUS PHYSICAL THERAPY QUESTIONNAIRE

1. Has patient had physical or speech therapy during this calendar year? □YES □NO
   If yes, list dates of your previous physical therapy: _____

2. Approximately how many times did you attend? _____

3. Did you receive home health care recently? □YES □NO
   If yes, when were you discharged from home health? _____

4. Please list the name and telephone number of the home health agency:
   _____

X_____ _____

SIGNATURE **DATE**

PATIENT FINANCIAL RESPONSIBILITY

VIP Therapy

FINANCIAL RESPONSIBILITY

Please read and place initials by each statement below:

____ I understand that I am financially responsible for my primary and/or secondary health insurance plan **deductibles, co-insurance amount, or any non-covered services.** Co-payments are due at time of service. **In the event my** primary health plan and/or supplemental/secondary insurance plan **does not cover any services rendered to me**, I will be responsible for all charges and agree to pay the costs of all such services provided. I understand that **VIP THERAPY** requires payment at the time of service for office visits. I am aware that **VIP THERAPY** will submit charges for services to my insurance unless I make other arrangements. I am also aware that **VIP THERAPY** expects payment of my balance within 7 – 10 days after receiving a statement.

ASSIGNMENT OF BENEFITS

____ I hereby assign all medical benefits to be paid directly to **VIP THERAPY** for any and all outpatient rehabilitation services provided to me. I understand that I am financially responsible for any and all charges not covered by this assignment.

MEDICARE REQUEST FOR PAYMENT

____ I request payment of authorized **Medicare benefits directly to VIP THERAPY** on my behalf for all services rendered to me by **VIP THERAPY.** I authorize any holder of medical or other information about me, to release to Medicare and its agents, any information needed to determine these benefits or benefits for related services.

RELEASE OF INFORMATION

____ I hereby authorize my insurance company and/or the Social Security Administration to disclose information regarding my insurance, or Medicare coverage, including but not limited to verification of benefits, effective dates, and type of coverage. I also request payment of benefits directly to **VIP THERAPY. VIP THERAPY** may release all or any part of the patient's record to any corporation or person which is or may be liable, under a contract, to **VIP THERAPY**, to the patient, to the family member, or to the employer of the patient for all or part of **VIP THERAPY's charges.**

RELEASE OF RECORDS

____ I hereby authorize the physician(s), hospital(s), employer/company, or other persons to whom a signed photocopy of this authorization is delivered to, to furnish any information, reports, or copies of records which may be requested by **VIP THERAPY.** I authorize **VIP THERAPY** to send reports to my physicians, attorney, and/or employer relating to my treatment at this office as specified below:

NAME	ADDRESS: City, State, Zip	PHONE #

_____ _____

PATIENT'S Signature **DATE**

_____/_____ _____

Agent's Signature in lieu of patient/Relationship to patient **Parent/Guardian's Signature** *if patient is under 18*

RELEASE & WAIVER OF LIABILITY

VIP Therapy

STATEMENT OF AWARENESS:

Physical therapy is the treatment of disease, injury or deformity by physical methods such as exercise, massage, and heat treatment rather than by surgery or drugs, to promote restoration of movement, increase joint mobility, relieve pain and increase circulation and overall physical function. At the recommendation of your physician, **VIP THERAPY** will provide treatment that utilizes specific therapeutic exercises such as **walking, jogging, weight lifting, balancing, the use of heat therapy, exercise equipment, electrotherapy, massage, patient education/training, and other activities** used for the purpose of providing a positive outcome for our patients. Some of these activities involve quick movements, change of direction, strenuous exertions using various muscle groups, or sustained physical activity which may pose inherent risks. Such risks include, but are not limited to: **minor injuries such as bruises, sprains, scratches, pain, soreness, stiffness and catastrophic injuries including paralysis or death.** In addition, all procedures and exercises will be thoroughly explained to you before you are asked to perform them. Patient is strongly encouraged to ask questions prior to performing any exercise procedures or therapy.

ASSUMPTION OF RISK:

Patient or his/her guardian or representative(s) understand that medical clearance from patient's physician is recommended prior to beginning any physical therapy program at **VIP THERAPY,** and that consultation with patient's physician to gain clearance to begin a rehabilitation program is Patient's (or his/her guardian or representative's) responsibility. Your therapist will take every precaution necessary to ensure that your safety is protected from any potentially hazardous situation. However, because you will be asked to exert effort to perform activities with increasing levels of difficulty, there is a potential that you could experience an increase in your level or pain or discomfort or an exacerbation (worsening) of a previously existing or current injury or condition. I understand I can request to stop treatment if I feel discomfort or pain and will never be forced to perform any procedure that I am not comfortable performing.

WAIVER OF LIABILITY:

Patient or his/her guardian or representative(s) hereby release **VIP THERAPY and its owners, directors, managers, employees, volunteers, interns, independent contractors, and agents** from all covenants, and agree not to sue for any and all claims arising from direct, indirect, consequential, incidental, or exemplary damages resulting

RELEASE & WAIVER OF LIABILITY

VIP Therapy

in injury or death. These potential circumstances may include but are not limited to: loss of livelihood, pain and suffering, emotional distress, loss of enjoyment, loss of profits, loss of future earnings, use and/or any other damages or intangible losses and any and all economic loss caused by or which may result from my use of the services of **VIP THERAPY**, and whether or not such injury or death was directly caused by **VIP THERAPY,** another participant, or any other person or cause. This agreement will apply in each in every instance in which I use the services of **VIP THERAPY** without requiring me to sign any additional form for each day, or use of said services.

INDEMNIFICATION & HOLD HARMLESS STATEMENT:

Patient or patient's guardian or representative(s) fully understands and acknowledges the terms outlined herein and further agrees to hold harmless and indemnify **VIP THERAPY** from any and all claims resulting from negligence and to reimburse any expenses incurred by **VIP THERAPY** in the process of investigating and defending a claim or suit especially if Patient or his/her guardian or representative's claim is withdrawn, or if a court arbitration determines that **VIP THERAPY** is not responsible for the injury or loss.

ACKNOWLEDGEMENT

Patient or his/her guardian or representative(s) has/have read this RELEASE & WAIVER OF LIABILITY and fully understands and acknowledges its terms and further understands he/she is participating in these sessions at their own risk and will not hold those named above responsible for any injury or exacerbation of previously existing conditions.

_____ _____

Patient Signature **Today's Date**

_____ _____

Parent/Legal Guardian Signature **Parent/Guardian Printed Name**
(If patient is under the age of 18)

PATIENT PRIVACY &
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT ("HIPAA")
VIP Therapy

The Health Insurance Portability & Accountability Act ("HIPAA") is a 1996 Federal law that restricts access to patients' private medical information and keeps it safe. **VIP THERAPY** believes all patients have the right to privacy and that all non-public, personal, financial and health information about you should be kept confidential. Our belief in your right to privacy is not new; however, HIPAA laws require that we notify you about our privacy policy. Our goal is to have all our patients trust that their medical records and other confidential information will remain private.

How do we use your personal information? As our patient, we create medical records about your health. These records include personal, clinical and accounting information. Here are some examples of how we will use your information:

- For medical treatment;
- To obtain payment for our services (i.e. to file your healthcare claims with your insurance company);
- For emergency situations;
- For appointment and patient recall reminders;
- To run our practice more efficiently;
- To ensure all our patients receive quality care;
- For research purposes;
- To avert serious threat to health or safety;
- For worker's compensation programs;
- In response to certain requests arising out of law suits or other disputes.

How do we protect your personal information? We are committed to protecting the information about you. We establish confidentiality agreements with our staff and contracted parties and we restrict access to your personal information on a need-to-know basis. **Please answer the questions below to help us protect your privacy:**

1. Please list **any family members or other persons if any, whom we may inform about your general medical condition and your diagnosis including treatment, payment and health care procedures** (*please do not list your doctors*)
   Name/Relationship:_____ Phone #:_____
   Name/Relationship:_____ Phone #:_____
   Name/Relationship:_____ Phone #:_____
   Name/Relationship:_____ Phone #:_____

2. Can confidential messages (i.e. appointment reminders) be left on your answering machine?
   □ YES □ NO □ Not Applicable
   If yes, what telephone number can we leave messages at? Phone #:_____

*****PLEASE NOTE THAT WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED IN #1 ABOVE*****

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the **Health Insurance Portability & Accountability Act ("HIPAA")** and associated Federal and State regulations, I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your **Notice of Privacy Practices ("NOPP")**. I note that NOPP is on display in the office lobby and is also available on our website. I also understand that **VIP THERAPY** has the right to change the **Notice of Privacy Practices** and that I may contact the practice at any time to obtain a current copy.

_____ _____
PATIENT/GUARDIAN SIGNATURE **Relationship to Patient (if other than patient)**

_____
DATE

CANCELLATION & NO-SHOW POLICY

VIP Therapy

Below are the policies of **VIP THERAPY** regarding cancellations and no-shows:

Please read and initial each statement below:

____ **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 which will ensure you complete the full number of prescribed treatments that week, whenever possible.

____ **There will be a $30 charge for cancellations without proper notice.** This charge will not be covered by your insurance, but will have to be paid by you personally.

____ For worker's compensation and personal injury patients: documentation of any missed appointments is forwarded to your Case Manager and Primary Physician which could jeopardize your claim.

____ You may be required to see a therapist other than the one who normally treats you, if you fail to reschedule your missed appointment. All of the therapists at **VIP THERAPY** are experienced professionals.

_____ _____

PATIENT'S SIGNATURE **DATE**

_____

PARENT/GUARDIAN'S SIGNATURE ***(if patient under 18)***

MEDICATION LIST

VIP Therapy

-Please list any current medication- frequency & dosage.

PLEASE PRINT CLEARLY!

Medication Name:	**Frequency:**	**Dosage:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies: (Please list any known drug allergies) _____

_____

_____

_____