MEDICAL HISTORY QUESTIONNAIRE

Date_____ **Hand Dominance: o Left o Right** **Weight: _____** **Height: _____**

Patient Name: _____ SSN: _____ DOB: _____

Email _____ **Email Reminder o** **Cell: _____** **Text Reminder o** **Home: _____** **Call Reminder o**

Employer : _____ Job Title: _____ Working: o Yes o No o Restricted/Light Duty

Family Doctor: _____ Family Doctor Group name: _____ **Send Notes o**

Specialist Doctor: _____ Specialist Group Name: _____ **Send Notes o**

Referring Physician: _____ Next Visit: _____ Group Name: _____

SOCIAL HISTORY:

Attorney: o Yes oNo If Yes Name: _____

Cultural/Religious: Do you have any customs or religious beliefs or wishes that might affect care? _____

Work/School/Leisure: o Working F/T o Working P/T o Unemployed o Retired o Student

MEDICAL HISTORY:

Please check if you have ever had:

o Alzheimer's	o Broken Bones	o Osteoporosis	o Blood Disorders
o Heart Disease/Problems	o High Blood Pressure	o Parkinson's	o Lung Problems
o Stroke	o Cancer	o Rheumatoid Arthritis	o Infectious Disease
o Current Infection	o Low Immune Systems	o Tramatic Brain Injury	o Seizures/Epilepsy
o Diabetes Type 1	o Lupus	o Skin Disease	
o Diabetes Type 2	o Obesity	o Ulcers/Stomach Problems	
o Fibromyalgia	o Other: _____		

Have you ever had surgery: o No o Yes If yes, please describe and include dates:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Have you received physical therapy in the past 12 months? o Yes o No If Yes for What: _____

GENERAL HEALTH:

Please Rate your Health : o Good o Fair o Poor o Other: _____

Do you exercise beyond normal daily activities and chores? o Yes o No If yes, describe the exercise: _____

_____

CURRENT ISSUE OR PROBLEMS:

Describe the problem(s) for which you seek physical therapy: _____

_____

_____

When did the current problem(s) begin? Date: _____ Have you had this problem before? o Yes o No

MEDICATIONS/VITAMINS/SUPPLEMENTS:

Do you take any prescriptions or over the counter medications/vitamins/supplements? o Yes o No

If yes, please list: _____

Patient Signature:_____

AUTHORIZATION AND AGREEMENT FOR TREATMENT

The attached signed Consent Form hereby makes the following Acknowledgments and Agreements regarding physical therapy to the patient whose name appears on Consent Form:

1. *Consent to Treatment:* I understand that physical therapy is necessary for the patient and that such treatment will be performed by independent physical therapists, their physical therapy assistants and by employees of FPTI DBA ATP, Inc. during the hours of clinic operation. I understand my permission to perform the evaluation and treatment is voluntary. I am freed to deny consent or stop the evaluation or treatment at any time. I understand that Physical Therapy has certain risks involved with the evaluation and treatment. We will take a thorough history of your condition and then evaluate you as to your ability to move, your strength and your response to this testing so we can plan a treatment program. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results which may be obtained. I have read the foregoing information and understand it. Questions concerning these procedures have been answered to my satisfaction. I also understand that I am free to deny answering the questions during the evaluation process, or to withdrawal consent, and discontinue participation during any treatment session. I also verify I have provided accurate information regarding my condition, health history, physical examination, and fitness.

2. *Description of potential risks*. There are every day risks experienced while working and performing activities of daily living. As such, you have the chance of re-injuring yourself or the possibility of developing a new injury. These include but are not limited to: increase in heart rate, fractures/breaks and re-fractures, fainting, changes/abnormal blood pressure, loss of opportunity to heal, disorders of the heart and in rare instances heart attack, stroke and or death. Every effort will be made to minimize these risks by the provision of appropriate supervision during the evaluation and treatment.

3. *Agreement to Pay for Services:* For and in consideration of the care and treatment provided to the patient, I promise to pay FPTI DBA ATP, Inc. all charges for services rendered to or on behalf of the patient.

4. *Release of Medical Information:* I hereby authorize FPTI DBA ATP, Inc. to release any medical information in connection with these services for health insurance purposes or to the patient's personal physician and/or case manager/adjuster/rehab nurse or employer for the purpose of a Worker's Compensation claim.

5. I understand that anyone accompanying the patient on his/her visit has my permission to be present during any discussions concerning the patient's health information.

6. I understand that the assignment below is applicable only if FPTI DBA ATP, Inc. bills my insurance carrier as a courtesy to me.

7. I understand that any overpayment to FPTI DBA ATP, Inc. from multiple insurance carriers may, at FPTI DBA ATP, Inc.'s election, be returned to the insurance carriers. Payment to FPTI DBA ATP, Inc. in excess of charges will be refunded to the responsible party.

Responsibility of the patient. I understand information I may possess about my health status, or previous experiences of unusual feelings with physical effort may affect the safety and value of my evaluation. As a result, I understand I should promptly report unusual feelings, discomfort, and/or pain during the assessment and treatment. I agree to work diligently and to be compliant. I understand that the therapist will discuss with me safety issues during the evaluation and treatment. I may stop my treatment at any point if I feel unwilling or unable to progress safely. I also understand that the therapist will stop my participation in treatment. I will communicate with the Physical Therapist how I feel during the evaluation and treatment. I can expect to have an increase in soreness with the evaluation and treatment. I will report changes in my symptoms to the therapist to help them in assisting me to get better. Any questions about the procedures used during the evaluation and treatment are encouraged. I understand if I have any doubts or questions, or need for further explanations. I will be given the opportunity to ask questions and receive an explanation.

ASSIGNMENT OF INSURANCE BENEFITS, AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize direct payment of all medical benefits to FPTI DBA ATP, Inc. The benefits referred to herein would be payable to me if I did not make this assignment. I also authorize FPTI DBA ATP, Inc. and my attending physical therapist to release any medical information required in the processing of applications for financial coverage for services rendered during my treatment.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLES AND ALL REMAINING CHARGES WHICH ARE NOT COVERED BY MY INSURANCE PLAN. I FURTHER UNDERSTAND THAT IN ABSENCE OF INSURANCE COVERAGE, I AM FULLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES.

Authorization to Use Name and Likeness in Marketing Video, In Print and On-Line

I, _____, a patient of Fowler Physical Therapy dba Accelerate Therapy & Performance ("FPTI DBA ATP"), understand that:

A. FPTI DBA ATP is preparing marketing materials (videos, newsletters, newspaper inserts, on-line, social media) which will demonstrate the success and results of the physical therapy it provides;
B. FPTI DBA ATP will provide copies of the material to potential referring Physicians, as well as to individuals who are potential patients;
C. In order to create the materials and show the results obtained by FPTI DBA ATP patients, it is necessary for FPTI DBA ATP to take pictures and video/audio recordings of patients prior to, during and following the treatments they receive at FPTI DBA ATP;
D. I have been asked and agree to appear in the materials;
E. Therefore, FPTI DBA ATP will take pictures and video/audio recordings of me prior to, during and after the treatment I receive from FPTI DBA ATP;
F. FPTI DBA ATP will incorporate the pictures and video/audio recordings stated above into the materials;
G. My likeness and/or name will appear in the materials;
H. The condition for which I am being treated at FPTI DBA ATP may be expressly stated in the materials;

I hereby authorize FPTI DBA ATP, its employees, agents, officers and directors to photograph, film, videotape, record and/or portray my name, likeness, voice and/or actions prior to, during and after the treatment I receive at FPTI DBA ATP and incorporate the same into the materials which are to be used for marketing purposes. I also authorize FPTI DBA ATP to incorporate my diagnosis into the materials, along with such other information, as FPTI DBA ATP deems appropriate. I waive any rights I may have to inspect or approve the incorporation of the pictures and video/audio recordings of me into this material. I understand that all rights in and to the above authorized material, including copyright, shall be FPTI DBA ATP's sole and absolute property.

I understand FPTI DBA ATP cannot control the further dissemination of the materials after they leave the control of FPTI DBA ATP. Accordingly, I release FPTI DBA ATP from any liability related to the dissemination of the materials.

I understand that I can revoke this Authorization at any time. My revocation must be in writing and sent via certified mail to Fowler Physical Therapy dba Accelerate Therapy & Performance, Inc., 1508 West Innes St. Salisbury NC 28144. However, FPTI DBA ATP will still be authorized to distribute any copies of the material that has been produced through the end of the day on which FPTI DBA ATP receives my revocation.

I agree that I have read and understand this Authorization and am at least eighteen years of age and intending to be legally bound hereby, I set my hand and seals on the date below written.

Witness: _____

Date: _____

Signature: _____

Date: _____

☐ I wish to OPT OUT of this program. Signature: _____ Date: _____

HIPAA Privacy Consent

HIPAA is an acronym for the **Health Insurance Portability & Accountability Act** of 1996 (a federal law). Important to healthcare organizations is the Administrative Simplification section of the Act which requires healthcare organizations to comply with specific rules concerning:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction and Code Sets for transmitting data electronically
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these regulations have been developed by the Department of Health and Human Services and will go into effect in a staged manner – healthcare organizations will generally have 24 months to achieve compliance as each regulation becomes final. You have a right to request a copy of FPTI dba ATP, Inc. Notice of Privacy Practices.

The HIPAA Privacy Rule, for the first time, creates national standards to protect individuals' medical records and other personal (protected) health information (PHI). However, the HIPAA Rule permits providers to communicate with their patients regarding their healthcare, which includes communicating by phone, through the mail or in some other manner. It does not prohibit leaving messages on answering machines or with a family member or other person who answers the phone when the patient is not available. Also, any information shared between patient and provider in a group-type setting, is considered private and confidential and may not be used or disclosed by other individuals participating in that group setting.

The HIPAA Privacy Rule requires providers to make reasonable efforts to limit use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The Rule also requires providers make their own assessment of what PHI is reasonably necessary for a particular purpose – this is a reasonableness standard that calls for an approach consistent with Best Practices and guidelines already used by FPTI dba ATP., Inc. The Rule does not prohibit the use, disclosure of or request for an entire medical record. However, if the medical record contains older portions of the patient's medical history, the provider does not have to disclose or release the entire record if the older information does not pertain to the patient's current status. Individuals do not have a right under the Privacy Rule to request that a provider restrict a disclosure of PHI about them for Worker's Compensation purposes when that disclosure is required by law or authorized by, and necessary to comply with, a Worker's Compensation or similar law.

By the attached Consent Form, you confirm your understanding of this HIPAA notice and authorize FPTI dba ATP, Inc. and the staff to leave medical information pertaining to your care by the following methods and will assume responsibility to notify FPTI dba ATP, Inc. whenever this information changes:

Home Telephone, Answering Machine, Work Telephone, Voicemail, Fax,
Cell Phone/Voicemail, Pager, and/or fax medical records to another entity.

In situations where a patient requests the provider to communicate with him or her in a confidential manner only or if you would like a copy of FPTI dba ATP, Inc. Notice of Privacy Practices, please list on attached Consent form.

1508 W Innes Street
Salisbury NC 28144

280 N Talbert Blvd
Lexington NC 27292

CONSENT FORM

I,___________________________, have read **Accelerate Therapy& Performance Authorization and Agreement for Treatment**, **Patient Bill of Rights, Cancellation Policy, Notice to all Workers' Compensation Patient (if applicable), and HIPPA Privacy Consent** fully understand the same.

Signature: ____

Staff Witness Signature: ____

Date: ____________________________

Any Special Request: ☐

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I ______________________ request a printed copy of Accelerate Therapy & Performance:

☐ Authorization and Agreement for treatment
☐ Bill of Rights, Cancellation Policy, Notice to all Workers Compensation patients
☐ HIPPA Privacy Consent

Signature: ____