



Personal Insurance Intake Form

CONCORD, NH

Patient Information:

Name _____

Home Phone _____

Address _____

Work Phone _____

Social Security # _____

Email _____

Date of Birth _____

Sex **Male** **Female**

Height _____' _____" Weight _____ lbs

Occupation _____

Marital Status _____

Employer _____

No of Children _____

Address _____

If minor, name of parent or guardian _____

Nearest relative not living with you _____

Relation _____

Phone _____

Address _____

Attorney _____

Phone _____

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

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

Injury Information:

Why are you seeing the Physical Therapist today? _____

When did your injury occur, or when did you start experiencing symptoms? _____

Insurance Information:

Insurance Company _____

Policy Holder's Name _____

Coverage _____

Deductible _____

Has it been met? **Y N** Co-pay \$ _____

Patient Signature _____

Date _____

OFFICE USE:

Date Insurance Verified _____

Rep Name _____

Pre-authorization needed? **Y N**

Rep Phone (w/ext.) _____

Limitations (per injury, lifetime, calendar year) _____

Initials _____



CAPITAL

PHYSICAL THERAPY

Current Health Conditions

What is your major complaint? _____

When did symptoms start? _____

Other Doctor(s) seen for this complaint: _____

Have you received any Home Health Services? _____

Have you fallen in the last 12 months? Y N How many times? _____

Please shade in what you are being treated for by Physical Therapy

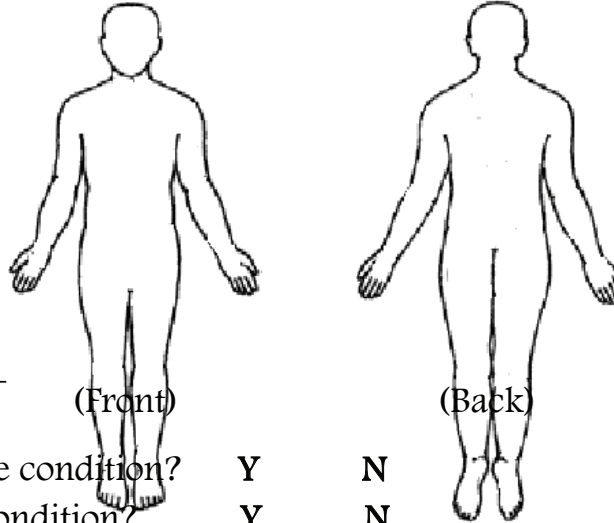
Pain scale: 0 1 2 3 4 5 6 7 8 9 10

Pain is:

__achy __burning

__sharp __dull

__throbbing __other _____



Are there others in your family with same condition? Y N

Have you missed work because of your condition? Y N

If so, what dates? _____

Condition due to work? Y N Motor Vehicle Accident? Y N

If so, date of injury? _____ If so, date of injury? _____

Have you had major surgery? Y N If yes, what type? _____

Have you had any major accidents or falls? Y N If yes, what type? _____

Have you ever been hospitalized for other conditions? _____

Have you been treated for other conditions in the past 12 months? Y N

If so, please explain: _____

List current medications including dosage _____

Patient's Initials _____



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:** _____

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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



CAPITAL PHYSICAL THERAPY

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: _____