_____ _____
Nickname Date of Today

_____, _____ , ____ _____ _____
Last name **First name** **MI** **last 4 SS#** **DOB**

Circle one:

Gender
Male
Female
Transgendered

Marital Status
Married
Single
Other _____

Employment status
Employed
Unemployed
Student
Retired
Other _____

Physical address: _____

Mailing Address:_____

Email Address: _____@_____

Phone: Cell:( )_____ Home: ( )_____Work: ( )_____

Spouse/Guardian Name:_____
Address, if different:_____
Contact Phone number:_____

Emergency Contact Name:_____
Relationship to patient:_____
Address, if different:_____
Contact Phone number: ( )_____

Person Responsible for bill
Name: _____
Relationship to patient:_____
Address, if different: _____
Contact Phone number: ( ) _____

Employer Name: _____
Address: _____
Contact Phone number: ( ) _____

Work related injury: yes / no Date of Injury:_____
Employer: _____ Insurance: _____ Claim#:_____
Claim Adjustor name: _____ Phone Number: _____
Attorney involved: _____ Phone Number:_____

Motor Vehicle accident injury: yes / no Date of Accident: _____
Insurance: _____Claim #: _____ Insured Name:_____
Claim Adjustor: _____ Phone Number: _____
Attorney involved: _____ Phone Number: _____

Primary Physician: _____ Clinic: _____
Address: _____ Phone Number: _____

Referring physician: _____Clinic: _____
Address: _____ Phone number: _____

Primary Insurance:
Company: _____Policy#: _____ Group#:_____
Patient's relationship to subscriber: self / spouse / parent / other _____
Subscribers Name:_____DOB: _____ SS#:_____
Secondary Insurance
Company: Policy#: Group#:
Patient's relationship to subscriber: self / spouse / parent / other_____
Subscribers Name: _____ DOB: _____ SS#:_____

Medical / Physical Changes
It is important that any and all changes in medical care or medical status be reported to your physical therapist

_____ Initial acknowledgement of medical changes

Medicare Patients Yes / No
Have you had home health PT, OT, RN or other services in the past 30 days? If you fail to report this to your therapist, you will be solely responsible for all bills associated with your care.
Initial acknowledgement of home health services_____

Assignment of benefits

I understand that I am responsible for my physical therapy charges and I agree to pay in a timely manner my deductible, co-insurance, co pays or charges not reimbursed by my insurance carrier. I authorize Out Patient at Home Physical Therapy LLC to bill my insurance company and I authorize payment from the insurance carrier directly to Out Patient at Home Physical Therapy LLC. I authorize Out Patient at Home Physical Therapy LLC to release medical or other information necessary to process this claim.

I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. I understand that some insurance companies have deductibles, co-pays, and/or required medical or administrative pre-authorizations for treatment. I understand that I am responsible for knowing and meeting the requirements of my insurance plan. Incorrect information from my insurance carrier regarding my benefits is not the responsibility of Out Patient at Home Physical Therapy LLC.

If the patient is seeking treatment for injuries which may give rise to third-party personal injury claim. The following applies:

Under AS34.35. 450-.482 Out Patient at Home Physical Therapy LLC may assert a lien for unpaid medical charges against liable party, the liable party's insurer and the patient's attorney.

Patient may be entitled to a pro rata reduction of Out Patient at Home Physical Therapy LLC service for attorney's fees and costs incurred in the pursuit of Patient's third-party personal injury claim. (ANMC v Settlement Funds, 2004 WL 179026). Patient agrees to wave balancing the bill for all unpaid claims, regardless of outcome from any settlement proceedings. If made, the decision to obtain legal representation is the patient's and not his/her right to reduce Out Patient at Home Physical Therapy LLC service charges lien for costs and attorney's fees as set forth above for, but **will waive this right for Out Patient at Home Physical Therapy LLC waiting without payment in full at the time of services being rendered.** Patient acknowledges that Out Patient at Home Physical Therapy LLC will balance the bill for all unpaid claims, regardless of outcome from any settlement proceedings and will not hold Out Patient at Home Physical Therapy LLC responsible for any portion of incurred attorney fees. By signing this waiver, patient acknowledges that his/her rights to pro rata reduction of Out Patient at Home Physical Therapy LLC 's lien for attorney's fees and costs incurred in the pursuit of patient's third-party personal injury claim have been explained to him/her.

By signing this waiver, patient agrees to waive pro rata reduction of Out Patient at Home Physical Therapy LLC's Lien for attorney's fees and costs incurred in their pursuit of patient's third-party personal injury claim and to pay Out Patient at Home Physical Therapy LLC **in full** upon settlement of any third party personal injury claim. If necessary, patient agrees to pay his/her attorney, any monies due under ANMC v Settlement Funds, 2004 WL 179026 (Alaska 1/30/04) and/ or pro rata reduction of Doctor's Lien for attorney's fees and costs incurred, whereby freeing Out Patient at Home Physical Therapy LLC of any financial responsibility to patient's attorney. IF YOU ARE IN A CAR ACCIDENT YOU HAVE A NON NEGOTIATION AGREEMENT.

I understand my responsibility for the payment of my account

Print Name:_____

Signature:_____ **Date:**_____

I have read and agree to the above policies.

I do hereby agree and give my consent for Out Patient at Home Physical Therapy LLC to provide medical care and treatment to me considered necessary and proper in diagnosing or treating his/her/my condition.

Print Name:_____

Signature (responsible party):_____ **Date:**_____

HIPAA Compliance Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. **Get an electronic or paper copy of your medical records by request:**
   We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
2. **Ask us to correct your medical record:**
   You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but will give a reason in writing within 60 days.
3. **Request confidential communications:**
   You can ask us to contact you in a specific way or send mail to a different address.
4. **Ask us to limit what we use or share.**
   If you pay for service or health care items out of pocket in full, you can ask us to not share information for purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share the information.
5. **Get a list of those with whom we've shared information.**
   You can ask for an accounting of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free and will charge a reasonable fee if you ask for another one within 12 months.
6. **Get a copy of this privacy notice:**
   You can ask for a paper copy of this notice at any time.
7. **Choose someone to act for you:**
   If you have given someone a medical durable power of attorney or legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has authority and can act for you before taking action. File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at 907-250-3932. You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, calling 108770696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
8. **For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these~~,~~ cases, you have both the right and choice to tell us to:**
   Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. Contact you for fundraising efforts.
9. **If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission:**
   Marketing purposes, sale of your information, most sharing of psychotherapy notes.

Initial & date:_____

HIPAA Compliance Policy (continued):

10. **How do we typically use or share your health information? We typically use or share your health information in the following ways:**
    For communication with other health care providers, to run our practice, improve your care, and contact you when necessary. We may review the competence or performance of those who render your healthcare. Used for billing and payments for services rendered.
11. **How else can we use or share your health information? We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.**
    For more information see:
    http://www.hhs.gove/ocr/privacy/hipaa/understanding/consumers/index.html.
12. **We can share health information about you for certain situations such as:**
    Help with public health and safety issues; preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety; do research comply with the law if state and federal law requires it; respond to organ and tissue donation requests; work with medical examiner or funeral director; address worker's compensation, law enforcement; and other government requests.
13. **We can use or share health information about you:**
    For workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military, national security, and presidential protective services.
14. We share health information about you in response to a court or administrative order, or in response to a subpoena.
15. We are required by law to maintain the privacy and security of your protected health information.
16. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
17. We must follow the duties and privacy practices described in this notice and give you a copy of it.
18. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gove/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date of this notice: October 1, 2019

I, _____, acknowledge that my signature below indicates that I have received this notice and have been given the opportunity to ask questions about the policies and procedures contained within.

_____
Signature Date_____

Missed appointment Policy

We at Out Patient at Home Physical Therapy LLC, understand that you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible. (with at least a 24-hour notice). You can cancel by calling 907-250-3932. To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, in addition to not wasting a medical professionals time by not being home for prearranged appointments please take note and be ready for the visit. A reminder the day before the visit can be given upon request.

Please review the following policy:

1. Please cancel your appointment with at least 24 hours' notice: there is a waiting list to see the Doctor at Out Patient at Home Physical Therapy LLC, and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If you give less than a 24-hour cancellation this will be a "no-show" appointment.

3. If you are out of your home at the time of your scheduled appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-show" appointment you will receive a phone call or letter warning that you have broken the policy and a $50 no show fee will be applied to your account to be paid in advance of the next scheduled visit. ***This is not a billable service and your insurance will not cover the charge.

5. If you have 2 "No-show" visits you will be charged $50 and immediately discharged and will not be accepted for further care in the future.

I have read and understand Out Patient at Home Physical Therapy LLC's, missed appointment policy and understand my responsibility to plan appointments accordingly and notify Out Patient at Home Physical Therapy LLC, appropriately if I have difficulty keeping my scheduled appointments.

Patient Name _____ DOB_____ Date_____

_____ _____

Patient/Guardian signature Relationship to patient Date

_____ _____

Staff Signature Date

Current Complaint

Overall, my health is: Excellent / Good / Fair / Poor
List your top health goals, in order of importance:

- 1.
- 2.
- 3.
- 4.
- 5.

List your symptoms, in order of importance:

- 1.
- 2.
- 3.
- 4.
- 5.

List all doctors or other health practitioners you have seen for this problem with date:

- 1.
- 2.
- 3.

List anything else you have tried in order to resolve this problem
_____
_____
_____
_____
_____

Expectations

How long do you expect it to take to fully resolve your problem?

What lifestyle changes do you think you will have to make in order to achieve your health goals?

On a scale of 1-10 how important is it for you to improve this situation?

Unimportant | 1| 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | I'd do anything to fix it

Medical history please circle Yes or No:

Allergies	Yes No	Emphysema/Bronchitis	Yes No	Multiple sclerosis	Yes No
Anemia	Yes No	Fibromyalgia	Yes No	Muscular Disease	Yes No
Anxiety	Yes No	Fractures	Yes No	Osteoporosis	Yes No
Arthritis	Yes No	Gallbladder Problems	Yes No	Parkinson's disease	Yes No
Asthma	Yes No	Headaches	Yes No	Rheumatoid arthritis	Yes No
Autoimmune disease	Yes No	Hearing Impairment	Yes No	Seizures	Yes No
Cancer	Yes No	Hepatitis	Yes No	Smoking	Yes No
Cardiac Conditions	Yes No	High Cholesterol	Yes No	Speech problems	Yes No
Cardiac Pacemaker	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Chemical Dependency	Yes No	HIV/AIDS	Yes No	Thyroid Disease	Yes No
Circulatory problems	Yes No	Incontinence	Yes No	Tuberculosis	Yes No
Depression	Yes No	Kidney Problems	Yes No	Vision issues	Yes No
Diabetes	Yes No	Metal Implants	Yes No		
Dizzy spells	Yes No	MRSA / Staph infection	Yes No		

Describe any other conditions or surgeries:

_____
_____
_____
_____
_____

Fall History:

Is the injury the result of a fall in the past year? Yes No Date of Fall:_____

Two or more falls in the last year? Yes No Date of Falls:

.

Current medications and herbal supplements:

Drug_____ Dose_____ Reason for taking _____

Drug_____ Dose_____ Reason for taking _____

Drug_____ Dose_____ Reason for taking _____

Drug_____ Dose_____ Reason for taking _____

Drug_____ Dose_____ Reason for taking _____

Drug_____ Dose_____ Reason for taking _____

Drug_____ Dose_____ Reason for taking _____

Drug_____ Dose_____ Reason for taking _____

Printed Name:_____

Patient/Guardian Signature:_____Date:_____