



Rehabilitation • Sports Science

Patient History and Intake Form

Name: _____ Date: _____

Prefer to be called _____

Date of Birth: _____ SS#: _____

Gender: Male _____ Female _____

Patient's Address Street: _____

City, State, Zip _____

Home Phone: _____ Work/Cell phone: _____

Emergency Contact _____ Phone _____

Employer: _____ Occupation: _____

Work Address: _____

City, State, Zip _____

Work Phone: _____

Primary Insurance: _____

Primary Insurance Holder: _____

Insurance Holder's Date of Birth: _____ SS# _____

Insurance Holder's Address: _____

Insurance Holder's Phone: _____ Work Phone: _____

Is this a work related injury? Y__ N__ *OR* is this auto related injury? Y__ N__

Work Comp Carrier _____

OR

Auto Insurance Carrier _____

Billing Address _____

Contact Person _____ Phone _____

Claim Number _____ Date of injury/accident _____

I authorize the release of any medical information necessary to process this claim and all future claims. I authorize and request payment of medical benefits directly to MBF and it's subsidiaries. This constitutes my signature on file.

Signature of Patient or Responsible Party

Date



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Systems Review:

Please mark all of the following that you are having problems with or have a history of:

General Systemic Review

- Paleness/
discoloration of skin
- Night sweats
- Fainting/ Blackouts
- Unexplained fever
- Dizziness
- Unexplained wt. gain/loss
- Pain unaffected by movement
- Pain worse at night

Cardiovascular System

- High blood pressure
- High cholesterol
- Heart valve dysfunction
- Heart murmur
- Heart palpitations
- Peripheral vascular disease
- Circulatory problems
- Congestive Heart Failure
- Pacemaker
- Rheumatic fever

Other Issues

- Ear problems
(type) _____
- Vertigo/disequilibria
- Eye problems
(type) _____

Blood/Immune System

- Anemia
- DVT/phlebitis/clots
- Swollen glands
- Jaundice
- Lupus
- Cirrhosis

Cancer History: yes no

Type: _____

Treatment: _____

Digestive System

- Ulcer
- Abdominal pain
- Nausea/vomiting
- Constipation
- Diverticulitis
- Hepatitis
- Colitis
- Irritable bowel syndrome
- Diarrhea
- Hiatal hernia/reflux
- Pancreatitis
- Rectal bleeding/pain
- Change in bowel habits
- Hemorrhoids

Respiratory System

- Shortness of breath
- Wheezing
- Tuberculosis
- Productive/bloody cough
- Asthma
- Supplemental Oxygen
- Emphysema/COPD
- Bronchitis
- Pneumonia
- Nose/sinus problem
- Throat problems
- Pulmonary embolism

Urinary/Genital

- Bladder infection
- Kidney problems/stones
- Urinary incontinence
- Prostate infections
- Uterine/ovarian problems

Musculoskeletal System

- Joint pain
- Muscle weakness
- Back or neck pain
- Rash/skin breakdown
- Cramping / spasms
- Arthritis
(type) _____

- Osteoporosis/osteopenia
- Joint replacement surgery
- Loss of sensation
- Fractures

Nervous System

- Numbness/tingling
- Loss of strength
- Stroke (CVA/TIA)
- Headaches
(type) _____
- Seizures/epilepsy
- Multiple sclerosis
- Parkinson's disease
- Recent Falls
- Injury/ Hospitalization due to fall

Metabolic System

- Tired/sluggish
- Diabetes: (type) _____
- Excessive Thirst
- Thyroid problem

Psychological System

- Nervousness
- Anxiety
- Depression
- Difficulty sleeping

Pregnancy

Are you/could you be pregnant? Yes No

Thank you!



AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Arbor Medical Services/Medically-Based Fitness to release information from my medical records to any health care provider involved in my care and treatment. I authorize release of information to any party assisting in the collection of treatment charges and to any person or entity which may be liable for all or part of the charges, including but not limited to, Medicare programs, my insurance carrier, any third party payer and third party utilization and quality review agent. I release the right of data collection based on the evaluation and therapy carried out for research purposes, with the understanding that all patient confidentiality will be upheld. I authorize release of information needed for discharge planning, transfer, and follow-up purposes.

Please Initial _____

FINANCIAL POLICY COMPONENTS

All financial and payment arrangements need to be determined prior to initial treatment session.

Medicare Certification: Arbor Medical Services/Medically-Based Fitness is a participating provider for Medicare, and will file all Medicare claims on my behalf. I certify that the information given in applying for Medicare programs is correct, and I authorize the release of information needed to act on this request. I request the payment of authorized Medicare benefits be made to Arbor Medical Services/Medically-Based Fitness on my behalf for their charges.

Secondary Insurance Carriers: Arbor Medical Services/Medically-Based Fitness will file claims with the secondary insurance carriers. I understand that some secondary insurance carriers do not cover rehabilitation and therapy services. In the event that the secondary insurance denies payment of any of the remaining amount, I understand I will be responsible for the remaining balance. Arbor Medical Services/Medically-Based Fitness will resubmit all claims twice after the initial denial, at which point I understand I am responsible for the remaining balance and will have to contact the insurance company directly to appeal the denial.

Insurance Coverage: I understand there is no guarantee of reimbursement from any insurance company or other payor. I acknowledge that I am financially responsible for and agree to pay all charges incurred with therapy and physician services. I understand that I will receive a statement monthly after my insurance company has paid or denied my claim. It is my responsibility to pay the remaining balance for therapy services if the insurance companies deny my claim. I understand I am responsible for the defined charges.

Please Initial _____

CANCELLATION/ COMPLIANCE POLICY

In order to allow time to utilize a cancelled visit, cancellations must have a 24 hour notice. Cancellations made with less than 24 hour notice are subject to a \$40.00 fee.

Compliance is measured by program attendance. If compliance drops below an effective level of 80% for a one month period, without proper notification or outstanding cause, we may discharge you from the program.

I understand and agree to the above stated cancellation/compliance agreement and am accountable to any financial charges involved as a consequence. I understand poor compliance in the clinic may result in being discharged from the care of Medically-Based Fitness. I understand that consistent attendance, proper advanced notice of cancellations, and valid reasons for absences are required for participation in the program.

Please Initial _____

AGREEMENT, CONSENT AND RELEASE OF LIABILITY

I voluntarily request and consent to the rendering of health care and physical therapy services provided through Arbor Medical Services/Medically-Based Fitness and by its employees and agents and other services or procedures which may be administered to or performed on me under the general and special instruction of my physician, or my therapist, or their designees. I understand that I have the right to discuss proposed procedures or treatments with my physician or therapist, and to consent to or refuse such procedures or treatments. I understand that the practice of medicine and physical therapy is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as to the result of treatment or services rendered by Arbor Medical Services/Medically Based Fitness.

Please Initial _____

1. In consideration of being allowed to participate in the activities of Arbor Medical Services/Medically-Based Fitness, I, _____, hereby acknowledge that I am in the facilities of Arbor Medical Services/Medically-Based Fitness to use its equipment and programs. I hereby waive, release, and forever discharge Arbor Medical Services and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities of liability for the injuries or damage resulting from my participation in any of Arbor Medical Services/Medically Based Fitness or my use of equipment in the Arbor Medical Services/Medically Based Fitness facilities.

Please Initial _____

2. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

Please Initial _____

3. I do hereby acknowledge that I have been informed of the need for a physician’s approval for my participation in an treatment activity or in the use of the equipment and machinery at Arbor Medical Services/Medically-Based Fitness. Furthermore, it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise and training equipment for specific recommendations. I acknowledge that I have either had a physical examination and have been given my physician’s permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Please Initial _____

I ACKNOWLEDGE THAT I HAVE READ THIS FORM, UNDERSTAND ITS CONTENTS, AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT OR A PERSON AUTHORIZED BY THE PATIENT OR OTHERWISE TO SIGN AND ACCEPT THIS AGREEMENT AND CONSENT ON BEHALF OF THE PATIENT.

Signature _____ Date _____
Patient, Authorized Representative or Responsible Person

Name Printed _____

If signed by an Authorized Representative:

Print or type name _____

State authorization _____

HIPAA Notice of Privacy Practices

Arbor Medical Services, P.C. / DBA Medically-Based Fitness

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.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is the information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your MBF physician, therapy staff or office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services pertaining to your care. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Your protected health information may also be disclosed to your physician who referred you to therapy services to effectively manage your case.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining authorization for therapy visits may require that your relevant protected health information be disclosed to the health plan to obtain approval for therapy services.

Research Purposes: Your protected health information may be used to determine the efficacy of your treatment. Your data will only be referred to as a patient number. All data and information will be kept confidential.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of the clinic. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy and clinical exercise physiologists, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to physical therapy or clinical exercise physiology students that see or treat patients at our clinic. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician or therapist is ready to see you. We may use or disclose your protected health information, as necessary, when calling to inform you of appointments or any other health information regarding your care.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law: public health issues as required by law, communicable diseases, health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroner; funeral directors and organ donation; research; criminal activity; military activity and national security; workers compensation; inmates; required uses and disclosures. Under the law, we must take disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that Medically-Based Fitness has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Medically-Based Fitness is not required to agree to a restriction that you may request. If the clinician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to seek the care of another healthcare professional.

You have the right to request to receive confidential communications from use by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your MBF physician or therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

This notice is effective as of **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person or by phone at our Boulder office at 303-447-2873.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____ Date: _____