ACTIVE HEALTH
PHYSICAL THERAPY

PATIENT INFORMATION/INTAKE FORM

Facility Name:_____Facility #_____

Patient information

Name:_____

Date of Birth:_____ Sex: _____ Telephone #:_____

Street Address: _____

City: _____ State: _____ Zip Code:_____

S.S.#_____ Marital Status: S M D W

Responsible Party: _____ Relationship:_____

Contact Phone: _____ Address: _____

Doctor Name & UPIN: _____ MD or DO_____

Doctor Specialty: _____

(*Please provide copies of insurance cards*)

Primary Insurance/Responsible Party: _____Policy#:_____

Address: _____ Phone: _____

Policy Holder Name:_____ Relationship: _____

DOB & SS# of Policy Holder _____

Secondary Insurance/ Responsible Party: _____Policy# _____

Address: _____ Phone: _____

Policy Holder Name:_____ Relationship: _____

DOB & SS# of Policy Holder _____

Work Related: Yes No Auto Accident: Yes No Liability Accident: Yes No

W/C Claim #: _____ Date of Accident: _____

Are you currently being seen by another healthcare professional? Yes No

If yes, please specify: _____

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MEDICAL HISTORY FORM

Last Name:_____First Name:_____

Date:_____Date of Birth:_____

Yes No Are you under the care of a physician? If yes, please state name & phone number of doctor:

Yes No Have you ever had any serious illness(es), operations,or been hospitalized in the past five years? If yes, please describe:

Yes No Are you now taking any medicine, including non-prescription medication? If yes, what medication?

Yes No Do you have any disease or problem not listed below that you feel we should know about? If yes, please explain:

Do you have, or have you had, any of the following diseases or problems?

Yes	No	Diabetes	Yes	No	Hypertension
Yes	No	Allergies	Yes	No	Pace-maker
Yes	No	Alcoholism	Yes	No	Immune system
Yes	No	Anemia	Yes	No	Liver disease
Yes	No	Bowel	Yes	No	Mental illness
Yes	No	Cancer	Yes	No	Renal disease
Yes	No	Circulatory	Yes	No	Respiratory
Yes	No	Nervousness	Yes	No	Seizures
Yes	No	Depression	Yes	No	Loss of spouse Stroke
Yes	No	Easily frustrated	Yes	No	Loss of socializing skills
Yes	No	Drug Abuse	Yes	No	Urinary
Yes	No	GI Disturbances	Yes	No	Visual
Yes	No	Hearing problems			
Yes	No	Heart disease			

I certify that I have read & understood all of the above. I hereby declare that the inquiries above have been answered to the best of my knowledge & that I will not hold the program or any of it's staff responsible for any error or omissions that I have made in the completion of this form.

Patient's Signature:_____Date:_____

Responsible Party:_____Date:_____

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PATIENT CONSENT FORM

We are committed to providing sensitive, patient specific & comprehensive rehabilitation services to increase independence & improve the quality of life. In order to initiate these services, your signature on this authorization form will be needed. Please read & sign this form & don't hesitate to ask questions. We look forward to working with you.

Patient:_____

Therapy:_____

Date:_____

Authorization for Treatment & Release of Information:

- I authorize this provider to render the treatment set forth above as ordered by my physician.
- I give authorization for therapy to be provided in areas not totally isolated from other patients & personnel.
- This authorization, or photocopy of same, authorizes the release of any medical information necessary for treatment and/or to process claims for services rendered by this provider.

Signature of Patient or Patient Representative:_____ Date:_____

If someone other than the patient has signed, state name & relationship to patient:

Name:_____ Relationship to Patient:_____

Reimbursement Coverage:

- I request & authorize that the patient's insurance coverage and/or Medicare to make payments of authorized benefits on the patient's behalf to this provider.
- I authorize the provider to represent the patient during the appeals process in the event of denial of Medicare benefits.
- Patient shall be responsible for paying deductible, co-insurance, or for any non-insured services authorized above.

Signature of Patient or Patient Representative:_____ Date:_____

If someone other than the patient has signed, state name & relationship to patient:

Name:_____ Relationship to Patient:_____

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CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM

Active Health recognizes the importance of protecting your privacy & personal health information. We encourage you to review & sign this consent form so you are aware of our concern & practices regarding the handling of personal health information.

Should you desire a more complete description of the permissible uses & disclosures of your protected health information, you have the right to review the "Notice of Privacy Practices" prior to signing this consent.

This document is available by request. Please note that Active Health reserves the right to change the privacy practices described in this document.

By signing this consent, you agree that Active Health may use or disclose your protected health information to carry out treatment, payment or healthcare operation.

You have the right to request that Active Health restrict how your personal health information is used or disclosed to carry out treatment, payment or healthcare operations. However, Active Health reserves the right to agree or disagree to such restrictions. If Active Health does agree to a restriction as requested by you, such restriction will be binding.

You have the right to revoke consent in writing, except to the extent that Active Health has taken action in reliance on your previously obtained consent.

Acknowledgement & Agreement:

I consent to Active Health Physical Therapy sending protected health information to the insured in the event that I am receiving treatment but am not the insured under my insurance policy. Such information may include, but not limited to, explanation of benefits (EOB) or invoices regarding my treatment. I understand that if I do not want such protected health information mailed to the insured, then I will notify Active Health of my objection & will complete a Request for Restriction of Use & Disclosure form.

I addition, I understand & accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I &other patients are treated simultaneously. I understand that some of my protected health information may be inadvertently overheard by other patients and/or therapists. I also agree not to disclose any protected health information that I might inadvertently overhear about other patients while I am receiving treatment.

I consent to Active Health Physical Therapy releasing my protected health information to the following individuals:

Name: Relationship to Patient

Name: Relationship to Patient

I have received a copy of Active Health Physical Therapy's Notice of Privacy Practices.

I hereby certify that I have read the provisions set forth in this consent. I understand & agree to the terms of this consent form.

Print Patient's Name Active Health PT Universal ID#

Signature of Patient or Representative Date

Name of Representative Relationship to Patient

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SECONDARY PAYER QUESTIONNAIRE

The questions listed below are for beneficiaries age 65 or older & is used for compliance with *Medicare Regulation 42 CFR 489.20(F)*.

1. Are you currently working full or part-time? Yes No

2. If married, is your spouse working full or part-time? Yes No

3. Are you currently, under any employer group health plan? Yes No

   If YES, please provide the following information:
   Name of Insured:_____
   Relationship to Patient:_____
   Name of Employer:_____
   Name of Carrier:_____
   Group/Policy #:_____

4. Are you entitled to Black Lung Benefits? Yes No

5. Is this service for treatment work related?

   If YES, please provide the following information:
   Name of Insurer:_____
   Name of Employer:_____
   Date of Injury:_____
   Group/Claim #:_____

6. Is this service for treatment related to an auto injury? Yes No

   If YES, please provide the following information:
   Name of Insurer:_____
   Name of Policy Holder:_____
   Date of Injury:_____
   Claim #:_____

7. Are benefits for services being submitted to any other party for reimbursement consideration? Yes No

Signature of Patient/Informant:_____Date:_____

Printed Name of Patient:_____