Atlantis Physical Therapy Group, Inc.

Personalized Fitness Solutions to Enhance People's Lives

62 Warren Street, Roxbury, MA 02119

Tele: 617.442.0111 Fax: 617.516.8491

www.atlantisphysicaltherapy.com

HEALTH INTAKE FORM

BASIC PATIENT INFORMATION/INFORMACION DEL PACIENTE

First Name/Nombre: _____Last Name/Apellido: _____ **M / F**

Address/Direccion: _____

City/Cuidad: _____ State/Estado: _____ Zip: _____

Home Phone:_____ Cell Phone/Celular: _____

Date of Birth/Fecha de nacimiento: _____ SSN/Fecha de Seguro Social: _____

Email: _____

HEALTH INSURANCE INFORMATON/INFORMACION DE SEGURO MEDICO

Do you have Health Insurance? Tiene usted seguro medico? **YES** **NO** (circle one)

Name of Health Insurance Carrier/Nombre de seguro:_____

Member I.D. Number/No. de tarjeta:_____

Name of your primary care hospital/Nombre del hospital: _____

Date of visit/Fecha de la cita: _____

Primary care physician/ Doctor de cabecera:_____

What are your major complaints/Cuales son sus quejas principales: _____

_____

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all money will be credited to my account upon receipt.

Patient's Name/Nombre: _____ Date/Fecha: _____

Patient's Signature/Firma: _____

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MEDICAL HISTORY/HISTORIAL MEDICO

EXISTING OR RELEVANT PREVIOUS CONDITIONS/CONDICIONES PREVIAS EXISTENTES O RELEVANTES

Allergies/Alergias	○ Yes	○ No	Dizzy Spells/Mareos	○ Yes	○ No	MRSA	○ Yes	○ No
Anemia	○ Yes	○ No	Emphysema/Bronchitis Enfisema/Bronquitis	○ Yes	○ No	Multiple Sclerosis Esclerosis multiple	○ Yes	○ No
Anxiety/Ansiedad	○ Yes	○ No	Fibromyalgia Fibromialgia	○ Yes	○ No	Muscular Decease Enfermedad muscular	○ Yes	○ No
Arthritis/Artritis	○ Yes	○ No	Fractures/Fracturas	○ Yes	○ No	Osteoporosis	○ Yes	○ No
Asthma/Asma	○ Yes	○ No	Gallbladder Problems Problemas de la vesicula biliar	○ Yes	○ No	Parkinson's	○ Yes	○ No
Autoimmune Disorder Desorden autoinmune	○ Yes	○ No	Headaches/Dolores de cabeza	○ Yes	○ No	Rheumatoid Arthritis Artritis Reumatoide	○ Yes	○ No
Cancer	○ Yes	○ No	Hearing Implants La discapacidad auditiva	○ Yes	○ No	Seizures/Convulsiones	○ Yes	○ No
Cardiac Conditions Condiciones cardiacas	○ Yes	○ No	Hepatitis	○ Yes	○ No	Smoking/De fumar	○ Yes	○ No
Cardiac Pacemaker Marcapasos cardiaco	○ Yes	○ No	High Cholesterol Colesterol Alto	○ Yes	○ No	Speech Problems Problemas del habla	○ Yes	○ No
Chemical Dependency Dependencia quimica	○ Yes	○ No	High/Low Blood Pressure Presion arterial alta/baja	○ Yes	○ No	Strokes/Golpes	○ Yes	○ No
Circulation Problems Problemas de circulacion	○ Yes	○ No	HIV/AIDS VIH/SIDA	○ Yes	○ No	Thyroid Disease Enfermedad de tiroides	○ Yes	○ No
Currently Pregnant Actualmente embrazada	○ Yes	○ No	Incontinence Incontinencia	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Depression/Depresion	○ Yes	○ No	Kidney Problems Problemas de rinon	○ Yes	○ No	Vision Problems Problemas de la vista	○ Yes	○ No
Diabetes/Diabetes	○ Yes	○ No	Metal Implants Implantes de metal	○ Yes	○ No			

DESCRIBE ANY OTHER CONDITIONS/DESCRIBA CUALQUIER OTRA CONDICION:

If "Yes" to any of the above, please explain and give approximate dates. Describe any other conditions.

Si responde "Yes" a cualquiera de las opciones anteriores, explique y proporcione fechas aproximadas.

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MEDICAL PRECAUTIONS/PRECAUCIONES MEDICAS:

____

____

____

____

FALLS HISTORY/HISTORIA DE OTONO:

Injury as a result of a fall in the past year? Lesion como resultado de una caida en el ano pasado ○ Yes ○ No

Two or more falls in the last year? Dos o mas caidas en el ultimo ano? ○ Yes ○ No

Patient at risk of falls? Paciente en riesgo de caidas? ○ Yes ○ No

SURGICAL HISTORY/HISTORIA QUIRURGICA

Body Region Region del cuerpo:		Surgery Type Tipo de cirugia:		Date Fecha:	
Body Region Region del cuerpo:		Surgery Type Tipo de cirugia:		Date Fecha:	
Body Region Region del cuerpo:		Surgery Type Tipo de cirugia:		Date Fecha:	
Body Region Region del cuerpo:		Surgery Type Tipo de cirugia:		Date Fecha:	
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CURRENT MEDICATIONS/MEDICAMENTOS ACTUALES

Are you currently taking any medications? Estas tomando medicamentos? **YES** or **NO**
If **YES**, provide information about the medications you're taking below or bring your medications list.
Si **YES** indique la enformacion de los medicamentos en la parte vaja.

Drug/Droga: Dosage: Frequency: Route:

Reason for taking/Toma de la razon:

Drug/Droga: Dosage: Frequency: Route:

Reason for taking/Toma de la razon:

Drug/Droga: Dosage: Frequency: Route:

Reason for taking/Toma de la razon:

Drug/Droga: Dosage: Frequency: Route:

Reason for taking/Toma de la razon:

Patient's Signature/Firma: _____ **Date/Fecha:** _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: ATLANTIS PHYSICAL THERAPY GROUP, INC.

Address: 62 WARREN STREET

City: ROXBURY State: MA Zip Code: 02119

This request and authorization applies to:

- ○ Healthcare information relating to the following treatment, condition, or dates: _____

  _____
- ○ All healthcare information
- ○ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ∅ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ∅ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient's signature: _____ **Date Signed:** _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

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PATIENT BILLING ACKNOWLEDGEMENT FORM

Under your health plan, **you are financially responsible for co-payments, co-insurance or deductibles for covered services.** You are also financially responsible for all non-covered services as well as services that exceeded your benefit limit as defined by your health plan.

INSURANCE TYPE (if more than one type, indicate primary and secondary)

○ Aetna ○ Medicare ○ BCBS ○ Cigna ○ Mass Health ○ AllWays ○ Harvard ○ Tufts

○ United Health Care ○ Network Health ○ BMC Health Net ○ Self Pay ○ Other _____

I've had _____ **PT** _____ **OT** visits already this year (same/different body part?)_____

The following is a good-faith estimate of insurance coverage for physical therapy services. It is your responsibility to verify your insurance coverage and eligibility requirements of your particular insurance plan.

○ 100% coverage ○ _____% insurance coverage, _____% patient responsibility

○ $ _____ co-payment per visit ○ $ _____ deductible, $ _____ remaining ○ No coverage

○ $ _____ estimated co-insurance per visit

○ Other/Comments: _____

FINANCIAL ACKNOWLEDGEMENT

I, the undersigned:

- ○ Agree, that I am financially responsible for all services rendered to me (or to the patient, if different) by Atlantis PT Group;
- ○ Agree that I am personally responsible for all co-payments, deductibles, and any non-covered services or items (such as e-stim pads, tubing, iontophoresis pads) for the insurances for which Atlantis PT Group accepts assignment;
- ○ Agree to pay a $25 fee to Atlantis PT for any returned check (in addition to any fees my bank may charge me);
- ○ Agree to pay $35 per instance, prior to any subsequent treatments, for no-shows and same day cancellations;
- ○ Understand the importance of attending my PT sessions on time and as scheduled and that no-show and cancelled visits may prevent other patients from scheduling in that slot to obtain their needed care. I will make every possible effort to attend visits as scheduled, cal in a timely manner to reschedule visits should a problem arise, and give 24 hr notice whenever possible should I have to cancel a visit;
- ○ Agree to pay all attorney's fees/collection costs to the extent allowed by law for any delinquent account balance;
- ○ Authorize payment of medical insurance benefits directly to Atlantis PT Group;

Signed _____ **Date _____**

RELEASE OF INFORMATION

I hereby authorize the referring and/or primary care physician, insurance carrier, or the carrier's specified agent/representative to receive the necessary information pertaining as requested to expedite claim payment and/or further authorization for treatment.

Signed _____ **Date _____**

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Our mission here at Atlantis Physical Therapy Group is to provide you with personalized rehabilitation services. When you make an appointment, we reserve significant amount of time specifically for your treatment. Therefore, should you be unable to keep an appointment, we respectfully request that **you cancel or reschedule no later than 24 hours in advance.**

If you do not cancel by the deadline, you will be assessed a missed appointment fee. This fee is not covered by insurance carriers or Medicare and will be you responsibility to pay at the time of your next visit. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated as we institute this new policy.

I _____ understand that if I fail to appear and/or fail to reschedule any appointments within 24 hrs I will be charged a NO SHOW CANCELLATION FEE ($0 first no show, 10$ second no show, 20$ third no show). I also understand that no services will be rendered until the fee has been completely paid in full.

Patient's signature: _____ **Date:** _____

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HIPAA 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 READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including your demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. Uses and Disclosure of Protected Health Information

Uses and Disclosure of Protected Health Information
Your protected health care information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health care information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health care information, as necessary, to a home health agency that provides are for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training or medical students, licensing, and conducting or arranging for the other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse of Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcements: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print name: _____ **Signature:** _____ **Date:** _____