TRINITY
PHYSICAL THERAPY

Patient Health History Information

Full Name _____ Nickname_____

Primary complaint_____ Surgery date or date pain began_____

Describe your injury, surgical procedure or cause your pain. _____

_____

Are you legally disabled or applying for disability?_____ Disability eligibility date_____

Were you involved in an automobile accident?____ Date of automobile accident_____

Do you have an attorney? ____Attorney/Firm'sname_____ Phone #_____

Pain level ranges: Please circle the lowest and highest your pain has ranged in the last week.

Lowest your pain gets on a scale of 0-10. **No pain** 0 1 2 3 4 5 6 7 8 9 **10 unbearable pain.**

Highest your pain gets on a scale of 0-10. **No pain** 0 1 2 3 4 5 6 7 8 9 **10 unbearable pain.**

Have you fallen in the last 12 months? _____ With injury? ____ More than once? _____

List ALL surgical procedures you have had **and date of surgery.** _____

_____

_____

Have you ever been diagnosed with or experienced any of the following? ***Please circle.***

- Heart Attack (date: _____)
- Stroke (date:_____)
- Diabetes
- Cancer (Type:_____)
- Asthma
- Osteoporosis
- Tuberculosis
- Epilepsy
- Sleep Apnea
- High Blood Pressure
- Pulmonary disease (lung/breathing)
- Arthritis
- Chronic Heart Failure
- Thyroid Disorder
- Seizures
- Depression
- Anxiety
- Hepatitis
- HIV
- MRSA
- Measles
- C-diff

List any other conditions or problems that are not listed above. _____

_____ Allergies:_____

Describe your exercise habits. _____

Are you mainly **extremely active, fairly active,** or **not active at all**? *Please circle one.* Do you smoke?_____

Do you live alone?_____ Apartment?_____ One level home?_____ Home with stairs?_____

What kind of work do you do?_____

Off work__ Part time___ Full Time___ Light duty___ Full duty___ Do you plan to return to work? ____

****How did you hear about our clinic?** _____

Office Hours:

Monday - Thursday: 8:00 am to 5:00 pm

Friday: 8:00 am to noon

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Patient name: _____ **Date:** _____

Please read the information below and sign when required. If you have any questions, please ask our office staff.

Consent for Medical Treatment:

I understand that I have been diagnosed with a condition that requires diagnostic and/or medical treatment. I understand that Trinity Physical Therapy is an outpatient orthopedics clinic. I consent to care from Trinity Physical Therapy, LLC as may be deemed necessary by their judgment, under the prescription of a physician, PA, or CRNP. Even though I expect that the care I receive will meet customary standards, I do understand that the practice of medicine has no guarantees and that the results of my treatment(s) and/or evaluation(s) have no guarantees as well. Also, if I refuse treatment that is suggested for me, I will not hold Trinity Physical Therapy, LLC or any individual responsible for any consequences resulting from my decision. I understand that Trinity Physical Therapy, LLC does not discriminate against any person on the grounds of race, color, creed, national origin, religion, sexual orientation, age, gender, or disability. I also understand that Trinity Physical Therapy, LLC has the right to refuse treatment to any person who exemplifies disruptive behavior or who is threatening to our staff and/or patients.

Patient Signature (or legal guardian): X_____

***Insurance information:** Trinity Physical Therapy, LLC will bill your insurance company as a courtesy to you. **It is your responsibility to know your policy benefits as well as limitations, deductibles, and copays.** Please provide your insurance card(s) and any additional information that we may need in order to bill your insurance for you. It is strongly recommended that you contact your insurance company directly to verify your Physical Therapy coverage so that there are no discrepancies between our office and what you thought your insurance would pay for. Most insurance companies provide a 1-800 number on the back on your card to assist you with customer service. Our office can help answer questions you may have regarding your insurance coverage and your bill. A copy of your insurance benefits can be provided to you upon request.

***Payment options: Any portion of your treatment that is not covered by your insurance becomes your responsibility. Patients are required to pay applicable deductibles/copays at the time of service. We accept most major credit/debit cards, cash, checks, CareCredit, and medical spending account cards.**

Return check fees: A **$39.00** fee will be charged to the patient for each incident that a check is returned to us for insufficient funds.

Collection of accounts: A **$35.00** fee will be charged to the patient for any account turned over to a collection agency for non-payment. This fee is in addition to any and all other fees that have become delinquent.

Supplies: Supplies for home use are to be paid in full at the time the patient receives the supplies.

Worker's Compensation Cases/Claims: We will bill your open and approved workers' compensation claim for you. Understand that if your claim is denied you will be responsible for all charges. It is good practice for you, the patient, to maintain a relationship with your case manager and/or worker's compensation insurance adjuster.

Scheduling appointments: At the time of your first appointment we will work with you to build a schedule that meets your needs. Please understand that you are expected to arrive to each appointment on time and ready to begin your treatment. If you need to reschedule an appointment please call our office during normal business hours the day before your appointment in order to change it. A 24 hour notice is preferred. This will allow us to accommodate others who are waiting to be seen by the Physical Therapist. **Same day cancellations and no-show appointments will result in a fee of $50.00 billed to your account and you may be removed from our schedule**. It is important that you become committed to your treatment plan so that we can do our best to help you get better.

I understand and agree to the policies listed above.

Patient Signature (or legal guardian) _____ Date: _____

Trinity will strive to give you the very best care possible with exceptional customer service. We achieve results though education, encouragement, and enthusiasm. We sincerely appreciate you choosing Trinity PT. We are thankful for the opportunity to serve you! Please tell others about your experience at Trinity and let us know how we can serve you better in the future.

3/23/2012

Patient Name:		Date:	
Medicine	**Dose**	**Frequency**	**Delivery**
Prescriptions			
Vitamins Minerals and Herbs			
Over the Counter			

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Patient Demographic Information

Please complete the information in the column ***to the right*** of each line.

Patient Name (Last, First, Middle Initial)	
Date of Birth	
Social Security Number	
Primary phone number	
Alternate phone number	
Home Street Address	
City, State, and Zip code	
Address where you receive mail (if different)	
Email address	
Name of Physician who referred you here	
Diagnosis given	
What is your main complaint today?	
Name of Primary Care Physician	
Emergency contact person (relationship?)	
Emergency contact person phone number	
Employer	
Employer phone number	
Your occupation	
Full duty, light duty, or off work	
Is this a work related injury?	
Case Mgr/Insurance Adjuster name for WC claims	

Primary Insurance Carrier	Secondary Insurance Carrier
Cardholder's Name	Cardholder's Name
Relationship	Relationship
Cardholder's date of birth	Cardholder's date of birth

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby assign all medical benefits to which I am entitled to Trinity Physical Therapy, LLC in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance(s). In the event my account balance becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection agency service fees, attorney fees, and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Trinity Physical Therapy, LLC as may be directed by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Authorized Signature X_____ **Date**_____

Please inform front desk if you would like to complete a financial hardship application.

TRINITY
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Patient Information Privacy Practices

This notice describes how medical information about you may be used or disclosed and how it will be shared, as well as clinic practices to ensure your privacy during treatments. Please read carefully.

Trinity Physical Therapy, LLC is required by law to protect the privacy of your personal health information and records. We are required to provide you this notice about our information practices and follow these practices which are disclosed below.

Trinity Physical Therapy, LLC uses your medical information primarily for treatment, obtaining payment for treatment you receive, conducting internal administrative activities, and for evaluating the treatment(s) that we provide you as well as their quality. Trinity Physical Therapy, LLC will provide information to proper authorities when required by a law.

Trinity Physical Therapy, LLC may also use and/or disclose your medical information for public health purposes, emergency situations, and internal research studies.

In any other situation Trinity Physical Therapy, LLC obtains authorization by you, and/or your guardian if applicable, before disclosing your medical information. At any time you can request (in writing) our office to revoke that authorization in future instances. If changes to our policy are made you will be informed by a notice displayed in our office reception area and you can also obtain a revised/updated copy.

You have the right to obtain and/or review a copy of your medical information and if any information is deemed incomplete or inaccurate by you, you may request (in writing) that our office correct these records. You may also request (in writing) that we provide you with a list of instances where we have disclosed your medical information for reasons other than treatment, payment, or other administrative reasons.

You may also request (in writing) that Trinity Physical Therapy, LLC not use or disclose your medical information for treatment, payment, and administrative reasons unless specifically authorized by you, when required by law, or in emergency situations. We will consider such requests but is not legally required to consent to them.

It is not usual for more than one patient to be treated at the same time in the treatment area. Patients' family members, caregivers, transportation, friends, children, etc. must remain in waiting room while treatment is in progress. This is to ensure that each patient's privacy is protected during that time. Only minor patients may have an adult with them while treatment is in progress. Non-patients in the treatment area can pose a safety issue as there is limited room and multiple patients are exercising at the same time. This can also disrupt a patient's session and interfere in a way that could harm the patient. Family members will be informed of treatment and changes to treatment plan, if necessary, with patient's consent.

If you have concerns/questions or would like to make a complaint that Trinity Physical Therapy, LLC has violated your patient privacy rights please contact our HIPAA Compliance Officer at our office address. You may also send a written complaint to the United States Department of Health and Human Services.

Trinity Physical Therapy, LLC. 7402 Hwy 69 S. Tuscaloosa, AL 35405
Attention: Holly Holmes (205) 758-6832

I have read and fully understand the Information Practices notice provided by Trinity Physical Therapy, LLC. I understand that Trinity Physical Therapy may disclose and/or use my medical information for the purposes of carrying out my treatment(s), obtaining/collecting payment(s), evaluating the services provided to me as well as their quality, and any administrative operations related to treatment(s) or payment(s). I understand that I have the right to restrict how my medical information is disclosed and/or used for treatment(s), payment(s), quality, and administrative purposes if I notify Trinity Physical Therapy, LLC in writing. I understand that Trinity Physical Therapy will consider all requests but is not legally bound to agree to such restrictions. I hereby consent to the disclosure and/or usage of my medical information for purposes stated in Trinity Physical Therapy LLC's notice of Patient Information Privacy Practices and understand that I reserve the right to revoke (in writing) this consent at any time.

Patient Name: _____ Legal Guardian: _____

Patient Signature (or Legal Guardian): _____ Today's Date: _____

3/23/2012

Trinity Physical Therapy, LLC

Individuals authorized to request/receive information

I hereby authorize one or all of the following parties designated below to request and/or receive information concerning my Protected Patient Information in regards to my treatment(s), payment(s), quality, and/or administrative operations. I understand that the designated party(s) must be verified before the release of my information.

Authorized party:

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

Patient Name: _____ Legal Guardian: _____

Patient Signature (or Legal Guardian): _____ Today's Date: _____

I give Trinity Physical Therapy permission to leave a message on my:

Answering machine at home:	YES	NO
Answering machine at work:	YES	NO
Cell phone:	YES	NO
With a family member:	YES	NO

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Cancel/No-show Fee Policy

Please read the following policy carefully regarding missed appointments and scheduling.

In the event you wish to make changes or to cancel an appointment, please call Trinity Physical Therapy 24 hours in advance or one business day. Our scheduler can be reached at 205-758-5832 Monday through Thursday from 8 am to 5 pm and Friday from 8 am to noon, except for holidays.

In the event you do not attend a scheduled appointment and a cancelation is not given in advance, a $50.00 fee will be billed to your account and will be due at your next appointment.

As a courtesy to you, our clinic will email you a reminder one day before each scheduled appointment, if an email address is provided. When a schedule change needs to be made, we will be happy to reschedule or make changes to your schedule at that time. It is in your best interest to keep your scheduled appointments so that you can receive the quality care that you deserve and that your therapy is uninterrupted by missed appointments.

Please notify our office as soon as possible if you anticipate being late to an appointment.

I understand this policy.

Patient Name: _____

Signature: _____ Date: _____

We have this policy in place because our patients deserve good care and we are here to provide it. When you give advanced notice that you will not attend your appointment, another patient who is waiting to be seen can be scheduled during that time. Missed appointments disrupt the clinic flow and our ability to provide quality care for all of our patients.