

**PATIENT
INTAKE
FORM**

PATIENT INFORMATION

TODAY'S DATE _____

Last Name _____ First _____ Social Security _____ - _____ - _____

Home Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone _____ Cell Phone _____ Sex M F

Email Address _____ Marital Status: S M D W

Referring Physician _____ Primary Physician _____

Emergency Contact _____ Phone _____ Relation _____

INSURANCE INFORMATION

Primary Insurance _____ Phone _____

Policy Number _____ Group Number _____

Relationship to Patient _____ SSN _____ - _____ - _____ DOB _____

Responsible Party Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

Secondary Insurance _____ Phone _____

Policy Number _____ Group Number _____

Relationship to Patient _____ SSN _____ - _____ - _____ DOB _____

Medicare Patients: Are you receiving home care services? Yes or No

Have you received Therapy Services this year? Yes or No

** As of January 1, 2011 Medicare limits all physical, occupational and speech therapy to \$1,870 per calendar year. You will be responsible for any therapy services provided beyond the Medicare limitation.**

Medicare Patients Please Initial _____

INFORMATION ABOUT YOUR NEED FOR THERAPY

Date of Injury or Onset of Problems _____

Tell us about your injury or condition _____

Is this injury the result of an Auto Accident? Yes or No

If Yes, how are you filing: __ Auto Insurance __ Medical Insurance __ Self Pay __ Through a 3rd Party

Did this injury occur at work? Yes or No

If Yes, was the injury reported and filed under Workers Compensation? Yes or No

Carrier Company: _____ Case Number: _____

Case Manager: _____ Phone: _____ Ext: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? (CHECK ALL THAT APPLY)

Advertisement _____ Been Here Before _____ Doctor _____ Friend _____

Family _____ Insurance Provider _____ Newspaper _____ Phone Book _____

Website _____ Other _____

OUR POLICIES

Scheduling - We will make every effort to schedule an appointment at the most convenient day and time for you. Please call at least 24 hours in advance to cancel an appointment so that we may use that time for another patient. If you need to change an appointment we will make every effort to accommodate your busy schedule. We suggest that you schedule your appointments 2-3 weeks in advance. After 3 cancellations you will be referred back to your physician to renew your prescription. After 2 no shows your physician and insurance company will be notified which may result in the denial of payment, making you responsible for any balance on your account.

Prescriptions – A prescription for physical therapy signed by a Georgia Licensed Physician is required for treatment and it is the patient’s responsibility to ensure that it is up to date and valid.

Insurance – We are happy to bill your insurance company as a courtesy and convenience if we are provided with appropriate billing information. If we do not receive proper information, payment may be requires at the time services are rendered.

No Insurance – We are happy to provide services to patients not participating in a health insurance program, but we insist payment be made at the time services are rendered.

Medical Supplies – The patient will be responsible for the cost of any durable or medical goods supplied in the event the insurance carrier does not cover these expenses.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

- 1) I have reviewed a copy of **n motion Hand & Physical Therapy’s** Notice of Privacy Practices. Yes No Initial _____
- 2) I agree to the open treatment or gym area used by **n motion Hand & Physical Therapy** (private treatment room available upon request). Yes No Initial _____
- 3) I agree that I must sign a sign in sheet at each visit and I understand that subsequent visitors have the opportunity to read my name. Yes No Initial _____
- 4) I authorize **n motion Hand & Physical Therapy** to send me newsletters by mail or email. Yes No Initial _____
- 5) I authorize **n motion Hand & Physical Therapy** to call me at my home or on my cell phone with regards to my appointments. Yes No Initial _____

Signature

Print Name

Date

N motion Hand & Physical Therapy Staff Only - We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign ____ Communication barriers ____ Other _____

Signature: _____ Date: _____



Hand and Physical Therapy

No Show/Cancellation Policy

In order for nmotion Hand and Physical Therapy to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. Your appointment time is reserved for you. **Casual no shows and cancellations:**

- Delay your recovery
- Deny others the use of available treatment times
- Costs the facility productive time and resources

Effective **January 3rd, 2011** if you miss your appointment or cancel with less than 24 hours notice we reserve the right to bill you \$25 for each no-show and cancellation.

We do realize that on rare occasions emergencies may arise and we will address these situations with you at that time. Three (3) consecutively missed appointments will be considered a self discharge and a discharge summary will be provided to your physician and/or case worker.

Good rehabilitation is a Team effort and cannot be accomplished effectively with frequently missed appointments.

I, _____, have read and understand the no-show/cancellation policy as outlined above.

Your Name

Date



Hand and Physical Therapy

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2007 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. n motion Hand & Physical Therapy utilizes an open treatment facility. It is possible that while under our care an unauthorized individual may have access to your protected health information via overheard verbal communications. We will do everything possible to protect your rights to privacy and confidentiality. During your care we also ask that you sign in each visit, subsequent patients will have the opportunity to read the names of those signed in before them.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Notice of Privacy Practices Continued

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$.10 (ten cents) for each page, \$15.00 (Fifteen dollars) per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before November 1, 2007. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

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Alpharetta, GA 30005
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