HEALTH IN BALANCE
PHYSICAL THERAPY
Improving health. Creating balance. One patient at a time.

NEW PATIENT INFORMATION

Print these forms out and fill in the information asked below before your scheduled appointment. If you would like to fill in the information electronically before printing them out, you can do so by viewing this document in Adobe Reader. Once open in Adobe Reader, you can click on the "Date" field, fill in the information and then TAB to the following informational fields. If you don't have Adobe Reader, you can download for free here: https://get.adobe.com/reader/

Date:_____

Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Phone: (Home)_____ (Work)_____ (Cell)_____

Email:_____

Date of Birth:_____ Gender: M F

Marital Status: Single Married Divorced Widowed SSN#_____

Emergency Contact:_____ Referred by:_____

Employer:_____

Spouse:_____ Date of Birth:_____

Responsible Party:_____ Relationship:_____

Is this injury due to an auto accident? Y N

Is this a worker's compensation claim? Y N

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NEW PATIENT INTAKE FORM

Patient Name:_____ Date:_____

Referring Doctor:_____

Primary Doctor:_____

Reason for seeking physical therapy:

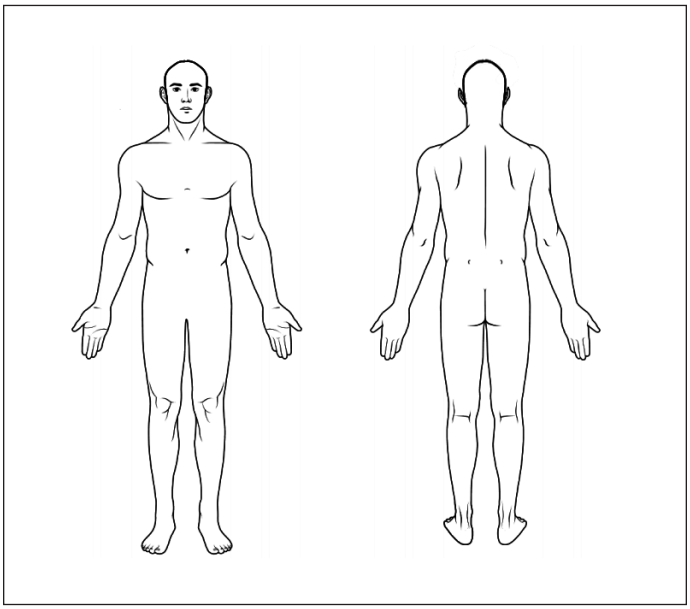
Injury/Trauma	Disease
Congenital	No injury

Nature of Condition:

Initial onset (within the last 3 months)
Recurrent (mulitple episodes of < 3 months)
Chronic (mulitple episodes of > 3 months)

What body part is affected:

Pain Diagram



Please mark your pain/symptoms on the model

Left or right side of the body: Left Right

Rate your worst pain on a scale of 0-10, 10 being the worst:_____

What increases the pain:_____

What decreases the pain:_____

Please list any diagnostic tests performed: i.e. x-ray, MRI, CT scan

Have you fallen in the last: 6 Months 1 year How many times?

Do you have difficulty walking: Yes No >>>> Do you use a cane or walker: Yes No

Are you receiving any home health care: Yes No

Please list any allergies:_____

Are you employed: Full-time Part-time Not employed due to injury Not employed

What is your occupation:_____

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NEW PATIENT INTAKE FORM

Do you have difficulty completing your job tasks because of pain? What tasks?

What goals would you like to achieve through physical therapy?

Check activities that you have difficulty completing:

Walking	Prolonged standing	Up/down stairs	Recreational Activities
Personal Care	Prolonged sitting	Sleeping	Reaching
Carrying	Lifting	Driving	Squatting
Cooking	Grocery shopping	Laundry	Community Activities

List any past injuries, surgeries, or reasons for seeking a doctor/ physical therapists' care:

Medical History: Have you ever been diagnosed with any of the following?
(Check all that apply)

Cancer (What type):		Heart Problems	High Blood Pressure
Asthma	Emphysema	Chemical Dependency	Thyroid Problem
Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Depression
Hepatitis	Kidney Disease	Tuberculosis	Stroke
Epilepsy	Anemia	Other:	

Do you smoke? Yes No If yes, how much? _____

Have you recently experienced any of the following? (Check all that apply)

Fever/chills/sweats	Unexplained Weight Change	Malaise	Nausea/vomiting
Bowel Dysfunction	Numbness	Weakness	Fainting
Night Pain	Dizziness/lightheadedness	Sexual Dysfunction	Shortness of Breath
Urinary Frequency Changes/Difficulty			

MEDICATIONS

Please list all current medications including vitamins and supplements.

NAME	DOSAGE	FREQUENCY

For Office Use:

Height:_____ Weight:_____ BMI:_____

VAS:_____ Functional Reach:_____ Timed Get Up And Go:_____

Functional Testing:

Test Used:_____ Score:_____

FINANCIAL POLICY

In order to keep your cost of physical therapy services to an absolute minimum, Health In Balance Physical Therapy, LLC has adopted the following financial policy. This policy applies to all clients and specifies responsibility regarding payment for services rendered.

HEALTH INSURANCE

The client's health insurance is a contract between client and insurance company, and is a vehicle to help pay for medical care. As a service to you, we will call your insurance company prior to your first visit in an attempt to determine your benefits (if you provide us with the information before you come in). Please keep in mind that insurance companies DO NOT guarantee payment for service over the phone, and you are ultimately responsible for any expenses incurred if your insurance does not pay what you expected they would. It is in your best interest to be aware of your physical therapy benefits before you come in for your first appointment. We will submit claims to your insurance company if you provide us with current insurance information. Depending on the insurance company, our fees may or may not be considered usual and customary. Insurance companies use many different equations to form a fee schedule.

Clinic policy requires that all anticipated co-pays, coinsurance and visit fees be collected at time of service. These payments may be applied against any applicable unmet deductibles. If your insurance company pays more than anticipated, your account will be credited. We accept cash (exact amount is appreciated), personal checks, and credit cards (Visa and MasterCard). The clinic charges a $30 fee to you for any NSF checks received, which is payable before or at the time of your next scheduled visit.

The client is ultimately responsible for timely payment of services rendered. Any insurance balances outstanding after 60 days are due in full by the client. It is the client's responsibility to negotiate with the insurance company for any unpaid services.

PRIVATE PAY

If you will be paying for visits privately (not through an insurance company), clinic policy requires payment at time of service. Acceptable methods of payment are cash, check, or credit card. Please be prepared to make payment at the time of your visit. If you have questions regarding clinic fees, please contact our office staff.

FINANCIAL POLICY

ASSIGNMENT OF BENEFITS (client signature required for clinic to bill insurance)

Since my health insurance may cover the cost of service, I hereby authorize Health In Balance Physical Therapy, LLC to release to my insurance company and/or associated professionals any information from my medical records which may be necessary to determine benefits payable under my policy. This information may be transmitted electronically. I authorize payment directly to Health In Balance Physical Therapy, LLC for the benefits otherwise payable to me for the amount which covers but does not exceed services delivered. I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits.

Date:_____**Client Signature:**_____

FAILURE TO PAY

Our staff of physical therapy clinicians and office support professionals provide confidential, compassionate, and effective care to our clients. We adhere to the highest standards of ethical practice and service your needs in good faith. In order to continue our services to you and other members of our community, we expect payment for services rendered in a prompt manner. If payment is denied by your primary insurance company and you have a secondary insurance company they will be billed. If extenuating circumstances arise, please consult with our office staff regarding an acceptable payment arrangement. Failure to do so may result in the need to curtail further sessions until the financial situation is resolved.

A late charge of $25.00 will be added to the patient's account if a patient balance is not paid by the 20th of the month in which the amount is due. If it becomes apparent that a client does not intend to satisfy his/her financial responsibility, a collection agency or attorney may be contacted to pursue collection of the account. A collection fee will be charged to the client's delinquent account for collection agency services.

I have read and understood the above financial policy.

Date:_____**Client Signature:**_____

CANCELLATION & NO SHOW POLICY

You are coming to therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments.

ALL missed appointments MUST be made up the same week so you may fully recover.

Health In Balance Physical Therapy requires 24 hour advance notice for any cancellation. If you are unable to give 24 hour advance notice or you do not show for your scheduled appointment an administrative fee of $75.00 will be billed to you.

Health In Balance Physical Therapy **requires 24 hour advance notice for any cancellation. If you are unable to give 24 hour advance notice or you do not show for your scheduled appointment an administrative fee of $75.00 will be billed to you.**

I,_____have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

Patient name (Printed):_____

Patient name (Signature):_____

Date:_____

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ASSUMPTION OF RISK AND WAIVER OF LIABILITY

I acknowledge the inherent risks involved in using any type of fitness equipment at Health In Balance Physical Therapy, LLC ("Health In Balance") and in all other physical therapy sessions relating therein. In agreeing to receive care by Health In Balance and use the facilities provided, I agree as follows:

I fully understand and acknowledge that the activities in which I will engage as part of the treatment provided by Health In Balance and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards. I understand that my participation in such activities and use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments which could cause serious disability. By my participation in these activities and use of equipment, I hereby assume all risks and dangers and all responsibility for any losses or damages whether caused in whole or in part by the conduct of myself, Health In Balance (including its directors, staff, employees and other contracted parties) or any other person, including other patients.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release, waive, discharge and covenant not to sue Health In Balance and its representatives, employees, and assigns from any and all claims, actions or losses, including negligence, for bodily injury, property damage, wrongful death, loss of services or other actions which may arise out of my use of any equipment or my participation in physical therapy activities at Health In Balance.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND I UNDERSTAND AND ACCEPT ITS TERMS.

Signature:_____ Date:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

I acknowledge that I have received a copy of the Health In Balance Physical Therapy, LLC Notice of Privacy Practices.

Signature:_____Date:_____

Print Name:_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign | **Communications barriers prohibited obtaining the acknowledgment**

Other (please specify)

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

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.

In this Notice, "we", "our" or "us" means Health In Balance Physical Therapy, LLC (referred to herein as "Health In Balance"). "You" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal law to protect the privacy of your individual health information. Certain types of health information may individually identify you. Because we must protect this health information, we call this Protected Health Information---or "PHI". We are also required to provide you with this notice regarding our legal duties and privacy practices with respect to your PHI, and to abide by the terms of this Notice, as it may be updated from time to time. Should any state or local laws impose stricter requirements than those required by federal law, we will follow the stricter regulations.

Health In Balance receives and maintains Protected Health Information about you in the course of providing services to you. Health In Balance also hires business associates to help it provide these benefits to you. These business associates may receive and maintain Protected Health Information about you in the course of assisting Health In Balance.

The effective date of this Notice is [insert date], 2016. This Notice replaces any previous notice of privacy practices issued by Health In Balance. Health In Balance is required to follow the terms of this Notice until it is replaced. Health In Balance reserves the right to change the terms of this Notice at any time. If Health In Balance makes changes to this Notice, the new notice will become available to all patients of Health In Balance at that time.

Purposes for which Health In Balance may use or disclose your PHI without your consent or authorization:

1. Treatment

We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we may send a copy or summary of our report to your referring physician at the physician's request.

2. Payment

We may use or disclose your Protected Health Information to other parties involved in paying for your treatment or care. For example, we may use or disclose Protected Health Information about you to an insurance representative in order to authorize payment for services.

3. Health Care Operations

We may also use and disclose your PHI for other operations that may be necessary to maintain or operate Health In Balance. For example, our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Other operational uses may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

4. Uses & Disclosures Required by Law

We will use and disclose your PHI when required by federal, state or local law. For example, Health In Balance will disclose your PHI pursuant to a court order or subpoena.

5. To Business Associates

Health In Balance may disclose PHI about you to third parties (called business associates) that we hire for assistance. Each business associate of Health In Balance must agree in writing to uphold the same privacy and security standards that apply to Health In Balance regarding your PHI.

6. Other Permitted Uses and Disclosures

Health In Balance may also use or disclose your PHI for the following purposes:

- Public Health Activities. We may release your PHI for public health activities. These include disclosures relating to disease control and prevention; the quality, safety, or effectiveness of a product; child abuse and neglect; the duties of coroners, medical examiners and funeral directors; and organ, eye and tissue donation purposes.
- Victims of Abuse, Neglect, or Domestic Violence. We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly. In some circumstances we are required to inform you or procure your consent to such a disclosure.
- Health Oversight Activities. We may disclose your PHI to health agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of government regulatory programs.
- Judicial and Administrative Proceedings. We may disclose your PHI in the course of an administrative or judicial proceeding in response to a court order, subpoena, discovery request, or other lawful process.
- Law Enforcement Purposes. We may disclose your PHI to a law enforcement official for the following law enforcement purposes:

    1. to identify or locate a suspect, fugitive, material witness or missing person, provided that the PHI is limited in nature;

2. in response to a request about an individual who is or is suspected to be a victim of a crime if we are unable to obtain the individual's agreement under certain circumstances; and

3. in the event we believe that a crime occurred on our premises.

- Research. Your PHI may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the waiver of authorization.
- To Avert a Serious Threat to Health or Safety. We may disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of another person or the general public.
- **Specialized Government Functions.** We may disclose your PHI for certain government functions, including but not limited to military and veterans activities, national security and intelligence, and federal protective services.
- Workers Compensation. We may disclose your PHI to the extent necessary to comply with laws relating to workers compensation programs.
- Others Involved in Your Healthcare. Unless you object, we may disclose to one of your family members a close personal friend, or to any other person identified by you, your PHI that is directly relevant to the person's involvement with your care or payment related to your care. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your health care.
- Information Not Personally Identifiable. We may use or disclose your PHI if it is de-identified in accordance with HIPAA requirements.
- Appointments. We may contact you for appointments. Messages left for you will not contain specific health information.

Uses and Disclosures Requiring Your Authorization

Health In Balance will not use or disclose your PHI for any other purposes than those stated above unless you give us your written authorization to do so. If you give us your authorization to use or disclose your PHI for a purpose that is not described in this Notice, you may revoke such authorization in writing at any time. Your revocation will not affect or reverse any use or disclosure that occurred before you notified us of your decision to revoke.

Future Communications and Marketing

Health In Balance may use your name, address and phone number to contact you to provide newsletters or information about other services we offer. However, we may not use your PHI for other marketing purposes without your authorization. “Marketing” does not include face-to-face communications between you and Health In Balance staff, or promotional gifts of nominal value provided to you. If you have provided your authorization, and as a result of engaging in the marketing activity Health In Balance receives compensation or some other form of remuneration, we are required to disclose that remuneration to you.

In addition, we may contact you about fundraising efforts we are engaged in. You have the right to opt-out of receiving any of these communications. If we contact you for fundraising purposes, you will be provided information on how to remove yourself or opt out of receiving future fundraising soliciations.

Your Rights

You have the following rights regarding your PHI that Health In Balance maintains. Requests to invoke the following rights must be in writing:

1. Right to Request Limited Use or Disclosure

You have the right to request that we do not use or disclose your PHI in a particular way. We will respectfully consider your request, but we are not required to abide by your request. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations, is not otherwise required by law, and the PHI pertains solely to an item or service for which we have been paid in full.

2. Right to Confidential Communication

You have the right to receive confidential communications from us. You may request confidential communications of your PHI by alternative means or at a different location than Health In Balance currently utilizes. Your request must specify the alternative means or location (e.g., phone number).

3. Right to Inspect and Copy Your PHI

You have the right to inspect and copy your PHI. If we maintain our records in paper, that will be the format utilized; however if we maintain our records electronically you have the right to review and/or have copies made in an electronic format. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection.

4. Right to Amend Your PHI

You have a right to request an amendment of your PHI if you believe that it is incorrect or incomplete. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record.

5. Right to Request an Accounting of Disclosures (Paper Records)

You have the right to request an accounting of certain disclosures of your PHI that we or our business associates have made over the past six years. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations.

6. Right to Request an Accounting of Disclosures (Electronic Records)

You have the right to request an accounting of disclosures over the past three years of any of your PHI that we maintain electronically. You have the right to request the accounting annually. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations.

7. Right to Receive Electronic Copy of this Notice

You have the right to receive an electronic copy of this Notice. You also have the right to receive a paper copy of this Notice at any time even if you agreed to receive the Notice electronically.

8. Right to Receive a Security Breach Notice

You have the right to be notified in the event that we or one of our business associates discover a breach of unsecured PHI, and determine through a risk assessment that notification is required. We will notify you of any such breach in accordance with federal requirements.

How to Exercise Your Rights

To exercise your rights described in this Notice, submit your request in writing to our Privacy Officer at:

Health In Balance Physical Therapy
Attn: Privacy Officer
6028 W. Mequon Rd. Ste. 100
Mequon, WI 53092

Complaints

If you believe your privacy rights have been violated, you may complain directly to us by writing to our Privacy Officer at the address listed above or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us.

Contacting Us

To request additional copies of this Notice or to receive more information about our privacy practices or your rights, please contact our Privacy Officer at:

Health In Balance Physical Therapy
Attn: Privacy Officer
6028 W. Mequon Rd. Ste. 100
Mequon, WI 53092

HIPAA

Use and disclosure of PHI by Health In Balance is regulated, in part, by a federal law known as the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the HIPAA privacy and security rules as they apply to us. The HIPAA rules will supersede any discrepancy between the information in this Notice and the rules.