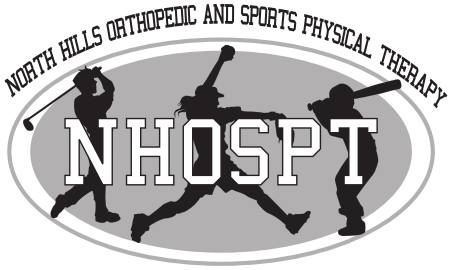


YOUR *CHOICE* FOR P.T.

2591 Wexford-Bayne Road, Suite 107 | Sewickley, PA 15143 | Ph: 724.934.1988 | **www.nhospt.com**

PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ / _____ / _____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER SSN: XXX-XX- _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

(Please check the box to indicate your preferred means of communication)

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____ EMAIL: _____

EMPLOYER: _____ MARITAL STATUS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PHONE: _____ LOCATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

POLICY HOLDER ADDRESS:

STREET: _____

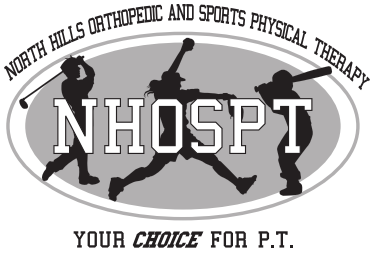
CITY: _____ STATE: _____ ZIP: _____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **NORTH HILLS ORTHOPEDIC AND SPORTS PHYSICAL THERAPY.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____



_____FINANCIAL RESPONSIBILITY AGREEMENT:
Initials

I agree to assign insurance benefits to North Hills Orthopedic and Sports Physical Therapy. We bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients. I acknowledge full financial responsibility for services rendered by North Hills Orthopedic and Sports Physical Therapy and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize all insurance payments to be made directly to North Hills Orthopedic and Sports Physical Therapy. Payment is expected at the time of service. We will file your insurance as a courtesy to you. If your deductible has not been met and/or you are responsible for a co-payment under your plan, we will expect the payment of such upon delivery of services and immediately upon the end of your visit. There will be a $30 fee for returned checks.

_____PATIENT PRIVACY PRACTICES:
Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

_____CONSENT OF TREATMENT:
Initials

I authorize North Hills Orthopedic and Sports Physical Therapy to evaluate and treat me or my family member for any illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies.

_____PROOF AND CHANGE OF INSURANCE:
Initials

Patients are required to show proof of insurance at their initial visit. The patient (parent/legal guardian) is responsible for informing our office of any changes in your insurance coverage since your last visit. Please assure that notification is made no later than 24 hours prior to your appointment to avoid having to reschedule your appointment.

_____MISSED APPOINTMENT POLICY:
Initials

We must be notified at least 24 hours in advance of an appointment cancellation/need to reschedule.

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the "Notice of Privacy Practices" for North Hills Orthopedic and Sports Physical Therapy. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize North Hills Orthopedic and Sports Physical Therapy to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X_____ _____
Patient or Guardian Signature Date

NORTH HILLS ORTHOPEDIC AND SPORTS PHYSICAL THERAPY

NHOSPT

YOUR *CHOICE* FOR P.T.

Today's Date: _____

Full Name: _____ **Date of Birth:** _____

Dominant Hand: _____ **Referred By:** _____

Reason for appointment: _____

Pain scale:
If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible. _____

Current problem is the result of (check all that apply):
Work Accident [ ] Car Accident [ ] Accident [ ] Other [ ]

This occurred during (check all that apply):
Lifting: [ ] Reaching: [ ] Pulling [ ] Squatting: [ ] Pushing: [ ] Hit by Object: [ ]
Twisting: [ ] Falling: [ ] Bending: [ ] Not Known: [ ]

How long ago did this problem start? _____

Treatment that has been previously tried (check all that apply):
Ice & Rest: [ ] Home Exercises/Stretching: [ ] Therapy: [ ] Anti-inflammatories: [ ] Cortisone Injections: [ ]
Bracing: [ ] If bracing, what type: _____

Previous treatment has provided:
Good Relief: [ ] Minimal Relief: [ ] No Relief: [ ] Made Worse: [ ]

Are you currently receiving Home Health Care, Physical/Occupational Therapy or Chiropractic Care from any other facilities?
[ ] Yes [ ] No If yes, where: _____

Do you need assistance with activities at home? [ ] Yes [ ] No
If yes, what type? _____

Previous testing (check all that apply): _____
X-ray: [ ] MRI: [ ] CT: [ ] EMG: [ ] Bone Scan: [ ] Other: [ ]
***If you had something done, where & when:

_____

Do you exercise? [ ] Yes [ ] No [ ] Unable to exercise

_____

Please list all medications you are currently taking with dosage, how long you have been taking them & any side effects:

_____

_____

_____

_____

_____

Please list any allergies:

Review of Symptoms/Illnesses:

Are you currently having or have you had any problems with or taking medications for the following:

Eyes	No [ ]	Yes [ ]	If yes, explain:
Ears, Nose, Throat	No [ ]	Yes [ ]	If yes, explain:
Thyroid Problems	No [ ]	Yes [ ]	If yes, explain:
Heart Problems	No [ ]	Yes [ ]	If yes, explain:
Pacemaker/Defibrillator	No [ ]	Yes [ ]	If yes, explain:
Metal Implants	No [ ]	Yes [ ]	If yes, explain:
Stroke	No [ ]	Yes [ ]	If yes, explain:
Lungs, Breathing (short of breath)	No [ ]	Yes [ ]	If yes, explain:
Digestion	No [ ]	Yes [ ]	If yes, explain:
Bowel Movement	No [ ]	Yes [ ]	If yes, explain:
Bladder Problem	No [ ]	Yes [ ]	If yes, explain:
Recent Weight Loss/Gain	No [ ]	Yes [ ]	If yes, explain:
Diabetes	No [ ]	Yes [ ]	If yes, explain:
High Blood Pressure	No [ ]	Yes [ ]	If yes, explain:
Low Blood Pressure	No [ ]	Yes [ ]	If yes, explain:
High Cholesterol	No [ ]	Yes [ ]	If yes, explain:
Bleeding Problems	No [ ]	Yes [ ]	If yes, explain:
Balance Problems	No [ ]	Yes [ ]	If yes, explain:
Numbness/Tingling	No [ ]	Yes [ ]	If yes, explain:
Blackout/Fainting	No [ ]	Yes [ ]	If yes, explain:
Psychological Problems: Anxiety/Depression/Bi-Polar	No [ ]	Yes [ ]	If yes, explain:
AIDS	No [ ]	Yes [ ]	If yes, explain:
Cancer	No [ ]	Yes [ ]	If yes, explain:
Arthritis	No [ ]	Yes [ ]	If yes, explain:
Polio	No [ ]	Yes [ ]	If yes, explain:
Tuberculosis (TB)	No [ ]	Yes [ ]	If yes, explain:
Hepatitis	No [ ]	Yes [ ]	If yes, explain:
Epilepsy	No [ ]	Yes [ ]	If yes, explain:

Please list all past surgeries, the year and if any complications occurred:

Patient's Signature **Date** **Signature of Guardian if patient is a minor** **Date**

Therapist's Signature **Date**

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At North Hills Orthopedic And Sports Physical Therapy, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 16, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit North Hills Orthopedic And Sports Physical Therapy, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

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

Your Health Information Rights

Although your health record is the physical property of North Hills Orthopedic And Sports Physical Therapy, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

North Hills Orthopedic And Sports Physical Therapy, is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and,
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a physical therapist or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physical therapist will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observation. In that way, the physical therapist will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this practice.

We will use 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.

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, your location, and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your case or payment related to your care.

Workers compensation: We may disclose health information to the extent, authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

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

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member of 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.