DECATUR HAND & PHYSICAL THERAPY SPECIALISTS PATIENT DATA SHEET

DO NOT EMAIL The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home:	☐	
Work:	☐	
Cell:	☐	

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Preferred language: **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: ____________________ **Occupation:** ____________________

Address: ____

____

Phone: ____________________

Employer: ____________________ **Occupation:** ____________________

Address: ____

____

Phone: ____________________

INSURANCE INFORMATION

Primary Insurance: ____________________

Policy Holder's Name: ____________________ **Holder's Birth Date:** ____________________

Policy or Certificate #: ____________________ **Group #:** ____________________

Policy Holder's Employer: ____________________

Secondary Insurance: ____________________

Policy Holder's Name: ____________________ **Holder's Birth Date:** ____________________

Policy or Certificate #: ____________________ **Group #:** ____________________

Policy Holder's Employer: ____________________

How did you hear about us?

- [ ] Physician
- [ ] Employer
- [ ] Case Manager
- [ ] Former Patient
- [ ] Adjustor
- [ ] School
- [ ] Hospital
- [ ] Cross Referral
- [ ] Friend - Word of Mouth
- [ ] Attorney
- [ ] Self
- [ ] Screens - Open Houses
- [ ] Marketing Ad - Print
- [ ] Marketing Ad - TV
- [ ] Marketing Ad - Billboard
- [ ] Marketing Ad - Direct Mail - Email
- [ ] Marketing Ad - Facebook
- [ ] Marketing Ad - Other ________________

Specify if other : ____________________________________

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name ____________________ Relationship ____________________

Name ____________________ Relationship ____________________

Signature of Patient ______________________________ **Date** ____________

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT
I consent to rehabilitation and related services at:
DECATUR HAND & PHYSICAL THERAPY SPECIALISTS
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**__________

TREATMENT OF MINORS
I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:**__________

LIABILITY
I know and agree that: DECATUR HAND & PHYSICAL THERAPY SPECIALISTS is not responsible for loss or damage to personal valuables. Initials:__________

WAIVER AND RELEASE
I hereby release, discharge and acquit: DECATUR HAND & PHYSICAL THERAPY SPECIALISTS its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: __________

AUTHORIZATION OF PAYMENT
I hereby assign all benefits directly to: DECATUR HAND & PHYSICAL THERAPY SPECIALISTS. I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.
Initials:__________

FINANCIAL POLICY
I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
To assist in establishing your account, please:
- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:**__________

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS
I acknowledge receipt of Notice of Privacy Practices. **Initials:**__________
I acknowledge receipt of the Statement of Patient Rights. **Initials:**__________

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature____________________ Witness Signature ____________________

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of DECATUR HAND & PHYSICAL THERAPY SPECIALISTS. This form must be completed in its entirety and must be provided to DECATUR HAND & PHYSICAL THERAPY SPECIALISTS prior to initiation of therapy services.

DECATUR HAND & PHYSICAL THERAPY SPECIALISTS MEDICAL HISTORY FORM

PATIENT NAME: ________________________ TODAY'S DATE: ________________
REFERRING PHYSICIAN'S NAME: ________________ DATE OF INJURY OR ONSET: __________
PRIMARY CARE PHYSICIAN'S NAME: ________________ ARE YOU PRESENTLY WORKING? Y ES NO
CAUSE OF INJURY OR ONSET: ________________ DATE OF NEXT MD APPT: ____________

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: ____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: ______________

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: ________

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO ____________

WHAT IS YOUR REASON FOR ATTENDING THERAPY: ______________________________

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. ____
2. ____
3. ____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. ____
2. ____
3. ____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? ______ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN____________
AND WHY____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? ____

CURRENT MEDICATIONS: ____
____

ALLERGIES: Medication __________Reaction____________ Other ____________Reaction________________
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction__________________
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction______________________

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ CANCER
- ☐ CARDIOVASCULAR PROBLEMS
- ☐ HOLTER MONITOR - currently wearing?
  - ☐ PACEMAKER
  - ☐ HIGH BLOOD PRESSURE ☐ controlled ☐ uncontrolled
- ☐ LOW BLOOD PRESSURE
- ☐ CURRENTLY PREGNANT
- ☐ DIABETES ☐controlled ☐uncontrolled
- ☐ DEPRESSION
- ☐ DIZZINESS/FAINTING
- ☐ FRACTURES
- ☐ HEADACHES
- ☐ HEPATITIS/HIV
- ☐ KIDNEY PROBLEMS
- ☐ MRSA (Methicillin Resistant Staphylococcus Aureus)
- ☐ OSTEOPOROSIS
- ☐ RESPIRATORY PROBLEMS
  - ☐ ASTHMA ☐ controlled ☐ uncontrolled
  - ☐ COPD ☐ controlled ☐ uncontrolled
  - ☐ Other
- ☐ SEIZURES ☐ controlled ☐ uncontrolled
- ☐ THYROID PROBLEMS
- ☐ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: ____

☐ ANY OTHER MEDICAL PROBLEMS: ____

SIGNATURE OF PATIENT: ________________ REVIEWED BY Therapist: ____________Date__________

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CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE

I, ______________________________________, hereby consent to allow DECATUR HAND & PHYSICAL THERAPY SPECIALISTS and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

____ _________________________

Participant Name Date

____

Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, __________________________________, hereby consent and authorize DECATUR HAND & PHYSICAL THERAPY SPECIALISTS and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

____ _____________________

Participant Name Date

____

Parent/Legal Guardian (If Participant is a Minor)

APPOINTMENT AND CANCELLATION POLICY

At **Decatur Hand & Physical Therapy Specialists**, our goal is to provide quality Physical and Occupational therapy care in a timely manner. We have implemented an appointment/cancellation policy which enables us to better utilize available appointments for our patients in need of care.

We understand that everyone is busy and it is easy to forget appointments. As a courteous to you, our automated call system will call you 48 hours prior to your appointment for confirmation. If you do not confirm then a text message or another call will be made 24 hr prior to your appointment. Please let us know your preference(s) of how to contact you.

___ Cell Phone: ( )______________________
___ Home Phone ( ) ______________________
___ Text ( ) ______________________________
____ Email _________________________________

Cancellation Policy

Please be courteous and call Decatur Hand & Physical Therapy Specialists promptly if you are unable to attend an appointment or are going to be more than 15 min late for your appointment. Available appointments are in high demand and your early cancellation will give another person the possibility to have **access** to timely care.
If it is necessary to cancel your scheduled appointment, we require that you give **at least 24 hours notice.**

The patient will be charged a **$40.00 cancellation fee** if the cancellation is less than 24 hours OR if the patient "**No Shows"** for a scheduled appointment. Since things sometimes happens beyond our control, we will waive the fee on the first occurrence. **Initial________________**

When you miss a scheduled therapy appointment, or if you cancel it **less than 24 hours**, we consider it as "**no show**". Missing more than 2 scheduled appointments without advance notice may result in scheduling your future appointments on a day to day to basis or being discharged from our care.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that I agree by these guidelines

_______________________________________ ________________
Patient Signature Date