

Franklin Physical Therapy Medical History Intake

Family and Personal History

Date: _____

Name: _____ DOB: _____ Age: _____

Diagnosis: _____

Past Medical History

Please check if either you or an immediate family member have ever been told you suffer from any of the following? (Please check all that apply).

	<u>Patient</u>		<u>Family</u>			<u>Patient</u>		<u>Family</u>	
	Yes	No	Yes	No		Yes	No	Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

	<u>Patient</u>		<u>Family</u>			<u>Patient</u>		<u>Family</u>	
	Yes	No	Yes	No		Yes	No	Yes	No
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/ Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis/ Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

	<u>Patient</u>		<u>Family</u>			<u>Patient</u>		<u>Family</u>	
	Yes	No	Yes	No		Yes	No	Yes	No
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Alcohol/drugs)				
Ulcers/Stomach Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

	<u>Patient</u>		<u>Family</u>			<u>Patient</u>		<u>Family</u>	
	Yes	No	Yes	No		Yes	No	Yes	No
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia/Myofacial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain. _____

Are there any other medical conditions we should know about? Yes No

If yes, please list and explain. _____

Franklin Physical Therapy

General Health

No Yes

1. Are you taking any prescription or over the counter medications (including supplements)? If yes, please list. _____		
2. Have you had any illnesses within the last 3 weeks? (e.g. colds, influenza, bladder/kidney infection)		
3. Have you had an unexplained weight loss or gain in the last month?		
4. Are you pregnant?		
5. Do you smoke or chew tobacco? If yes, how many packs a day? _____ For how many years? _____		
6. Do you have any urine leaking? (e.g. with coughing, sneezing, or exercising)		
7. How much caffeine do you consume daily? (e.g. coffee, tea, soda pop, or chocolate) ____ # of drinks		

Work Environment

Occupation: _____

Does your job involve:

- Prolonged sitting (e.g. desk, computer, driving)
- Prolonged standing (e.g. equipment operator, sales clerk)
- Prolonged walking (e.g. delivery service)
- Use of small or large equipment (e.g. telephone typewriter, cash register, forklift, drill press)
- Lifting, twisting, bending, climbing, turning
- Exposure to chemicals, pesticides, toxins, or gases
- Other: please describe: _____

Do you use any of the following?

- Back cushion, neck cushion
- Back brace or corset
- Other kind of brace or support for any body part (please list: _____)

History of Falls *please check all that apply*

- I have had no falls
- I have just started to lose my balance/fall
- I fall occasionally
- I fall frequently (more than twice during the past 6 months)
- Certain factors make me cautious (e.g. curbs, ice, stairs, getting in and out of the tub)

Medical Testing

No Yes

1. Have you had any x-rays, sonograms, CT scans, or MRIs done recently? If yes, when? _____ Which body region? _____ Results? _____		
2. Have you had any laboratory tests recently (urinalysis or blood test)? If yes, when? _____ What test? _____ Results? _____		

3. Please list any operations you have had and the date(s):

Operation	Date

Franklin Physical Therapy Patient Information and Office Policies

Our Purpose

Our purpose is to assist you and your physician in restoring your health and fitness and preventing a recurrence of your problem. This is best done in an atmosphere of congeniality, sincerity and honesty. We encourage you to ask questions about your treatment. In our understanding of you and your goals, we can progress you towards our common goals of relieving your pain and improving your health.

Appointments

We make every attempt to provide treatment at your scheduled time. If you need to cancel an appointment, please call in advance as a courtesy to other patients. **You may be charged a fee for appointments not cancelled by the end of the day before your scheduled appointment.** If you arrive early for an appointment, we will try to see you early. If you are late for an appointment, your treatment may be shortened or rescheduled.

Payment Policy

Our primary objective is to accomplish your treatment goals. If the charges are a burden that would limit your continued attendance, please discuss this with the staff. Co-payments are due prior to treatment. We do our best to assist you with billing. For answers to any additional billing questions, please call Doreen at (617) 523-2766. You are responsible for contacting your insurance company to determine how they handle physical therapy charges. **By signing below, you agree to pay any amount not covered by any insurance plan, including auto insurance claims.**

Worker's Compensation

If your injury is a result of an accident at work and you have filed a claim, you will not be expected to pay for any portion of the treatment. We accept the payment by your Worker's Compensation insurance carrier as payment in full. We are required to notify your physician, employer and claims adjuster regarding any missed appointments. Three (3) missed appointments may result in discontinuation of further treatments.

Medicare

We are happy to provide our services to Medicare patients and **we accept assignment.** Medicare pays us 80% of their allowable amount for physical therapy services provided. You are responsible for your annual medical deductible and the remaining 20% of the Medicare allowable charges (unless you have a Medicare supplemental policy). We compensate for the difference between the Medicare allowable amount and our actual charges. We will also bill any co-insurance you may have after Medicare has determined the allowable payment.

I have read, understood and agree to abide by Franklin Physical Therapy Office Policies.

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

FRANKLIN PHYSICAL THERAPY

TO ALL PATIENTS:

Please be aware of the following:

All co-payments are due at the time of the visit. Co-pays that are 30 days overdue will be subject to a \$10.00 service fee. This fee will be applied to your account for every 30 days that your account has been past due. Therefore, if your account is 60 days overdue the fee will be \$20.00.

Almost all insurance's require that patients have some form of a referral or authorization. It is your responsibility as a patient to obtain this information. If you do not have the necessary paperwork required by your insurance, and your visits are denied, then you will be responsible for payment.

Please sign below to acknowledge that you have received and understood this notification and return it to the office as soon as possible. Thank you.

Patient Signature

Date



HIPPA NOTICE OF INFORMATION 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.**

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care of treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals' participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where and why others may access your health information.

Understanding your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522)
- Obtain a paper copy of the **notice of information practices** upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with Worker's Compensation or other similar programs established by law.

We will use your health information for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication. After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to the public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Please sign below that you have read and understand this document.

Name (please print)

Signature

Date