HANDS ON PHYSICAL THERAPY — NEW PATIENT FORM

Circle Location: Fuquay Varina Cary Clayton Zebulon

PLEASE PRINT CLEARLY

DATE: _____

Name (First) _____ (Last) _____ (M.I.) ____

Home Address _____

Email Address _____ Marital Status: M S W D

City _____ State _____ Zip _____

Home Phone (____)_____ Work (____)_____ Cell (____)_____

Social Security _____ DOB _____ Age _____ Sex: M / F

Employer _____ Occupation _____

Employer Address _____

Emergency Contact _____ Telephone # _____

Reason for your visit _____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____ Injury Date _____

Referring Physician _____ Telephone # _____

Referring Dr. Address _____

Attorney Involved Yes / No Attorney Name_____

Address_____ Telephone_____

Primary Insurance _____

I.D. #_____ Group #_____

Subscriber Name _____ Social Sec. #_____ DOB_____

Secondary Insurance _____

I.D. #_____ Group #_____

Subscriber Name _____ Social Sec. #_____ DOB_____

HANDS ON PHYSICAL THERAPY

MEDICAL HISTORY

Pain: Please rate your pain from 0-10. 0= No Pain and 10=Worst Pain: _____

Please mark the following if you have had:

_____ Angina

_____ Heart Attacks

_____ Stroke

_____ Heart Surgery

_____ Tumors

_____ Diabetes

_____ Epilepsy

_____ Arthritis

_____ Lung Disease

_____ Osteoporosis

_____ Neck Injuries

_____ Back Injuries

_____ Fractures

_____ Circulatory Problems

_____ Heart Disease

_____ Cancer

_____ High Blood Pressure

Check the following boxes if you have recently experienced:

_____ Headache

_____ Falls

_____ Difficulty sleeping

_____ Pain with coughing or Sneezing

_____ Muscular pain at rest

_____ Unexplained weight loss

_____ Tingling, numbness or loss of feeling

_____ Constant pain even at rest

_____ Muscular pain with activity

_____ Change in bowel and bladder habits

_____ Shortness of breath
_____ Balance Problems

_____ Dizziness

_____ Unusual Weakness

Please list any major surgeries and hospitalizations:

---------- **Date:**

---------- **Date:**

_____ **Date:**

Do you smoke? Yes/No _____ **Are You Pregnant? Yes/No** _____

Have you had Physical Therapy in the past? _____ **What were you treated for?**
_____

Please mark if the following diagnostic tests have been performed:

------ X-RAYS DATE:_____ RESULTS:_____
_____

_____ MRI DATE:_____ RESULTS:_____
_____

_____ EMG/NCV DATE:_____ RESULTS:_____

Is your problem due to an injury/work related/motor vehicle accident/or other PLEASE DESCRIBE YOUR PROBLEM.

Please check the following that best describes your current pain:

_____ Constant
_____ Intermittent
_____ Pain in the morning
_____ Worsening
_____ Improving

_____ Night pain
_____ Stiffness
_____ Dull/achey
_____ Sharp Pain
_____ Burning Pain

Pain is aggravated by:_____
Pain is relieved by:_____

HANDS ON PHYSICAL THERAPY OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Hands On Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

Parent / Guardian Signature _____ **Date** _____

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by an examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for **Hands On Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Hands On Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Medicare Members: Hands On Physical Therapy is a Medicare provider. The member is responsible for co-payments and any non-covered services or supplies deemed necessary by the physical therapist for your treatment.

WORKERS' COMPENSATION CLAIMS: All workman's compensation claims must be verified in writing by the employer. If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION & NO-SHOW POLICY: **Hands On Physical Therapy** requires 24 hours notice in the event of a cancellation. The charge for canceling an appointment without proper notice or no showing is $50. This charge is solely the patient's responsibility and will not be covered by insurance.
Absences: Three absences for any reason will result in immediate discharge from the program. (Cancellations made within 24 hours of your appointment are not considered an absence.) Discharge due to multiple absences will be reported to the referring physician and/or insurance adjuster, which may result in a loss of Worker's Compensation benefits.

FINANCIAL POLICY: If you have health insurance, we will help you receive maximum benefits. Hands On Physical Therapy will be glad to file claims to your insurance company provided we are in-network with them. The patient is responsible for paying the individual co-payment/deductible at the time services are rendered.
If have no insurance, you are expected to pay in-full at the time services are rendered.

Hands On Physical Therapy is committed to providing you the best possible care and we will be happy to discuss our professional fees with you at any time.

I have read the above policies and understand my responsibility for payment of my account.

_____ _____

Patient/ Responsible Party Signature **Date**

NOTICE OF PRIVACY PRACTICES

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

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect & Copy: To inspect and receive a copy of your medical information, you must submit your request in writing. We have the option to deny your request, in limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial reviewed. **Your Right to Amend:** I you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request. Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient/Legal Guardian Signature _____ **Date** _____

HANDS ON PHYSICAL THERAPY

□ 1439 N. Main Street
Fuquay-Varina, NC 27526
(919)557-2111 FAX (919) 557-5543

□ 530 West Gannon Ave.
Wedgewood Shopping Center
Zebulon, NC 27597
(919)269-0107 FAX (919)269-0207

□ 21-105 Anna Place
Clayton, NC 27520
(919)359-2222 FAX (919)359-2922

□ 590 New Waverly Place #220
Cary, NC 27518
(919)851-0711 FAX (919)851-4848

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Hands On Physical Therapy's Notice of Information Practices. I understand that Hands On Physical Therapy may use or disclose my personal health information for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Hands On Physical Therapy will consider for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Hands On Physical Therapy's Notice of Information Practices. In addition, I hereby consent to my image being recorded by video and/or camera for administrative & security purposes. Such recorded images will be kept in accordance with pertinent HIPPA regulations.

_____
Patient Name (please print)

_____
Signature

_____
Date of Birth

_____
Date

Hands On Physical Therapy

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare will not pay.

- Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision, you should read this entire notice carefully.
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (Estimated Cost: $ 10.00).

Medicare will not pay for: Electrode STIM PADS (DURABLE MEDICAL EQUIPMENT)

☐ 1. Because it does not meet the definition of any Medicare benefit.

☐ 2. Because of the following exclusion * from Medicare benefits:

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

* This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

Hands On Physical Therapy
590 New Waverly Place Ste. 220
Cary, NC 27518
(919) 851-0711

PATIENT SIGNATURE DATE

This notice explaining exclusions from Medicare benefits is published by the Centers for Medicare & Medicaid Services.