# Champion Physical Therapy New Patient Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date of Consultation** | | | | **Name of Doctor** | | | |
| **Referred by** | | | | **Area of complaint** | | | |
| | | | | | | | |
| **Patient registration details** | | | | | | | |
| **Name** | | | | | | **SSN** | |
| **Address** | | | | | | | |
| **City** | | | | **State** | | **ZIP** | |
| **Apt. #** | | **Home Phone** | | | | **Mobile Phone** | |
| **DOB** | | **Marital Status** | | | | **Male or Female** | |
| **Employer** | | **Work Phone** | | **Email** | | | |
| **Address** | | | | | | | |
| **Emergency Contact** | | **Phone number** | | | | **Relationship** | |
| ******FOR OFFICE USE ONLY****** | | | | | | | |
| **Primary Insurance** | | | | | **Phone** | | |
| **Address** | | | | | **Insured's ID** | | |
| **City** | | **State** | | **Zip** | | **Group #** | |
| **Contact/ adjuster** | | **Title** | | **Phone** | | **Claim #** | |
| **Co-pay** | | **Per visit** | | **Evaluation only** | | **Effective Date** | |
| **Deductible** | | **Amount Met** | | **OOP** | | **Amount met of OOP** | |
| **Coinsurance%** | | **Visit Limit** | | **Has pt. used any visits** | | **If yes, visits remaining** | |
| **Pre-Cert Required** | | **Telephone#** | | **Contact** | | **Auth#** | |
| **Medicare Cap** | **$1960** | **Amt of cap met for PT** | | **Enrolled in HMO** | | **Under Home Health** | |
| **Secondary Insurance** | | | | | **Phone** | | |
| **Address** | | | | | **Insured's ID#** | | |
| **City** | | **State** | | **Zip** | | **Group #** | |
| **Contact** | | **Title** | | **Phone** | | **Claim #** | |
| **Notes** | | | | | | | |
| **Self-Pay Rate** | | **Pt. Initials** | | **Provider Initials** | | | |

**The above is a brief description of your benefits for outpatient physical therapy as verified through your insurance company. There is no guarantee of payment. Authorization for treatment will be obtained if required, however, it is the patient's ultimate responsibility to know/understand his/her policy and make sure that their limitations are not/have not been exceeded. By signing below you are stating that you understand the above benefits, be liable for all treatment that exceeds or is denied for any reason what is allowed by your insurance plan, and understand payment of co-pays, estimate of coinsurance, supplies, and deductibles are required at time of service.**Please note If you have had therapy at another facility, you are responsible for keeping up with the number of times that you were seen so that you do not exceed the visit allowed by you insurance plan.**

Patient Signature_____ Date:_____

# Champion physical therapy
**2017 Patient Signatures**

**PATIENT NAME:** _____

_____ ***Consent for Care and Treatment***

I, the undersigned, hereby agree and give my consent for champion physical therapy to furnish care and treatment considered necessary and proper in treating my condition.

_____ ***Authorization for Signature on File and Release of Information***

I, the undersigned, hereby authorize the office of champion physical therapy to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

_____ ***Authorization for Assignment of Benefits***

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of champion physical therapy, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to champion physical therapy.

_____ ***Financial Responsibility***

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

_____ ***Cancellation Policy***

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. Habitual failure to do so may result in your discharge from our facility.

---

*I have read and fully understand all of the above information and hereby agree to comply as outlined above.*

**Patient or Guardian Signature**:_____ **Date:**_____

# 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**.

**Uses and Disclosures**

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Your confidential medical information is defined under federal law as "protected health information" ("PHI"). When we retain your confidential medical information on its computer system, it is called "electronic protected health information" ("ePHI"). This Notice applies to all PHI and ePHI related to your care that we have created or received. It also applies to any personal or general information we receive from patients, including information contained on driver's licenses. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

**USE AND DISCLOSURE WITHOUT PATIENT ACKNOWLEDGEMENT OF THIS NOTICE**

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

**Treatment:** We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care.

**Payment:** We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

**Operations:** Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

**USE AND DISCLOSURE WITHOUT ACKNOWLEDGEMENT OR AUTHORIZATION**

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

**AUTHORIZATION FOR USE OR DISCLOSURE**

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records without your specific written consent and authorization. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization. Your medical information will not be disclosed for marketing purposes or sold to any third party without your authorization.

Other uses and disclosures of your medical record information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to "take back" any disclosures that we have already made with your permission and that we are required to keep any records of the care that we provided to you.

**ADDITIONAL USES AND DISCLOSURES**

**Advice of Appointment and Services:** The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may interest you. The following appointment reminders may be used by the Practice: a) postcard mailed to you at your address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

**Individual Rights**

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services out of your own pocket, in full. This does not apply to services that are covered by insurance. You are required to pay cash, in full, for the services before the restriction applies.

3. With respect to ePHI, we agree to give you your ePHI in the form and format requested by you, if it is readily producible in that form or format. If it is not readily producible in the form or format requested, we will give you a readable hard copy form. Any directive given to us by you to transmit ePHI must be done in writing by you, signed and clearly identify the designated person and location to send the ePHI. We will provide you access to your PHI or ePHI within thirty (30) days from the date of request.

4. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

5. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

6. We may deny any request for amendment of your PHI or ePHI if the information was not created by us (unless the originator of the information is no longer available to act on your request); is not part of the designated record set maintained by us; is not part of the information to which you have a right of access; or is already accurate and complete, as determined by us. If we deny your request for an amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

7. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.

8. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.

9. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.

10. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

11. You have the right to receive notification from us if any breach of your unsecured protected health information occurs.

**Our Duties**
We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.

2. We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

**Complaints**
You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website: http://www.hhs.gov/ocr/hipaa.

**This Notice of Privacy Practices shall not be construed as a contract or legally binding agreement. Any non-compliance with any provision of this Notice shall not be construed as a breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law. By signing the Acknowledgment of Receipt of this Notice, you agree that the sole legal recourse for our non-compliance with this Notice is to file a written complaint to the Secretary of the U.S. Department of Health and Human Services, and that no complaint or cause of action may be filed in any federal or state court for breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law, or under any tort theory.**

**Contact Person**
All questions concerning this Notice, or requests made pursuant to it, should be addressed to:

**Champion physical therapy, llc**
Attn: Timothy Butcher, PT, Privacy Officer
7228 Norris Freeway
Knoxville, TN 37918
or by E-mail: tbutcher@championptllc.com

**Effective Date**
This Notice is effective **April 14, 2003 and revised September 23, 2013** and applies to all protected health information contained in your medical records maintained by us.

# CHAMPION PHYSICAL THERAPY

# 2017

## PATIENT INFORMATION ACKNOWLEDGMENT FORM

I have read and fully understand CHAMPION PHYSICAL THERAPY'S Notice of Information Practices. I understand that CHAMPION PHYSICAL THERAPY may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that CHAMPION PHYSICAL THERAPY will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in CHAMPION PHYSICAL THERAPY 'S Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

# 2017
## DESIGNATED INDIVIDUALS AUTHORIZATION FORM

**Company Name:** CHAMPION PHYSICAL THERAPY, LLC

*I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, scheduled appointments, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.*

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

# PATIENT MEDICAL HISTORY

**Name:** _____ **Date:** _____ **Date of Birth:** _____

**Referring Physician:** _____ **Family Physician:** _____

**Your chief complaint:** _____

**Date of Injury:** _____ **If not an injury, date of onset of symptoms:** _____

**Date of 1st doctor visit for this injury:** _____ **Are you aware of what your diagnosis is?** ☐ Yes ☐ No

**What are your rehabilitation expectations or goals?**

_____

**Occupation:** _____ **or** ☐ Retired ☐ Student

**Work Status:** ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work

**Last Date Worked Due to this Injury:** _____ **Date Returned to Work after This Injury:** _____

**Have you had Surgery for this injury?** ☐ Yes ☐ No **Type of Surgery:** _____

**Approximate date(s) of surgery:** _____

**Please list any Medications (prescription and non prescription) you are currently taking:**

_____

_____

**Have you had <u>any</u> of the following Medical or Rehabilitative Services for this Injury/Episode circle?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| X-ray | Y | N | Myelogram | Y | N | General Practitioner | Y | N |
| MRI | Y | N | Physical therapy | Y | N | Orthopedist | Y | N |
| CT-scan | Y | N | Occupational therapy | Y | N | Neurologist | Y | N |
| EMG / nerve conduction | Y | N | Massage therapy | Y | N | Emergency room care | Y | N |

**Please circle yes or no if you have, or have had, any of the following problems:**

| **Constitutional** | | | **Respiratory** | | | **Gastrointestinal** | | |
|---|---|---|---|---|---|---|---|---|
| Good general health | Y | N | Shortness of Breath | Y | N | Nausea / Vomiting | Y | N |
| Recent weight changes | Y | N | Excessive coughing | Y | N | Abdominal pain | Y | N |
| Fatigue | Y | N | Asthma | Y | N | Rectal bleeding | Y | N |
| Night sweats / fevers | Y | N | Bronchitis | Y | N | Blood in urine | Y | N |
| **Cardiovascular** | | | Emphysema | Y | N | Kidney stones | Y | N |
| Hypertension / High Blood Pressure | Y | N | **Neurological** | | | **Other** | | |
| Angina / chest pain | Y | N | Frequent headaches | Y | N | Changes in hair or nails | Y | N |
| Coronary artery disease | Y | N | Seizures / Epilepsy | Y | N | Rashes or itching | Y | N |
| Heart surgery / Pacemaker | Y | N | Numbness / tingling | Y | N | Breast lump | Y | N |
| **Musculoskeletal** | | | Dizziness | Y | N | Breast pain or discharge | Y | N |
| Muscle pains or cramps | Y | N | Weakness | Y | N | Changes in menstrual cycle | Y | N |
| Stiffness / swelling in joints | Y | N | Stroke/TIA | Y | N | Tuberculosis | Y | N |
| Joint pain | Y | N | **Hematologic/Lymphatic** | | | Cancer | Y | N |
| Osteoporosis | Y | N | Bruise easily | Y | N | Chemotherapy or radiation | Y | N |
| **Endocrine** | | | Slow to heal | Y | N | HIV/AIDS | Y | N |
| Excessive thirst / urination | Y | N | Enlarged glands | Y | N | Diabetes | Y | N |
| Thyroid disease | Y | N | **Eyes** | | | Blood clots | Y | N |
| Hormone problem(s) | Y | N | Wear glasses / contacts | Y | N | Depression | Y | N |
| **Ear/Nose/Throat/Mouth** | | | Blurred / double vision | Y | N | Insomnia | Y | N |
| Hearing loss/ringing in ears | Y | N | Eye disease or injury | Y | N | Confusion or memory loss | Y | N |
| Sinus problems | Y | N | Glaucoma | Y | N | Memory loss | Y | N |
| Nose bleeds | Y | N | **Allergies** | | | Do you smoke | Y | N |
| Sore throat | Y | N | Food | Y | N | Use tobacco products | Y | N |
| Voice changes | Y | N | Medicine | Y | N | Are you pregnant | Y | N |
| Please list any other illnesses or injuries not listed above | | | | | | | | |

Patient Signature: _____ Date

Therapist Signature: _____ Date