HEIM PHYSICAL THERAPY

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PATIENT INFORMATION

Name: | Date:

Street: City: State: Zip:

Home Phone: | DOB:

Work Phone: | SSN:

Cell Phone: | Sex: M / F Marital Status:

Employer Name: | Phone:

Employer Address

Emergency Contact: | Phone:

Email Address:

PRIMARY INSURANCE

Primary Insurance:

Insurance Address:

Insurance Phone:

Insurance ID#: | Group #: Copay

Policy holders Name:

DOB: | SSN:

Relationship of the Insured:

Policyholders Employer:

SECONDARY INSURANCE

Secondary Insurance:

Insurance Address:

Insurance Phone:

Insurance ID#: | Group #:

Policy holders Name:

DOB: | SSN:

Relationship of the Insured:

Policyholders Employer:

AUTHORIZATION, ASSIGNMENT AND RELEASE

I certify that the above information is true and intended for my physical therapist. I understand that this office will keep my records secure according to the guidelines of the health insurance portability and accountability act.

I authorize, assign and direct my insurance carrier to pay directly to Jefferson Sports Physical Therapy, DBA Heim Physical Therapy, all medical benefits, if any, otherwise payable to me for services rendered,. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that this office is legally obligated to collect all copays, deductibles & or co-insurance deemed to be patient/insured responsibility by the insurance company. I agree that in the event I receive any checks, drafts or other payment subject to this agreement, I will act as fiduciary agent to the office. I understand I am responsible for any referrals required by my insurance carrier. I understand I must provide all information required for my workers compensation/no fault insurance or I will be responsible for the expenses incurred. __N/A, __ INFO attached. I hereby authorize this office to release all information necessary to secure payment of benefits. I authorize use of this signature on all my insurance submissions whether manual or electronic.

X _____
Patient Signature Date

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Name:_____ D.O.B:_____ Today's Date:_____

Have you fallen in the last 12 months? Y N If yes, how many times? _____ were you injured? Y N

Are you presently working? Y N If female, are you pregnant? Y N Date of injury:_____

How did it happen?_____ Work related? Y N / Auto related? Y N

Have you had a related surgery? Y N date:_____ Date of next physician's visit:_____

I have stairs at home: Y N Current Litigation: Y N Your current Height: _____ Weight: _____

Do you have or have you had any of the following:

	Yes	No		Yes	No
Alzheimer's	☐	☐	Hernia	☐	☐
Allergies_____	☐	☐	Immunosuppression	☐	☐
Asthma/breathing difficulty	☐	☐	Kidney	☐	☐
Bowel/bladder	☐	☐	Liver/gallbladder	☐	☐
Cancer	☐	☐	Lupus	☐	☐
Cardiovascular disease	☐	☐	Metal implants	☐	☐
Chest Pain/Angina	☐	☐	Muscular dystrophy	☐	☐
Cerebral Vascular Accident	☐	☐	Nausea/vomiting	☐	☐
Cauda Equina Syndrome CES	☐	☐	Osteoarthritis	☐	☐
Current infection	☐	☐	Osteopina	☐	☐
Diabetes type I	☐	☐	Osteaoporosis	☐	☐
Diabetes type II	☐	☐	Ringing in ears	☐	☐
Dizziness/fainting	☐	☐	Rheumotoid arthritis	☐	☐
Fibromyalgia	☐	☐	Rheumotoid arthritis	☐	☐
Fracture or suspected break	☐	☐	Surgery	☐	☐
High blood pressure	☐	☐	Smoking/vaping	☐	☐
Headache	☐	☐	Seizures	☐	☐
Heart attack/disease	☐	☐	Traumatic brain injury	☐	☐
Heart palpitations	☐	☐	Urine leakage	☐	☐
Pacemaker	☐	☐			

Other_____

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

Are you presently taking any medication including over the counter & supplements? Y N Please list below or attach a lis

Medication	taken for	mg	times/day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please Turn Page Over

Any known results of recent X-rays or tests:

Do you participate in any sports, exercise program or activities on a regular basis? Y N

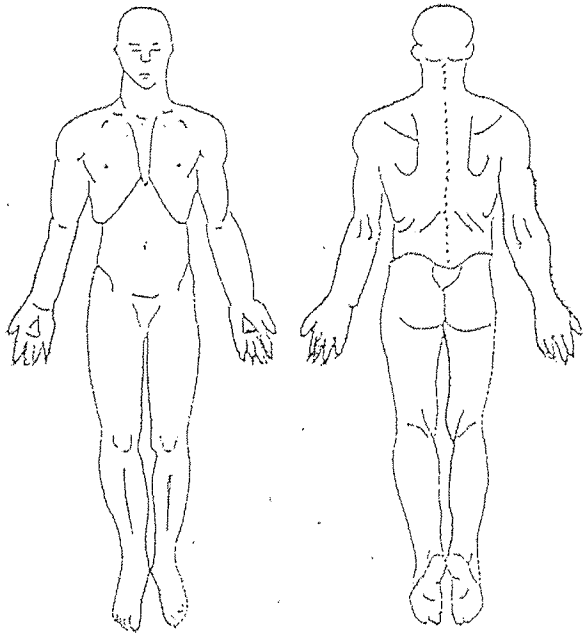
How would you rate your ability to perform routine daily activities:

No problems 90% 80% 70% 60% 50% 40% 30% 20% 10% Unable to Perform

How would you rate your ability to perform the activities associated with your job:

No problems 90% 80% 70% 60% 50% 40% 30% 20% 10% Unable to Perform

Please indicate below where your symptoms are located:



KEY
Numbness ====
Pins and Needles 0000
Burning Pain XXXX
Stabbing Pain /////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible _____

Consent to Treatment

I understand that I have been referred for rehabilitative treatment and care to Jefferson Sports Physical Therapy, PC. My treatment plan has been explained to me by the treating physical therapist. I understand that I have the right to asl and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have this facility provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature_____Date:_____

Signature of Parent/ Guardian_____Date:_____

Depression Scale

Instructions:

Choose the best answer for how you have felt over the past week:

1. **Are you basically satisfied with your life?** Yes **No**
2. **Have you dropped many of your activities and interests?** **Yes** No
3. **Do you feel that your life is empty?** **Yes** No
4. **Do you often get bored?** **Yes** No
5. **Are you in good spirits most of the time?** Yes **No**
6. **Are you afraid that something bad is going to happen to you?** **Yes** No
7. **Do you feel happy most of the time?** Yes **No**
8. **Do you often feel helpless?** **Yes** No
9. **Do you prefer to stay at home, rather than going out and doing new things?** **Yes** No
10. **Do you feel you have more problems with memory than most?** **Yes** No
11. **Do you think it is wonderful to be alive now?** Yes **No**
12. **Do you feel pretty worthless the way you are now?** **Yes** No
13. **Do you feel full of energy?** Yes **No**
14. **Do you feel that your situation is hopeless?** **Yes** No
15. **Do you think that most people are better off than you are?** **Yes** No

Score Meaning:

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression

A score ≥ 10 points is almost always indicative of depression

A score > 5 points should warrant a follow-up comprehensive assessment

HEIM PHYSICAL THERAPY

Health Insurance Portability & Accountability Act (HIPAA)

Patient's Name: _____ Date: _____

This form contains how your Protected Health Information (PHI) will be used in our office. By signing at the end of these policies, you agree to all stipulations.

1. I understand and agree to allow Jefferson Sports Physical Therapy, DBA Heim Physical Therapy to use my PHI for the purpose of treatment, payment, health care operations and coordination of care.
2. I have the right to my exam and to obtain a copy of my own health records at any time and request corrections. I may request the disclosures that have been made and submit in writing any further restrictions on the use of my PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. I may provide a written request to revoke consent at any time during care. This could not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Jefferson Sports Physical Therapy, DBA Heim Physical Therapy to assure that your records are not readily available to those who do not need them.
6. I understand that incidental disclosures of my PHI may be made. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
7. I have the right to file a formal complaint with the privacy official about any possible violations of these policies and procedures.
8. If I refuse to sign this consent for the purpose of treatment, payment, and health care operations, the office has the right to refuse care.

Please answer the following questions indicating any restrictions

9. I agree that the office has the right to call my home or place of employment regarding appointment and/or insurance issues.
   ___ Yes ___ No Restrictions: _____
10. I give permission to the office to call me and/or leave messages for me on an answering machine/ voicemail.
    ___ Yes ___ No Restrictions: _____
11. Other than myself, I authorize the physician(s)/ practitioner(s) of Jefferson Sports Therapy, DBA Heim Physical Therapy to share/discuss my medical information with:
    Name: Relationship Phone #
    Name: Relationship Phone #

I acknowledge that I have read or have had read to me the above information. I have also had the opportunity to ask questions about it and understand that I may receive a copy of this at my request. By signing below I agree to the above mentioned stipulations. I understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signed: _____ Date: _____
Signature of Patient or Legal Representative

If signed by a legal representative, please indicate the relationship: _____

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HEIM PHYSICAL THERAPY

Co-Payment Agreement

We have been in contact with your Insurance Company regarding your treatment coverage. According to your policy, your responsibility each visit is $ _____. This payment should be paid on a weekly basis.

If you have any questions concerning your payment agreement, please do not hesitate to come speak with us.

Please sign and date below, indicating that you agree to the terms stated above.

x_____ Date_____

No-Show Policy

Your time, as well as ours, is very precious. Please be advised that Heim PT will begin charging you $25.00 for each visit you do not show up to without a phone call prior to your appointed time.

You have read and agreed to the above policy.

x_____ Date_____

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