Date:_____ Eval Date / Time:_____

Intake Questionairre

Patient: _____ DOB: _____ Gender: _____

Phone (c): _____ Phone (h):_____ Email: _____

Address: _____

Health Insurance Information:

Primary Insurance Name :_____ Insurance Number: _____

Secondary Insurance Name: _____ Insurance Number: _____

Referring Provider: _____ Reason for visit: _____

Emergency Contact Name: _____ Phone Number: _____

Auto Accident Information:

Patient's Auto Insurance Name: _____ Claim Number: _____

Adjuster's Name : _____ Phone Number: _____

At-Fault Auto Insurance Name: _____Claim Number:_____

Adjuster's Name:_____ Phone Number: _____

Attorney Name / Firm: _____ Phone Number: _____

(For Office Use Only)

Cash Pay Rate: Initial Evaluation: _____ Follow-up Visits: _____

Deductible: _____ Met: _____ % Insurance: _____

% Patient _____ Co-Pay: _____

Terms of Agreements: The following terms are based on information given at the time of verification. If you have any questions regarding the accuracy of these terms, it is the patient's responsibility to contact their insurance provider. If coverage claim is denied, patient is responsible for payment of services. I authorize Expert Physical Therapy Inc. (EPT) to bill my insurance company directly for services rendered. I authorize my insurance carrier to pay EPT directly and I will forward any reimbursements received for payment of services directly to EPT. I agree to pay any co-payments, co-insurance or associated deductible outlined in my insurance policy (some exceptions for Medicaid). Any balances owed after claims have been processed will be billed to the patient to be paid in full within 30 days. I have read the above information and understand my responsibility for payment of my account.

Sign: _____ Date: _____

In order to provide you with the best care, please fill in the information below.

Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Are you pregnant? Y / N Due Date: _____ OB-GYN: _____

Area of the body we are treating: Low Back / Mid Back / Neck / Hip / Knee / Ankle

Shoulder / Elbow / Hand / Wrist

Other: _____

Did you have an accident: Y / N Auto / Work Date of Accident: _____

Circle if you have had any of the following medical conditions:

Asthma	Arthritis (Rheumatoid/Osteo)	Epilepsy	Pacemaker
High Blood Pressure	Cancer, type	Fainting	Allergies
Diabetes	Ulcers	Heart Disease	Blood Disorder
COPD	Immuno-Suppressed	Stroke	Artificial Joint (where)

Other:_____

Medications: _____ Occupation: _____

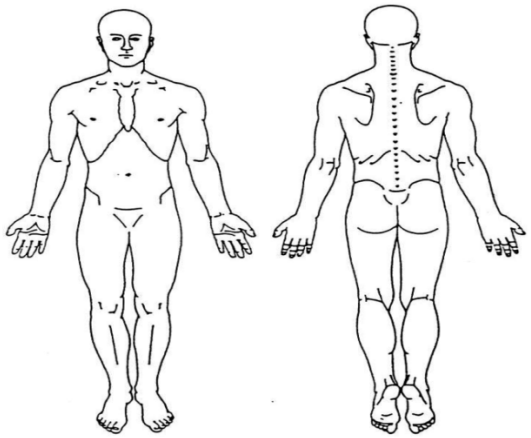
Pain rating today *(Please circle) (0 = no pain, 10 = worst pain)*

Headache: 0 1 2 3 4 5 6 7 8 9 10
Neck: 0 1 2 3 4 5 6 7 8 9 10
Mid-back: 0 1 2 3 4 5 6 7 8 9 10
Low-back: 0 1 2 3 4 5 6 7 8 9 10
Arm/Hands: 0 1 2 3 4 5 6 7 8 9 10
Legs/Feet: 0 1 2 3 4 5 6 7 8 9 10
{mild}{moderate}{severe}

Please describe the **type of pain** or discomfort that you are experiencing and the **locations**? (ie: neck, hands, back, legs, etc)

Stiffness: _____ Soreness: _____
Sharp: _____ Achiness: _____
Numbness: _____ Shooting: _____
Tingling: _____ Burning: _____

Indicate on the body diagram where you have symptoms or pain.



EXPERT
PHYSICAL THERAPY

Consent to Treatment

I do hereby agree and give my consent for Expert Physical Therapy Inc. to furnish care and treatment that is considered necessary and proper in the evaluating or treating of my physical condition. Dr. Hartman PT, DPT will be overseeing treatments administered by Chuck Walthall PTA (and any other PTA or support personnel on staff). I understand there may be certain risks that have been explained to me.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the intake information is true to the best of my knowledge.

Consent of Release of Information

I authorize the release of any information pertinent to my case to any physicians, rehabilitation consultants, insurance company, adjuster, or attorney involved in the case.

Office Policy

Expert Physical Therapy (EPT) strives to provide optimal customer service and expects patients to understand the importance of regular attendance for maximal progress. Since your treatment time is valuable, EPT reserves the right to cancel or reschedule your appointment if you are 15 minutes or more late. We also expect 24-hour notice to cancel or reschedule your appointment to allow other patients access to care. Three (3) cancel/no show appointments are reason for discharge. EPT also reserves the right to refuse patient care for medical or professional reasons.

Cupping

Cupping is a myofascial release method used to alleviate soft tissue restrictions and improve mobility and pain. This treatment has the potential for discoloration or bruising of the skin, which is expected and normally is not painful.

Trigger Point Dry Needling

Certain patients may benefit from Trigger point dry needling (TDN). This involves placing a small needle into the muscle trigger point in order to cause the muscle to contract and then release, improving muscle flexibility and decreasing symptoms. Your practitioner has had extensive training per Colorado State Board of Physical Therapy guideline requirements (4-CCR 732-1). TDN is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are a rare occurrence, they must be considered prior to giving consent to treatment.

Risks of the Procedure:
Though unlikely, the most serious risk is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require an x-ray and no further treatment. The symptoms of shortness of breath may last several days to weeks. A more severe lung puncture can require hospitalization. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely.

Please consult your practitioner if you have any questions regarding the treatment above. A copy of this consent can be provided to you at your request.

Do you have any known disease or infection that can be transmitted through bodily fluids? **YES** **NO**

Print name: _____

Signature: _____ ***Date:*** _____

NOTICE OF PRIVACY POLICIES – HIPAA

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.
You have ***the right to obtain a paper copy of this Notice upon request.***

Patient Health Information: Under federal law, your patient health information is protected and confidential. Patient health information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How we use your Patient Health Information: We use health information about you for treatment, to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or discuss the information without your permission.

Examples of Treatment, Payment and Health Care Operations:
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team with record Information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to family members who are assisting with your care.

Payment: We will use and disclose your health Information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to access the care and outcomes of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of benefit to you.

Other Uses and Disclosures: We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: 1. As required by law: we may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries or events. 2. Research: we may use or disclose information for approved medical research. 3. Public Health Activities: as required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information to public health authorities. 4. Health Oversight: We may be required to disclose information to assist in investigation audits, eligibility for government programs and similar activities. 5. Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order. 6. Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials. 7. Deaths: We may report information regarding deaths to coroners, medical examiners, funeral -directors and organ donation agencies. 8. Serious Threat to Health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety of the health and safety of another person. 9. Military or Special Government Functions: If you are a member of the armed forces, we may release Information as required by the military command authorities. We may also disclose Information to correctional Institutions or for national security purposes. 10. Workers compensation: We may release information about you for workers" compensations or similar programs providing benefits for work related injuries or illness. In any other situation, we will ask you for your written authorization before using or disclosing any identifiable health Information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights: You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. Request Restrictions: You may request restrictions on certain uses and disclosures of your information. We are NOT required to agree to such restriction, but If you do agree, we may abide by those restrictions. Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address. Inspect and Obtain copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies. Amend Information: If you believe that information in your record is incorrect, or if important Information is missing, you have the right to request that we correct the existing information or add the missing information. Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.
Our Legal Duty: We are required by law to protect and maintain the privacy of your health care information, to provide this Notice and our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes In Privacy Practices: We may change our policies at any time, before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each exam room. You can also request a copy of our Notice at any time.

Complaints: If you have any concerns that we have violated your privacy rights, or it you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request you will not be penalized in any way for filing a complaint.

Contact Person: If you have any questions or requests, please contact: (720) 287-1626.

_____
Print Name

_____
Sign Name

_____
Date