Carrollton
Douglasville
Villa Rica - Mirror Lake

New patient intake information

Last Name: ______________________ First Name: ____________________ MI: ______

Address: ____

City: _________________________ State: __________ Zip Code: _______________

Home Phone #: ____________________ Work Phone #: _________________________

Cell Phone #: ____________________ Email Address: _________________________

SS#: ___________________________ Date Of Birth: __________________________

Whom may we thank for referring you? (Physician Name): ____________________________

Emergency Contact Name: ______________________ Ph #: _______________________

Was the reason for your visit due to an accident? ☐ YES ☐ NO

Was this due to an Auto Accident? ☐ YES ☐ NO If so, state where accident occurred? ______

Was this due to a work related accident? ☐ YES ☐ NO If so, date of injury? _______________

Patient's Employer: ______________________________ Phone#: ____________________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired - Retirement date: ____________

Marital Status: ☐ Married ☐ Single ☐ Divorced Student? ☐ Full-time ☐ Part-time

If you are a Medicare Patient, are you currently receiving Home Health for ANY reason? ☐ YES ☐ NO

If you are a Medicare Patient, have you had Physical or Speech Therapy at all since January 1st?

☐ YES ☐ NO If so, please tell us where? _____________________________________

Insurance Company: ____

Please give Insurance Card(s) to front desk to be copied for important information.

Are you the Insured? ☐ YES ☐ NO

If NO, please tell us Insured's Name: ____

Insured's Date of Birth: _________________ Insured's Employer: ______________________

Patient name: ______________________________

Are you presently working? ☐ Yes ☐ No

Date of next physician's visit: _____/______/______

Date of injury / onset: _____/______/______

Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ work related injury
☐ motor vehicle injury
☐ cause unknown
☐ recurrence of previous injury
☐ injury related to lifting
☐ athletic / recreational injury
☐ injury related to falling
☐ other: _____________

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain/Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea / Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other	☐	☐	Stroke/CVA	☐	☐

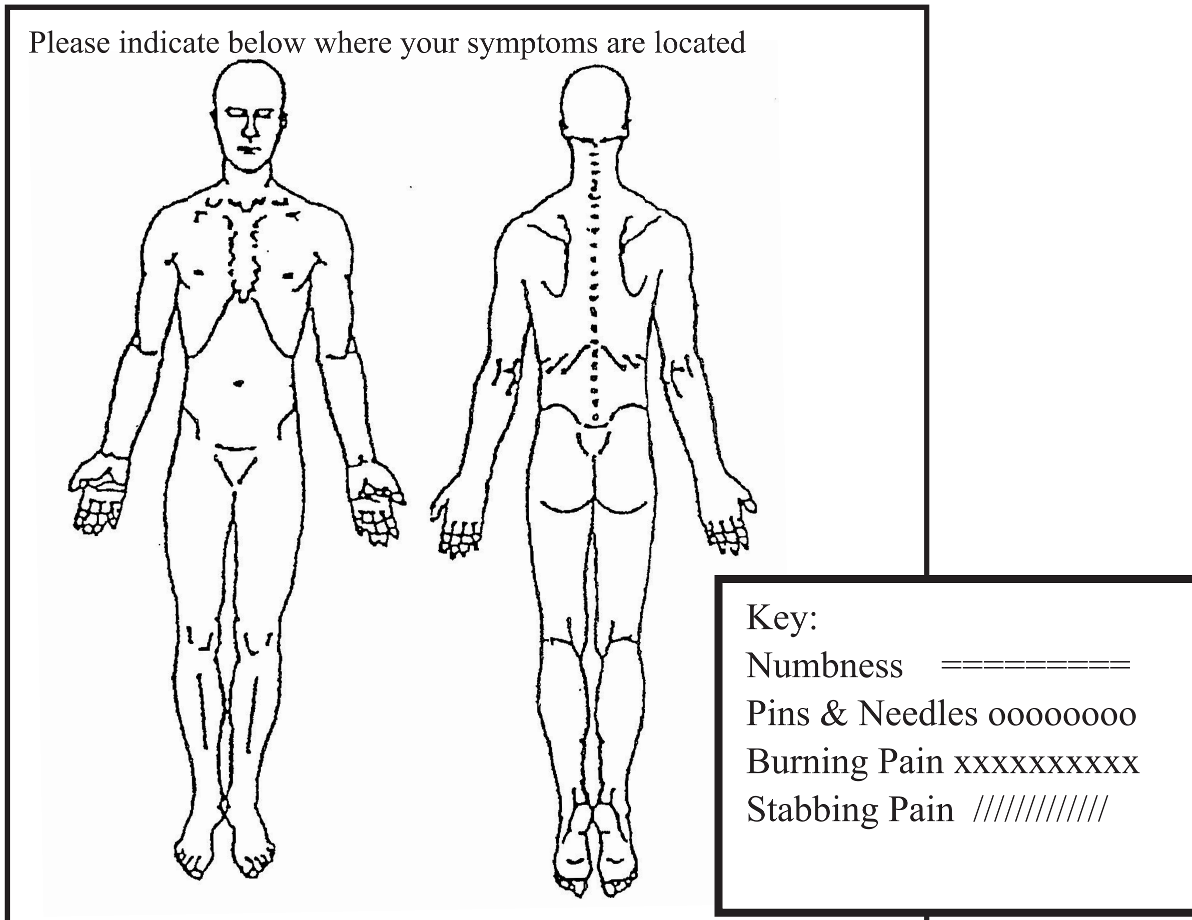
If yes on any of the above , please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know?

Are you presently taking Medication? ☐ Yes ☐ No If yes, Please list what medications and for what condition.

In the rare instance of an emergency, whom should we contact?
Name: _______________________________________ Phone: ____________________

Do you participate in any sports, exercise programs, or activities on a regular basis? ☐ Yes ☐ No



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: _____________.

______________________	__________	______________________	__________
Patient's Signature	Date	Signature of Guardian if patient is a minor	Date

______________________	__________
Therapist Signature	Date

Acct# __________________________(office use)

Date: __________________________

Patient Last Name: ___________________ First Name: ____________________

New Patient Intake Information

Statement of financial responsibility, consent to treat and release information

Accel appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.
You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

To Whom It May Concern:

I have read the above policy regarding my financial responsibility to Accel for providing rehabilitative services to the above named patient or me. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Accel. I agree to pay Accel the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: ____ **Date:** _________________

(Relationship to patient: ☐ self ☐ guardian ☐ other ______________)

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Accel through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.
I further authorize Accel to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Signature: ____ **Date:** _________________

(Relationship to patient: ☐ self ☐ guardian ☐ other ______________)

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

The terms of this notice of privacy practices apply to Accel physical therapy and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Accel Physical Therapy.

We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and disclosures for treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professional involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and disclosures for payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bull to send to you or to the person responsible for your payment.

Uses and disclosures for health care operations: With your agreement, we will make uses and disclosures of your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care. Individuals involved in your care: With your written or oral agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditations, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. Your have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality

requirements applied by an Institutional review board which oversees the research or by representatives of the researchers that limited their use and disclosure of patient information.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects or to participate in product recalls.
- To your employer when we have provided health care to you at the request of our employer.
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law to report wounds and injuries and crimes;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION

Access to your personal health information: Your have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative.

Amendments to your personal health information: You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary.

Accounting for disclosures of your personal health information: You have the right to receive an accounting of certain disclosures made by us of your personal health information. Requests must be made in writing and signed by you or your legal representative. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on use and disclosure of your personal health information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction request if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints: You may file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of our rights. There will be no retaliation for filing a complaint. Workers Compensation: For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use or disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

For further information: If you have any questions or need further assistance regarding this notice, you may contact Justin Rich or Eric Morante at 2000 mirror Lake Blvd, Suite S, Villa Rica, GA 30180; 770-456-7877

__________________________________ ________________
Patient (or representative) Signature Date

New Patient Intake Information

Billing disclosures to individuals involved in patient's care

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize Accel Physical Therapy to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

Name	Relationship
______________________________	______________________
______________________________	______________________
______________________________	______________________

I ***do not*** wish to have my health information disclosed to individuals involved in my care.

Name	Relationship
______________________________	______________________
______________________________	______________________
______________________________	______________________

______________________________________ ________________

Signature of Patient (or patient's representative) Date

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐ Power of attorney ☐ Guardian ☐ Surrogate Decision-maker

☐ Executor or Legal Rep. ☐ Parent ☐ Other (please specify) _______________

Provide documentation or explanation of your authority to act for the patient: __________________

____

Your appointment is a specific time that has been scheduled for you and your therapist to spend time together working on your rehabilitation goals. It is extremely important to be timely. If you are unable to attend, **YOU MUST NOTIFY THE CENTER IN ADVANCE AND RESCHEDULE TO MAKE UP THE MISSED APPOINTMENT.** Failure to attend your appointment may hinder your recovery process as well as disrupt the schedule of your therapist and other patients.

CANCELLATION

Cancellation or failure to attend three (3) consecutive appointments may result in termination of your therapy program. If therapy is terminated, your Physician and Insurance Company will be notified of your non-compliance to attend therapy as prescribed.

IN THE EVENT YOU ARE COVERED BY WORKERS' COMPENSATION and fail to keep the appointment as recommended by your physician, the appropriate parties will be notified of your absence in writing. Typically, the notification will be to your physician, insurance carrier, employer and case manager. Each canceled and no-show appointment will also be noted in your chart. Please understand that failure to actively participate in your rehabilitation program may result in the impression that you are disinterested in your therapy or you are able to return to work immediately. Failure to attend may have a negative effect on your workers' compensation coverage.

Thank you for your assistance.

Patient signature: ____________________________________

Therapist signature: __________________________________

Date: ________________________