NEW PATIENT INTAKE

Please Bring Your Insurance Card And Photo ID On Your First Visit

Patient's Name:

_____

Marital Status: Married____Single_____Other_____

Patient's D.O.B.: _____ Age: _____

Social Security #: _____

Patient's Telephone #: _____

Patient's Address: _____

_____

Name of Insured: _____ Soc. Sec. #: _____

Insurance Company: _____
Telephone #: _____
Address: _____
Contact Person: _____

Insurance ID #: _____ Group #: _____
Claim # (if any) _____

Employer: _____

Diagnosis: _____ DOI: _____

In Case of
Emergency/Contact: _____ Relationship: _____

DOB : _____ Telephone #: _____

Email Address: _____

*** Are you currently receiving home health services: _____

HPT PHYSICAL THERAPY

HEALTH HISTORY

Name: ______________________________ **Date of Birth:** ____________

Have you been under the care of a physician for:

Angina/Chest Pain	__No	__Yes	Date: ________	Abnormal Heart Beat	__No	__Yes	Date: _______
Heart Attack	__No	__Yes	Date: ________	Stroke	__No	__Yes	Date: _______
Heart Surgery	__No	__Yes	Date: ________	Epilepsy/Seizures	__No	__Yes	Date: _______
Heart Angioplasty	__No	__Yes	Date: ________	Cancer	__No	__Yes	Date: _______

Hypertension __No __Yes
Medication: __________________

Severe dizziness/fainting __No __Yes
Anemia __No __Yes

Diabetes Mellitus __No __Yes
Medication: __________________

Arthritis __No __Yes
Medication: ___________________

Asthma __No __Yes

Back/Knee Pain __No __Yes

Are you a smoker? __No __Yes

Other Joint Problems __No __Yes

Are you pregnant? __No __Yes

Explain: ________________________________
____

Have you had Physical Therapy before? __No __Yes Date: __________ Where? _________________________

List any recent illness/hospitalization: ____
____

List any Surgery:
____
____

List any medications you are currently taking:
____
____
____
____
____

Do you have any known allergies? ____
____

Please list any other medical problems: ____

OFFICE USE ONLY

Date:	Changes in Medication:	Changes in Allergies:	Changes in Medical History:	Comments:
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
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________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________
________	__No __Yes	__No __Yes	__No __Yes	____________________________

RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

ASSOCIATES IN REHAB, PIKEVILLE LLC DBA HPT PHYSICAL THERAPY AND SPORTS MEDICINE

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need the record to provide you with quality care and to comply with certain legal requirements.

We are required by law to:

* Make sure that health information that identifies you is kept private.
* Give you this notice of our legal duties and privacy practices with respect to your health information.
* Follow the terms of the notice that is currently in effect.

We may use and disclose health information about you for multiple reasons including but not limited to treatment, payment, healthcare operations, as required by law, and to avert a serious threat to health and safety.

Your rights regarding health information about you: you have the following rights regarding health information we maintain about you:

Respect of inspect and copy: You have the right to inspect and copy health information that may be used to make decisions about your care.

Right to amend: If you feel that health information we have about is incorrect or incomplete, you may ask us to amend the information.

Right to accounting of disclosures: You have a right to request a list of accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, as previously described.

Right to request restrictions: You have the right to request a restriction of limitation on the health information we use to disclose about you for treatment, payment or healthcare operations.

Right to request confidential communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a paper copy of this notice: You have the right to obtain a paper copy of this notice at any time.

* The Notice of Privacy Practices you have been given describes the above rights and requirements in detail
* You are free to refer to this notice at any time before you sign this form.
* When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operation.
* You also signify that you have received a copy of our Notice of Privacy Practices.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Associates in Rehab, Pikeville LLC DBA HPT Physical Therapy and Sports Medicine. If you have any questions about this notice, please contact HPT Physical Therapy and Sports Medicine at 606-637-1830 or 175 Weddington Branch Road Pikeville, Ky 41501

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by or under contract with Associates in Rehab, Pikeville DBA HPT Physical Therapy and Sports Medicine.

Patient/relative or guardian _____/_____

Signature (Print Name)

Date _____ _____

(Relationship, if signed by person other than client)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Associates in Rehab, Pikeville DBA HPT Physical Therapy and Sports Medicine Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____

(Print Name)

_____

Signature of Patient/Personal Representative

Date: _____ Witness Signature: _____

175 WEDDINGTON BRANCH ROAD
PIKEVILLE, KY 41501

PHONE: 637-1830
FAX: 637-1832

RELEASE OF INFORMATION CONSENT FORM

I authorize the staff of HPT Physical Therapy to make a copy of, and release my Physical Therapy Medical Records to _____, if I am unable to pick them up myself.

The copy would be for my personal use, and this consent will expire 90 days post discharge from Physical Therapy Services at HPT Physical Therapy.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____