PREMIER
PHYSICAL THERAPY

NEW PATIENT INFORMATION

Call: 904-996-6922 | Fax: 904-996-6923

Demographics:

FIRST:________________________MIDDLE_______________LAST__________________________

DOB:_________________________________SS # ____

Address ____

City_____________________________State______________________Zip_____________________

Phone:____________________Work:_______________________Cell ________________________

Email address:_____________________________________

Emergency Contact Information:

Name:____Relation: ______________________________

Best Number To Reach Your Emergency Contact? ____

YOUR INSURANCE INFORMATION: **I AM CURRENTLY INSURED** ☐ **YES** ☐ **NO**

Primary Insurance ____

Insurance ID #____________________________________Group # __________________________

Secondary Insurance ____

Insurance ID #______________________________________Group # __________________________

REFERRAL INFORMATION:

Referring Doctor ______________________ Primary Care Physician __________________________

Cause of Condition: Illness/ Injury: ____

Workers Compensation: ______________________ Motor Vehicle Accident: _____________________

Date of Incident:__________ State of Incident: _________ Other Info: __________________________

LEGAL INFORMATION

Do you currently have legal counsel: ☐ Yes ☐ No

If so please provide information:

Name: _____________________________ Office: ____

Phone: _____________________________

PATIENT NAME:______________________________**DATE OF BIRTH:**____/____/____

Please Check All Conditions That You Have Had or Currently Diagnosed With:

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder
☐ Cancer
☐ Cardiac Conditions
☐ Cardiac Pacemaker
☐ Chemical Dependency
☐ Circulation Problems
☐ Currently Pregnant
☐ Depression
☐ Diabetes
☐ Dizzy Spells
☐ Emphysema/Bronchitis
☐ Fibromyalgia
☐ Fractures
☐ Gallbladder Problems
☐ Headaches
☐ Hearing Impairment
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ High / Low Blood Pressure
☐ HIV / AIDS
☐ Incontinence
☐ Kidney Problems
☐ Metal Implants
☐ MRSA
☐ Multiple Sclerosis
☐ Muscular Disease
☐ Osteoporosis
☐ Parkinsons
☐ Rheumatoid Arthritis
☐ Seizures
☐ Smoking
☐ Speech Problems
☐ Strokes
☐ Thyroid Disease
☐ Tuberculosis
☐ Vision Problems

Describe any other conditions you have or precautions:

____

Falls History

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of Fall:______________________________

Two or more falls in the last year? ☐ Yes ☐ No Dates of Falls:______________________________

Surgical History

Body Region:______________Surgery Type:________________Date of Surgery: / /
Body Region:______________Surgery Type:________________Date of Surgery: / /
Body Region:______________Surgery Type:________________Date of Surgery: / /
Body Region:______________Surgery Type:________________Date of Surgery: / /
Body Region:______________Surgery Type:________________Date of Surgery: / /

Current Medications

Drug:________________Dosage:________Reason for Taking:____________________
Drug:________________Dosage:________Reason for Taking:____________________
Drug:________________Dosage:________Reason for Taking:____________________
Drug:________________Dosage:________Reason for Taking:____________________
Drug:________________Dosage:________Reason for Taking:____________________
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Drug:________________Dosage:________Reason for Taking:____________________
Drug:________________Dosage:________Reason for Taking:____________________
Drug:________________Dosage:________Reason for Taking:____________________
Drug:________________Dosage:________Reason for Taking:____________________

Who is your family physician? ______________________________
When was your last physical exam? ______________________________

Patient Health Questionnaire – PHQ

ACN Group, Inc. - Form PHQ-202
ACN Group, Inc. Use Only rev 7/18/05

Patient Name ______________________________ ***Date*** ______________________

1. Describe your symptoms ______________________________

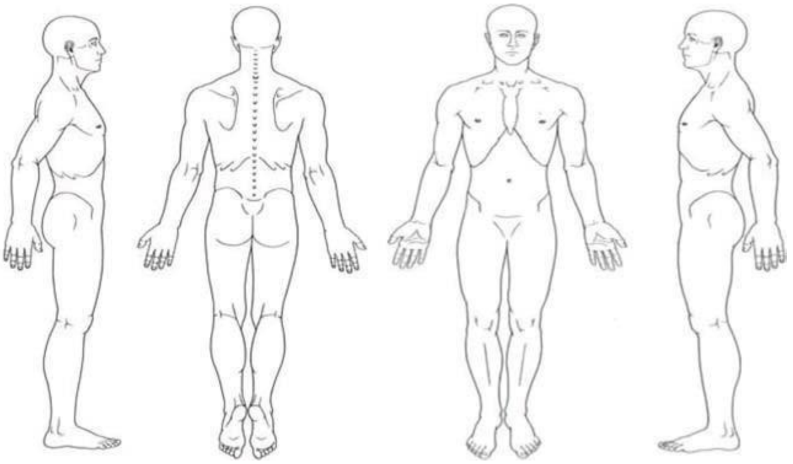
a. When did your symptoms start? ______________________________

b. How did your symptoms begin? ______________________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

①Sharp ④Shooting
②Dull ache ⑤Burning
③Numb ⑥Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

①Not at all ②A little bit ③Moderately ④Quite a bit ⑤Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

①Excellent ②Very Good ③Good ④Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③Medical Doctor ⑤ Other
②Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? ______________________________

b. What tests have you had for your symptoms and when were they performed?

①Xrays *date:* ____________ ③CT Scan *date:* ____________
② MRI *date:* ____________ ④ Other *date:* ____________

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤Other
②Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature ______________________________ ***Date*** ______________________

PREMIER PHYSICAL THERAPY CLINIC GUIDELINES

The staff at Premier Physical Therapy is dedicated to providing you with the best care possible. In order to do so, we ask that you read and comply with the following guidelines:

Please be prompt for your scheduled appointment. By doing so, we can ensure that all patients are afforded the courtesy of individualized care and attention allotted during their scheduled time slot.

When arriving for a scheduled appointment, we ask that you sign in, and be seated until your therapist brings you back. Please DO NOT proceed into the gym/treatment area unless escorted/invited by your Clinician.

Please wear or bring appropriate attire to allow proper access to the body part being treated (sneakers, shorts, t-shirts/ tank tops, etc.). We have rooms available for changing, at your convenience. Please provide adequate time to change prior to your scheduled treatment time.

NOTE: Premier Physical Therapy is not responsible for items lost or stolen.

CANCELLATION POLICY:

We understand that sometimes appointments have to be rescheduled or cancelled. If you are unable to attend a scheduled appointment, we ask that you provide at least 24 hours notice. **If proper notice is not provided, a $60.00 fee will be assessed to your account.** Following three unexplained cancellations or no-shows, Premier Physical Therapy reserves the right to cancel your remaining appointments, discharge your care and notify your physician.

FINANCIAL POLICY

Your insurance policy requires the payment of co-payments and deductible amounts from you at the time of service. Your insurance company also requires Premier to collect your co-payment or unmet deductible amount or we could be in violation of our contract with your insurance company and risk not being reimbursed for your treatment process.

As a courtesy, Premier will bill your insurance company for their portion of your payment. However it is your personal responsibility to know your policy and benefits and provide payment for all services rendered at time of treatment that are not covered by insurance.

We accept payment by Visa Mastercard, American Express, personal check or cash.

CONDITION OF ADMISSION:

Premier Physical Therapy and may disclose all or any part of your record to any per- son or corporation which is, or may be, liable under a contract to Premier or to the patient. We can also release to a family member or employer of the patient for all or part of Premier Physical Therapy's charges, including but are not limited to, hospital or medical service companies, insurance companies, workman's compensation.

The undersigned authorizes the Social Security Administration to disclose information regarding their Medicare coverage, including but not limited to, verification of my Medicare number, effective dates and type of coverage to Premier Physical Therapy. The undersigned also requests payment of government benefits and all medical benefits to Premier when applicable.

The undersigned consents to treatment or procedures rendered to the patient by Premier Physical Therapy. It is further understood that Premier Physical Therapy is authorized to carry out all instructions of the patient's referring doctor when applicable and that Premier Physical Therapy is hereby relieved of any and all liability from the performance of said doctor's instructions. The undersigned requests and authorizes the staff at Premier Physical Therapy to provide them with treatment and to perform any procedures now contemplated or such additional procedures as their doctor may deem reasonable and necessary. If no referring doctor is applicable the undersigned consents for Premier Physical Therapy to treat them in a manner or practice that would be deemed both medically practical and efficient. The undersigned's signature waives Premier Physical Therapy of all liability for said treatment rendered barring any acts of medical negligence.

Premier Physical Therapy provides treatment to its patients in the most efficient and effective manner possible, as opposed to only providing the modalities allowed and reimbursed by the patient's insurance company. Deemed medically necessary, the physical therapy treatment will be billed by Premier Physical Therapy AS A COURTESY, but there may be certain supplies and services not covered in the patient's insurance contract.

The undersigned agrees to be fully responsible for all costs not paid for by third-party The undersigned certifies that he/she has read the forgoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

This request is to remain in effect for one (1) year unless otherwise revoked.

Patient's Signature____

Person in Lieu of Patient: ____

Reason why patient is unable to sign: ______________________________________

Witness: person securing request ____

Relationship to Patient:_________________________________DATE: ____________

NOTICE OF PREMIER PHYSICAL THERAPY PRIVACY PRACTICES

Effective September 15, 2003

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.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE:

We receive information about you during your first visit with us, including your name, date of birth, gender, ways to contact you, your social security number, financial information, insurance information and other personal information. We also collect information regarding your condition, diagnosis and treatment. Along with collecting this information from you, we also get enrolment and eligibility status from your health insurer and medical information from other health care providers.

OUR PRIVACY COMMITMENT TO YOU:

The information we collect about you is private. We are required to give you an idea of our privacy practices. Only those individuals who have both the need and the legal right may view your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment, payment, business operations, and when we are required by law to do so, or for one of the other reasons listed below.

Treatment: We may use or disclose medical information about you to provide and coordinate your health care. For example, after your initial appointment with us we usually send a letter to you referring physician regarding your treatment. Another letter shall be sent after you have been discharged from our care.

Payment: Information may be disclosed so that the care you get receive can be properly billed and paid for. For example, we may send your health insurer a bill for our services explaining the treatment you received and why. Business Operations: We may need to use and disclose information in our business operations. For example,in order to improve activity necessary to run the business (training or for reviewing the quality of care that you and others receive from us).

Exceptions: For certain kinds of records, your permission may be required, even for release of treatment, payment and business operations. We will provide you with authorization and consent forms for your signature in order for us to release certain information.

Phone Messages: We may contact you via phone, answering machine or mail to provide you with authorization, referral, and billing information including information regarding other services that may be of interest to you. You may request in writing if you do not wish for this information to be left with a person other than yourself via phone. As required by Law and for other Government Functions: We will release information when required to do so by law or for other government functions. Examples of such releases would be for law enforcement, subpoenas or other court orders, for national security purposes, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety, or in other kinds of emergencies. Public Health and Safety: We may use or disclose information about you as necessary to prevent or reduce a serious threat to the health or safety of another person or the public. For example, we will have to disclose information about certain diseases (and immunizations) to public health officials.

Family and Friends: We may disclose your information to family members, friends or others you identity to the extent it is relevant to their involvement with your care or payment for your care, or to let them know about where you are and your condition.

After Death: We may disclose your information to coroners or medical examiners and funeral homes after you are deceased. With Your Permission: If you provide us permission in writing, we may use and disclose your personal information for the purposes you list. If you give us permission, you have the right to change your mind and revoke it, but this must be in writing. We cannot take back any uses or disclosures already made with your permission. Our use and disclosure of your personal health information must comply not only with federal privacy regulations but also with applicable Florida law. Florida law provides different protection to your personal health information. For example, Florida provides extra protection for minors; we must adhere to the more stringent state privacy protections.

YOUR PATIENT RIGHTS

You have the following rights regarding the health information we have about you. Your requests must be made in writing to us at:

Premier Physical Therapy
4230 Pablo Professional Ct #155
Jacksonville, FL 32224
Call: 904-996-6922 | FAX 904-996-6923

We are committed to ensuring that you receive information regarding your rights as a patient here at Premier Physical Therapy .

Your Right to Inspect and Copy: In most cases, you have the right to look at or receive copies of your medical records upon signing a Medical Record Release form, and in some cases paying a fee if we need to retrieve such records from storage. Please call ahead to ensure that we have your records available for you.

Your Right to Amend: You may request us to modify your records if you feel the records are not correct. We may deny your request for certain reasons, but we must provide in writing to you the reason for our denial.

Your Right to a List of Disclosures: You have the right to ask for a list of certain disclosures made after September 15, 2003. This list will include the times that information was disclosed for treatment, payment, or health care operations.
The list will include information provided directly to you or your family, or information that was sent with your permission. It will include information released without your name or other date that would identify you.

Your Right to Request Restrictions on Our Use or Disclosure of Information: You can ask for limits on how your information is used or disclosed. We are not required to agree to such a request, but may if we believe it is reasonable to do so.

Your Right to Request Confidential Communications: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your college address instead of your home address or you may ask that we treat you in a room other than the main treatment area. We will do our best to accommodate such a request.

CHANGES IN THIS NOTICE:

We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. If the changes are material, a new notice with be posted.

HOW TO USE THESE RIGHTS UNDER THIS NOTICE:

If you want to exercise your rights under this notice or have any questions regarding our privacy issues, you may call or write to us at:

Premier Physical Therapy
4230 Pablo Professional Ct #155
Jacksonville, FL 32224
Call: 904-996-96922 | FAX 904-996-6923

Please let us know right away if you believe that your privacy rights have been violated or you wish to express any concern regarding noncompliance of our privacy policies and procedures; you may file a complaint by writing to the above address. We will require a written complaint, and may further provide you with an official complaint form that you will need to fill out for our records. You will not be penalized for filing a complaint, we are here to serve you.

ADDITIONAL INFORMATION

HIPAA is the Health Insurance Portability and Accountability Act of 1996. The revised and updated Privacy Rule portion of HIPAA, including many of the policies described in this notice, went into effect September 15, 2003. You may further research the policies and guidelines of HIPPA via the internet. We will also keep a copy of the final Standards for Privacy of Individually Identifiable Health Information at our front desk for patients to view at their leisure.

**You will need to read and acknowledge (via signature) that you have read these privacy policies and procedures.
A copy of this acknowledgement will be filed in our office.**

ACKNOWLEDGEMENT OF RECEIPT

The undersigned's signature is attestation to the fact that they have received a copy of Premier Physical Therapy's practices and policies. The undersigned acknowledges that they have both read and will abide by the practices and policies set forth by Premier Physical Therapy.

1. **Clinic Guidelines**
2. **Cancellation Policy**
3. **Financial Policy**
4. **Condition of Admission**
5. **Privacy Practices**
6. **Patient Rights**

Patient Name: ____

Patient Signature: ____

Date: ___________________

PREMIER
PHYSICAL THERAPY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize____ to disclose to **PREMIER PHYSICAL THERAPY** or their agent, any information which they may have acquired by history, examination or other means of my physical and/or mental condition and I hereby release them of any consequences thereof

☐ **Office Notes** ☐ **Operation Reports** ☐ **Radiology Reports**

☐ **Other:** ____

Patient Name: ____

Patient Signature: ____

Date of Birth: ________________________

Please fax to: Premier Physical Therapy at 904-996-6923.

Thank you,
Premier Physical Therapy