Patient Intake Form

Patient Name:	Referring Physician:
Address:	Date of last appointment:
	Date of next appointment:
	Family Doctor:
Phone:	Circle the insurance to be billed:
Email Address:	Comp Auto Medicare
Age: Birthdate:	Major Medical Other__________________
Height: Weight:	Name of insurance:
Circle one: Male Female	Address:
Circle one: Single Married Widowed	
Social Security #:	Phone:
In case of emergency, notify: Name: Phone:	Who's name is the insurance under?
	What is their relationship to you? Spouse Parent Other
Area of pain:	ID or Claim #
Is your pain due to an injury? Y N	Group #
Date of injury:	**Assignment and Authorization** I hereby authorize and assign direct payment to Hess Physical Therapy, LLC of all fees paid for services rendered. I hereby authorize Hess Physical Therapy, LLC to furnish information to insurance and doctors concerning my illness and treatment.
Circle the place that the injury occurred Work Auto Home Other_____________	
Have you been off work? Since What date?	
Occupation:	Please sign and date below. Thank You! Sign_______________________________________ Date______________________________________
Name of Employer: Address:	
Phone:	

Office Only	Phone:	Contact:	Deduct:	Copay:	Out of Pocket:	Eff Date:

HESS
PHYSICAL THERAPY

Medical History Form

Patient's Name: Date:

Medical History: Do you have any of the following?

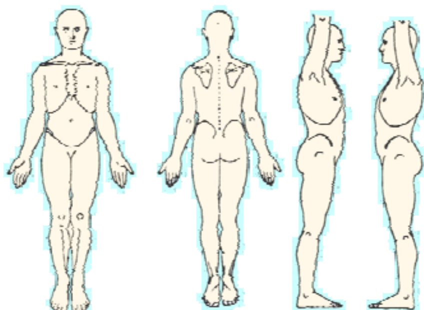
- ❑ High Blood Pressure
- ❑ Lung Disease
- ❑ Chest Pain
- ❑ Bowel/Bladder Problems
- ❑ Frequent Sweating
- ❑ Shortness Of Breath
- ❑ Female Problems
- ❑ Night Pain
- ❑ Irregular Heart Rate
- ❑ Weight Loss
- ❑ Cough up Blood
- ❑ Heart Disease
- ❑ Pacemaker
- ❑ Stomach Problems
- ❑ Constipation
- ❑ Pain Swallowing
- ❑ Gets Full Quickly
- ❑ Hoarseness
- ❑ Night Sweats
- ❑ Weakness
- ❑ Dieting
- ❑ Seizures
- ❑ Diabetes
- ❑ Metal Implants
- ❑ Loss of Appetite
- ❑ Diarrhea
- ❑ Fatigue
- ❑ Headaches
- ❑ Indigestion
- ❑ Skin Rashes
- ❑ Numbness
- ❑ Vision Changes
- ❑ Burning
- ❑ Cancer
- ❑ Pregnant
- ❑ Chills
- ❑ Dizziness
- ❑ Fever
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Tingling
- ❑ Cough

Are You Contagious? ❑Yes ❑No
Are You Allergic To: ❑Chlorine ❑Adhesive Tape ❑Iodine ❑Other______________________
Surgeries? Y N (List)____
List any medication you are taking for this condition:____
How would you rate your general health? ❑Poor ❑Fair ❑Good ❑Excellent
List other medical problems:____

History of Present Problem:

What is your current complaint?__________________________ When did it start?_______________
Due to: ❑an injury ❑an Illness (Explain)____
Did the symptoms begin: ❑Suddenly ❑Gradually Previous problems in this area? ❑Yes ❑No
Previous Therapy for this condition? ❑Yes ❑No (What Effect?)____________________________________
Are you getting: ❑Better ❑Same ❑Worse Are you better with rest? ❑Yes ❑No
Does activity make you worse? ❑Yes ❑No Which ones?____
Are you worse in the: ❑Morning ❑Afternoon ❑Evening Is your pain: ❑Continuous ❑Occasional
Does your pain radiate? ❑Yes ❑No Where?____
What reduces your pain?____
What can't you do because of your symptoms?____
Recent Tests: ❑X-Ray ❑CT ❑MRI ❑EMG ❑Myelogram ❑Other____________________________
Results:____
What did the Doctor tell you your diagnosis is?____
Did he put you on any restrictions? ❑Yes ❑No List:____
Based upon a scale of 0 to 10 (0 is none and 10 is severe), what is your pain:
Right Now:___ Your worst pain in the past 24 hours:___ Least pain in the past 24 hours:___

Please mark your area of pain on the body diagram below:



Office Use Only:
Blood Pressure____________________

HESS PHYSICAL THERAPY, LLC.
GENERAL OFFICE POLICIES

Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment in our clinic. We are always dedicated to quality for all of our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office patient policies are as follows. Please read them carefully and sign below.

1. We require 24 hours notice in the event of a cancellation. **It is your responsibility when you call to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.**
2. **There is a $25 charge for a cancellation without proper notice. This charge will probably not be covered by your insurance company but will have to be paid by you personally.**
3. You should understand that when you no-show, three people get hurt:
    - **Yourself** because you don't get the treatment you need as prescribed by your doctor and our staff.
    - **The therapist** who now has a "vacancy" in his schedule since your appointment time was reserved for you personally
    - **Another patient** who could have been given treatment if you had given the proper notice.
4. **Regarding lateness:** If you are late, you may not get in your full treatment because it would mean another patient's treatment would be delayed.
5. **Regarding being early:** Most of the time you will have to wait for your scheduled appointment time to be seen because there are other patients who are still receiving treatment.
6. **Regarding children:** If you choose to bring your child with you into the clinic they are to be with the parent/guardian at all times. They are not permitted to be on gym equipment or handle treatment supplies at any time. **Hess Physical Therapy will not be held responsible for any injury sustained to your child. Any damage to equipment or the clinic itself will be the responsibility of the parent/guardian.** Our staff at no point will be asked to supervise or entertain your child as it decreases clinic efficiency and takes away from the care of our patients.
7. For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist prepares a report for your doctor.
8. Please understand that your insurance policy is a contract between you and your insurance company. **While we may accept your insurance as payment, your contract with us is a separate agreement.** In other words, if your insurance refused to cover a certain treatment or otherwise, fails to pay us, your contract with us still exists and you are responsible for payment personally.
9. **Copays, deductibles and self-payments are due at the time of service. We accept payments by credit card, check and cash only.**
10. We will allow on special occasions, a long-term payment plan budgeted on the individual, according to need. In any event, if you request such a plan, you will sign a written agreement, which must be given final approval by the Clinic Director.
11. If at any point you have a problem regarding billing and payment, talk to our receptionist and she will arrange for you to speak with our Office Manager.

After you have read carefully the above, please sign the following:

I, _________________________________, agree to be treated at Hess Physical Therapy and agree to the terms specified above.

Patient's Signature ______________________________________ Date____________________________

Hess Physical Therapy, LLC.
500 Pine Hallow Rd., Kenmawr Plaza
McKees Rocks, PA 15136

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgment

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520 (c) (2) (i i), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations")

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and /or disclosure of personally identifiable health information about me by Hess Physical Therapy, LLC (the "Practice") for the purpose of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice with sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail. The way in which the Practice will make such use of disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:

   566 PineHollow Road, Kenmawr Plaza
   McKees Rocks, PA 15136
   Attention: Practice Compliance Director

4. I understand and acknowledge that I have the right to request that the Practice restrict how much information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by the restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank is no restrictions):
____
____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPYOF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_______________________________________ ______________

Signature of Patient or Representative **Date**

____

Patient's Name

____

Date of Birth

____

Social Security Number

____ _________________________

Name of Personal Representative (if applicable) **Relationship to Patient**

____

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_______Accepted **_______Denied** **_______Not Applicable**

_______Other (explain)____

____ _________________

Signature of Authorized Practice Representative Date

How did you hear about us?

Please check all that apply.

___Allegheny West magazine

___Websearch

___Yellow Pages

___ Tribune Review

___Lectures

___ Word of Mouth

Name______________________

___Referred by Physician

Physician Name_______________

___Pamphlet in local Business

Business Name________________

___ School Advertisements

School Name__________________

___Hess PT sign

___Television Commercial

___Workers' Comp Panel

___ Community Events