



CAPITAL

PHYSICAL THERAPY

Worker's Compensation Intake

CONCORD, NH

Patient Information:

Name _____

Address _____

Email _____

Sex **Male** **Female**

Occupation _____

Employer _____

Address _____

If minor, name of parent or guardian _____

Nearest relative not living with you _____

Relation _____

Address _____

Attorney _____

Home Phone _____

Work Phone _____

Social Security # _____

Date of Birth _____

Height _____' _____" Weight _____ lbs

Marital Status _____

No of Children _____

How did you hear about Capital Physical Therapy? Friend Website Former patient PCP

Gym member Drive by Walk in Yellow pages Moneysaver Other specialist _____

Accident Information:

Date _____ Time _____ AM PM

Was it reported? **YES** **NO**

Town accident occurred in _____

Street _____

Please explain in detail how the accident occurred _____

Please list symptoms felt immediately after the accident _____

Where were you taken after the accident? _____

If hospital, how were you taken? **AMBULANCE** **PRIVATE VEHICLE** **OTHER**

Were X-Rays done? **YES** **NO** An MRI? **YES** **NO** CAT scan? **YES** **NO**

Have you seen any other doctor(s) since the accident? **YES** **NO** Name _____

Have you missed any work since the accident? **YES** **NO** Date(s) _____

Did you ever experience similar symptoms prior to the accident? **YES** **NO**

Has your condition **IMPROVED** **WORSENERD** or **STAYED SAME** since the accident?

Please share any other information that might be important to your diagnosis and treatment _____

Insurance Information:

Insurance Company _____

Address _____

Phone _____

Adjustor's Name _____

Claim # _____

Utilization Company _____

Phone _____

Nurse _____

Fax _____

Patient Signature _____

Date _____



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PATIENT INFORMATION / HEALTH INTAKE

Name: _____

Date of onset, injury, or surgery: _____

Major complaint: _____

Any prior treatment for this condition? _____

Are you currently taking medications? If so please list: _____

Do you presently, or have you ever had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnant (currently) |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Hernia (ventral / inguinal) | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Trouble Swallowing |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Blackouts / Fainting |
| <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Bowel / Bladder Problems | <input type="checkbox"/> Excessive Vomiting |
| <input type="checkbox"/> Pins & Needles | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Drop Attacks | <input type="checkbox"/> Heart Attack(s) |
| <input type="checkbox"/> Dysarthria (difficulty with speech) | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Nervous Disorders | |

Have you had prior surgery? If so, please explain: _____

Are there any other medical conditions that your therapist should be aware of?



CAPITAL PHYSICAL THERAPY

Acknowledgement of Office Policies

*The following are Capital Physical Therapy's policies governing appointment scheduling, payment terms, and information releases. **Please read carefully** before signing, and be sure to ask questions you might have before signing the document.*

Appointment Scheduling. We at Capital Physical Therapy are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without notifying Capital Physical Therapy (emergencies considered), you may be dismissed from care and your file may be closed. *We only treat those patients who want to get well.*

Consent for Treatment. I, the undersigned, give Capital Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment.

Assignment of Payment. I hereby authorize my insurance company and/or my attorney to pay direct to Capital Physical Therapy, PC any monies due on my account for professional services rendered.

Acknowledgment and Understanding. It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ **Date:** _____

Name (Please Print): _____

Witness Signature: _____ **Date:** _____

Name (Please Print): _____



CAPITAL PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

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

Capital Physical Therapy's LEGAL DUTY

Capital Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Capital Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Capital Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Capital Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any situation, Capital Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provided us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Capital Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Capital Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Capital Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Capital Physical Therapy's health information practices, or if you have a complaint, please contact the following person:

**John Fitzsimmons
63 South Main Street
Randolph, MA 02368
Telephone (781)961-9200**



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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Capital Physical Therapy's Notice of Information Practices. I understand that Capital Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Capital Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Capital Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

DESIGNATE INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Name

Patient Signature

Date