ProActive Alliance

PATIENT INTAKE FORM Date Completed:

Full Legal Name: _____

Social Security #: _____

Email Address: _____

Address: _____ Male _____ Female _____

City, State and Zip: _____ Date of Birth: _____

Home Phone: (_____)_____ Married _____

Work Phone: (_____)_____ Single _____

Cell Phone: (_____)_____ Other _____

Emergency Contact: _____ (_____)_____

Responsible Billing Party and Address if different than stated above: _____

Please Circle One: Work Comp Auto Private/Health

Primary Insurance: _____ Phone: (_____)_____

Address: _____ ID: _____

_____ Group #: _____

Group Name: _____ Date of Injury: _____

Policy Holder: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Relationship: _____

Adjuster/Case Manager: _____ (_____)_____

Secondary Insurance: _____ Phone: (_____)_____

Address: _____ ID: _____

_____ Group #: _____

Group Name: _____ Date of Injury: _____

Policy Holder: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Relationship: _____

Attorney: _____ Phone: (_____)_____

Primary Physician: _____

We will make every effort to accommodate your schedule and, with notice, can rearrange appointment as needed. Cancellations require a 24-hour notice so that we may also accommodate others. We reserve the right to charge for habitual no shows or cancellations at our discretion. Please help us serve you better by keeping scheduled appointments.

Patient over 18 must sign consent to allow ProActive to discuss account details with *parents or guardians*:

_____ List: _____

Current Condition

Referring Physician: _____
Do we have permission to report your progress to these doctors? ☐ Yes ☐ No
How did you hear about us if different than referring physician? _____

Describe your primary problem:

_____

How and **when** injury occurred:

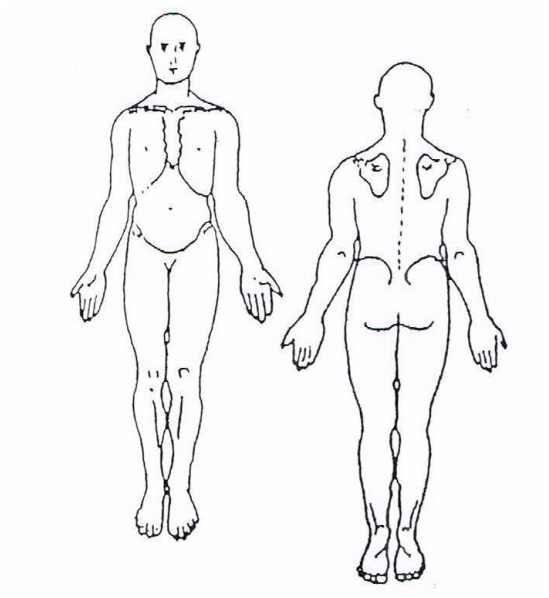
_____

Dominant side: ☐ Right ☐ Left

Occupation: _____

0-10 Pain Scale (0 = no pain; 5 = moderate pain; 10 = most extreme pain)
Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10
Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

In the past month have you been getting:
☐ Better ☐ Worse ☐ Same



Please list leisure activites:
_____
_____

What type of bed do you sleep in?
☐ Conventional Mattress ☐ Water Bed

What position do you sleep in most often?
☐ Back ☐ Stomach ☐ Right Side ☐ Left Side

Does pain wake you up at night? ☐ Yes ☐ No

*Indicate your symptoms on the body using the following KEY:
X – Pain
O – Numbness or Tingling

Please identify three important activities that you are unable to do or are having difficulty with as a result of your injury and score activities based on activity scoring scheme (0 – 10; 0 = unable to perform activity and 10 = able to perform active at the same level as before injury or problem).

Activity	Score: (0 – 10)
1.	
2.	
3.	

Patient Health History Questionnaire

Age: **Height:** **Weight:** **Do you smoke:** ☐**Yes** ☐**No**

Have you ever been diagnosed with any of the following :

☐ Diabetes	☐ Osteoporosis	☐ Hyperthyroid	☐ Heart Condition	☐ Bowel Changes
☐ Dizziness	☐ Osteopenia	☐ Hypothyroid	☐ Pacemaker	☐ Bladder Changes
☐ Arthritis	☐ Cancer	☐ Vascular Disease	☐ Tuberculosis	☐ AID/HIV
☐ Anemia	☐ Depression	☐ Arthritis	☐ Head Injury	☐ Stroke
☐ Hepatitis	☐ COPD	☐ Weight Loss	☐ Respiratory Problems	

Have you fallen in the last two years: Yes No

Women Only: Pregnant Births Pelvic Pain Menstrual Pain

Surgeries

Year	Reason

Hospitalizations

Year	Reason

How much caffeinated coffee/beverages do you drink per day? _____
How many packs of cigarettes do you smoke a day? _____
How many days per week do you use/drink:
Alcohol _____ How much do you drink at an average sitting? _____
Marijuna _____

Medication List

List All Current Prescription Medications

Name of Medication	Dosage	Frequency

List All Over-the-Counter Medications

Name of Medication	Dosage	Frequency

List All Herbals, Vitamins, Minerals, Nutritional Supplements

Name of Medication	Dosage

OUR FINANCIAL POLICY

Thank you for choosing ProActive Physical Therapy, LLC. We are honored to have the privilege of serving you. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing a therapist.

FOR YOUR CONVENIENCE, WE ACCEPT CASH, CHECK, VISA OR MASTERCARD

Regarding Insurance_____Initials:

You are ultimately responsible for the financial resolution of your bill. At your initial visit, we will ask you to provide us with the pertinent personal and financial information needed to process your bills. Your insurance policy is a contract between you and your insurance company. Therfore, if you believe your claims were processed incorrectly, please contact your insurance directly. As a courtesy to you, we will contact your insurance company to determine your level of benefits and to obtain pre-authorization if needed. This is not a guarantee of payment. Please be aware that some, and perhaps all, of the services provided may be non-covered and/or considered reasonable and necessary under the Medicare Program and/or other medical insurance.

We require co-pays be paid *at each visit* unless other arrangements have been made in advance with the billing office This is in accordance with contracting and uniform compliance rules. We require all deductible, co-insurance, and non-covered items be paid immediately upon receipt of receiving a statement from us. You may be asked to pay a minimum amount *towards* your deductible, please understand that you may still receive a bill from us once your insurance processes the claim. Extended payment plans are available. You are required to inform us immediately if your insurance coverage changes during your course of treatment.

Private Pay Patients_____Intitials:

You have indicated that it would create a financial hardship for you to pay our standard fee for service. In consideration, you will receive a discount provided payment is received at the time service is rendered. *No forms will be produced now or in the future for you or us to submit for insurance billing.*

Workers' Compensaion Patients_____Initials:

We are obligated legally to accept payment from your workers' compensation carrier as payment in full if your claim is accepted by your plan. In the case that they refuse to pay, you will be responsible for payment in full.

Liability Patients (Including Auto)_____Initials:

If your treatment is being covered by liablity or auto insurance, the insurance company may not pay until the case is settled. At the beginning of your course of treatment, please provdie us with your attorney and health insurance information, if appliciable. If neither are provided, we require a monthly good faith payment of $100.00

RELEASE OF INFORMATION AND CONSENT TO TREATMENT:

1. I consent to be treated at ProActive Therapeutic Alliance, LLC.
2. I authorize ProActive Therapeutic Alliance, LLC to request any information regarding illness, injury, medical history, treatment or copies of medical records from other healthcare providers.
3. I authorize ProActive Therapeutic Alliance, LLC to release any information requested by my insurance company or other healthcare providers, regarding my hedical history, treatment, evaluation or any other subject history.
4. I authorized and instruct my insurance company to make checks payable to ProActive Physical Therapy, LLC and mail directly to 3522 Hartsel Drive, Colorado Springs, CO 80920.

X _____ Date _____

Signature of Patient or Responsible Party

Functional Dry Needling

Functional Dry Needling® (FDN) involves inserting a small needle into a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Our physical therapists are certified FDN Practitioners. All training was in accordance with requirements dictated by the State of Colorado.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Costs: FDN is not currently a billable procedure under most insurance programs and is offered as a cash-pay treatment. The procedure fee is $10.00 per visit and will be collected upon check-in/out.

Patient's Consent: I understand no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the procedure cost, the probability of success as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as subsequent treatments by this Practice. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure and agree to pay the fee associated with this procedure prior to treatment. I also consent to any measures necessary to correct complications which may result.

Procedure: I, _____, authorize _____ to perform Functional Dry Needling® for my diagnosis of _____.

Please answer the following questions:
Are you pregnant? Yes No ☐
Are you immunocompromised? Yes No
Are you taking blood thinners? Yes No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

_____ _____ _____
Patient or Authorized Representative Date Time

_____ _____
Relationship to patient (if other than patient) (Patient name printed)

HIPAA Consent

I understand that, under the Health Insurance Portability & Accountablility Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare prividers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received ProActive's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that ProActive has the right to change its Notice of Privacy Practices from time to time and that I may contact at any; time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ProActive restrict how my private information is used or disclosed to carry ourt treatment, payment or health care operations. I also understand ProActive is not required to agree to my requested restrictions, but if ProActive does agree, then they are bound to abide by such restrictions.

_____ _____

Print Patient Name Date

_____ _____

Patient/Guardian Signature Print Guardian Name and Relationship

Notice of Privacy Practices for Protected Health Information (PHI)

ProActive Physical Therapy LLC

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!

Effective date: August 1, 2013

The Practice of ProActive Physical Therapy LLC is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of a Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;

- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend

information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;

- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (719) 535-2757, or in writing to us at:

Jacqueline Teets
ProActive Physical Therapy LLC
9320 Grand Cordera Parkway #125
Colorado Springs, CO 80924

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.