Amy Hill Fife
PHYSICAL THERAPY

Patient Privacy Policy & Procedure Statement

Dear Patient:

Amy Hill Fife Physical Therapy, PC maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer, Amy Hill Fife, at (970) 424-0221.

Amy Hill Fife Physical Therapy, PC reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations and guidelines.

Thanks for choosing our health care facility.

Signature____Date______________

Signature of Patient or guardian

Printed Name:____

Amy Hill Fife PHYSICAL THERAPY

PATIENT INFORMATION

Date: ________________________

Last Name: _______________________________ First Name: ____________________ Middle Initial:_______

How would like to be addressed:______________________ DOB: ___________________ Sex: M / F

Address: ____City/State/Zip: _________________________

Home Phone: ________________________Cell:_______________________ Work:________________________

Social Security Number___________________________ Marital Status: Single / Married / Divorced

Email Address: _______________________________ Would you like text reminders? Y N Cell Carrier___________

Employer____ Phone: __________________________

Referring Physician: ___________________________ Primary Care Physician: ___________________________

Emergency Contact Name: __________________________________ Relationship___________________

Phone number_____________________________

COMPLETE ONLY IF PATIENT IS A MINOR (17 YEARS OR YOUNGER)
Who is the financial guarantor on this account? ____
(THE PERSON BRINGING THE CHILD IN TO THE APPOINTMENT AND SIGNING THIS FORM IS RESPONSIBLE FOR THE BILL)

INSURANCE INFORMATION

Primary Insurance Company: ______________________________ ID#:___________________________
Group#:____________________________ Subscriber Name: (if not patient) _____________________________
Subscriber Date of Birth: ________________________ Relation:___________________________

Secondary Insurance Company: ______________________________ ID#:___________________________
Group#:____________________________ Subscriber Name: (if not patient) _____________________________
Subscriber Date of Birth: ________________________ Relation:___________________________

I authorize release of information requested by my insurance plan for payment. I understand that I am financially responsible for any balance due. I agree to comply with the terms and conditions as outlined on the Conditions and Consent Form. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.
Notice of Assignment of Benefits and Release of Medical Information. The above information is complete and correct. I hereby guarantee payment of all charges incurred with this office. I hereby assign and direct my insurance company or companies to pay any and all benefits for my medical services directly to this office.

Signature: ____ **Date:**______________________

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

I understand that I am a patient of Amy Hill Fife Physical Therapy, PC. My care is the exclusive responsibility of Amy Hill Fife Physical Therapy PC professional staff, not of any other practitioners who also may practice at this location.

Cooperation with treatment:

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy:

I understand that if I cancel more than 24 hours in advance, I will not be charged. **I understand that if I cancel less than 24 hours in advance or no show for the appointment, I will pay a fee of $45.00**

No Warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

INFORMED CONSENT FOR TREATMENT:

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential Benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of Medical Records: I authorize the release of my medical records to the following physicians or primary care provider or insurance company:

____

Financial and insurance responsibilities:

I agree to pay for my treatment (copays, coinsurance, deductibles, etc) at the time of service by cash, check or credit card. You are responsible for knowing if your health insurance is contracted with Amy Hill Fife Physical Therapy, PC. You are responsible for knowing your insurance coverage and benefits.

Confidentiality Agreement: I agree not to disclose in any way the Confidential Information obtained during my care, including but not limited to: verbal, written, visual and interactive advice, treatment programs, care plans, exercise programs, home programs and medical equipment.

I have read and understand the above information. I have had any questions pertaining to this answered to my complete satisfaction. I consent to physical therapy evaluation and treatment.

Signature____ Date_____________________________

Signature of patient or guardian

Date: ______________________

NAME:______________________________ **Age:** ________ **Date of Birth**: ____________________

1. Describe the current problem that brought you here

____

2. When did your problem first begin? ____

3. Was your first episode of the problem related to any specific incident? Y/N

If yes, describe and specify date:____

4. Are your symptoms getting _____Better _____Worse _____Staying the same

5. Describe previous treatment/exercises ____

____

6. How has your lifestyle/quality of life been altered/changed because of this problem?

Social Activities (exclude physical activities), specify ______________________________

Diet/Fluid intake, specify____

Physical activity, specify____

Work, specify____

7. Current Medications:____

____

8. Medical History-Falls

Have you fallen on your tailbone? Y/N

9. General Health Questions:

How is your health? Excellent__ Good__ Average__ Fair__ Poor__

10. Have you had any of the following conditions or diagnoses? (Circle all that apply)

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress Fracture	Irritable Bowel Syndrome
Depression	Acid Reflux/Belching	Hepatitis
Anorexia/bulimia	Joint replacement	Sexually transmitted disease
Smoking history	Bone fracture	Physical or Sexual abuse
Vision/eye problems	Sports injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/neck pain	Pelvic pain

11. Mental Health: Current level of stress: High__Medium__Low__ Counseling: Y/N

12. Social History: Marital Status: ____________________Education:______________________

13. Occupation:________________________ Restrictions?________________________________

14. What hobbies and activities bring you joy?____
____

15. Have you had any recent tests (x-ray, MRI, pelvic exam, etc.) for this problem? Y/N
If yes, which tests have you had?____

16. Surgical/Procedure History Have you had any of the following surgeries:

Abdominal surgery: Y/N	Hysterectomy: Y/N	Hip/knee surgery: Y/N
Prostatectomy: Y/N	Surgery with mesh: Y/N	Colon Surgery: Y/N
Bladder Sling: Y/N	Inguinal Hernia: Y/N	Other: __________________
Female organs: Y/N	Prolapse repair: Y/N	

17. OB/GYN History: Females Only (This section)

Child birth deliveries: Y/N #___	Vaginal dryness: Y/N
Episiotomy: Y/N #___	Menopause: Y/N When___
C-Section: Y/N #___	Painful Vaginal penetration: Y/N
Difficult Childbirth: Y/N	Prolapse or organ falling out: Y/N
Painful periods: Y/N	Pelvic/Genital pain: Y/N

Other: Y/N If yes, describe:____

18. Sexual Function

Are you sexually active? Y/N	Are you able to orgasm? Y/N
Do you have pain with intercourse? Y/N	Do you have pain with penetration? Y/N
Do you have pain deep? Y/N	Do you have pain during orgasm? Y/N

Do you have pain after intercourse? Y/N
Do you have low back pain during or after intercourse? Y/N
Do you have hip pain during or after intercourse? Y/N

19. Bladder and Bowel Function

Urine leakage: Y/N	Stool leakage: Y/N
Trouble feeling bladder urge/fullness: Y/N	Trouble feeling bowel urge/fullness: Y/N
Trouble controlling bladder urge: Y/N	Trouble controlling bowel urge: Y/N
Painful urination: Y/N	Painful bowel movements(BM): Y/N
Trouble emptying bladder completely: Y/N	Trouble emptying bowel completely: Y/N
Strain or push to empty bladder: Y/N	Constipation/straining ____%of time: Y/N
Dribbling after urination: Y/N	Need to support/touch to complete BM: Y/N
Blood in urine: Y/N	Blood in stool/feces: Y/N
Chronic bladder infections: Y/N	Hemorrhoids

20. What is your pain level (0 Best- 10 Worst): ____
21. What makes your symptoms worse? ____
____

22. What makes your symptoms better?____

____

23. Rate the severity of this problem from 0-10 with 0 being no problem and 10 being worst________________

24. What are the treatment goals/concerns you have?____

25. Males Only (This section only)

Prostate disorders: Y/N

Erectile dysfunction: Y/N

Shy bladder: Y/N

Painful ejaculation: Y/N

Pelvic/Genital pain location: Y/N

Other, describe: ____