INTAKE RECORD

PATIENT

PATIENT NAME:
GENDER: M/F
DATE OF BIRTH:
STREET:
CITY:
STATE:
POSTAL CODE:
MOBILE PHONE:
HOME PHONE:
EMAIL:
ONSET OF SYMPTOMS DATE:

EMERGENCY CONTACT

NAME:
PHONE:
RELATIONSHIP TO PATIENT:

WAITLIST PREFERENCES

MONDAY:	☐ 8 a.m. – Noon	☐ Noon – 4 p.m.
TUESDAY:	☐ 8 a.m. – Noon	
WEDNESDAY:	☐ 8 a.m. – Noon	☐ Noon – 4 p.m.
THURSDAY:	☐ 8 a.m. – Noon	
FRIDAY:	☐ 8 a.m. – Noon	☐ Noon – 4 p.m.

INTAKE

Patient Chief Complaint:
Body part injured:
Side of body injured:

ALLERGIES:

Work Related: Y/N Auto Related: Y/N History of Falls: Y/N

Previous History of Symptoms: Y/N

HISTORY OF PRESENT CONDITION:

MEDICAL HISTORY

In an effort to serve you better and manage your condition, we need a little information on your medical history. Please answer the following. Do not worry about elaborating, the therapist will ask follow-up questions as needed according to your answers.

Current Providers

Please note any other healthcare professional you are seeing, their name, and why.
Choose as many as you like.

Medical Doctor (s)
Chiropractor
Dentist
Psychiatrist/Psychologist

Medical Conditions

Please note whether you have experienced the following medical conditions:
Choose as many as you like.

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Psychological Illness
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Ulcers, Stomach Problems
- ☐ Skin Problems
- ☐ Lung Problems
- ☐ Other

Surgeries

List any surgeries:

Please note if you are affected by any of the following:
Choose as many as you like.

- ☐ Allergy to cortisone
- ☐ Allergy to latex
- ☐ Pacemaker
- ☐ Pregnant

Consent, Disclosure & Privacy

I hereby give consent to the physical therapists at ARKADELPHIA PHYSICAL THERAPY CENTER, INC. to provide physical therapy treatments to myself for conditions warranted by physical therapy treatment.

If I am to have my account paid by health insurance, workman's compensation or auto insurance, I hereby request and authorize my insurance company(s) or Medicare to pay directly to ARKADELPHIA PHYSICAL THERAPY CENTER, INC. any proceeds payable under the terms of my policy(s) for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy(s) as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital and physical therapy precertification, deductibles, coinsurance and copayments.

It is the policy of ARKADELPHIA PHYSICAL THERAPY CENTER, INC. to help the client in obtaining full benefits from his/her insurance company; however, the clinic is not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.

I understand that data collected during my visits to therapy may be used for research purposes.

I have been provided an opportunity to review and receive a copy of ARKADELPHIA PHYSICAL THERAPY CENTER, INC.'s privacy policies.

_____

Patient or Patient's Guardian, signature.

☐ I agree with the terms listed and all information provided is accurate.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize ARKADELPHIA PHYSICAL THERAPY CENTER, INC. to

☐ Use the following protected health information, and/or
☐ Disclose the following protected health information to:

Referring Physician:
Primary Care Physician:
Insurance Company:
Attorney:
Family:
Other:

Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.

This protected health information is being used or disclosed for the following purposes:

The only reason ARKADELPHIA PHYSICAL THERAPY CENTER, INC. will disclose protected health information is to your medical care and for reimbursement reasons. ARKADELLPHIA PHYSICAL THERAPY CENTER, INC. provides your physician with a copy of your evaluation and also progress notes. Upon request by your insurance company, we will provide them with copies of all physical therapy documentation.

(List specific purposes here. "At the request of the individual" is acceptable if the patient makes the request, and the patient does not want to state a specific purpose.)

This authorization shall be in force and effective until (1) Date_____; (2) event that relates to the patient or the purpose of the use or disclosure _____ at which time this authorization to use or disclose the protected health information expires. "End of the research study" and "none" is acceptable for authorization for research purposes.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 3030 Pine St., Arkadelphia, AR 71923. I understand that a revocation is not effective to the extent that my therapist has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. (If applicable because the authorization is obtained for marketing purposes.)

_____
Patient or Patient's Guardian, signature.
☐ I agree with the terms listed and all information provided is accurate.

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment:

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and preapproved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any preauthorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. If you have secondary insurance coverage, it is your responsibility to provide this information prior to your treatment. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have coinsurance charges, higher copayments and limited annual benefits. If you receive services as part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- A $50 no-show fee will be assessed for all visits that are not canceled within a timely manner prior to the appointment and will be the patient's responsibility. These charges are not subject to insurance billing. Frequent no shows may result is patient dismissal.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____

Patient or Patient's Guardian, signature

☐ I agree with the terms listed and all information provided is accurate.

ARKADELPHIA PHYSICAL THERAPY CENTER, INC.
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.

To Our Patients: The therapists and staff of ARKADELPHIA PHYSICAL THERAPY CENTER, INC. have always been committed to the absolute protection of every patient's health information. The Health Insurance Portability and Accountability Act requires that we provide notice to each of our patients of how this information is used.

We safeguard information about your health and person (Protected Health Information, "PHI"). We collect information from you and store it in a medical record, which may be electronically stored on computer. Our medical record charts are stored in a secure area and are available only to designated staff and only for specific reasons. If your record is computerized, we use security measures to protect it.

How We May Use and Disclose your Protected Health Information.
We use your PHI in many ways to help in treatment, payment, and clinic operations. Some examples include:

• Obtaining your medical history and treatment and recording it in your chart.
• Consulting your physician about your care.
• Providing your physician with medical records.
• Obtaining approval/payment from your health insurer(s) for treatment, tests, or equipment.
• We may use your PHI to create bills we submit to the insurance company.
• Notifying you of test results.
• Discussing your care with person responsible of taking care of you.
• Providing treatment to you in the event there is a language or communication barrier.

Our business associates that may have access to PHI are required to sign a written agreement protecting any use or disclosure of your PHI, in order to protect your privacy.

We may be required by law to use or share your PHI, without your written authorization, for the following:
• When required by federal, state, and local law.
• Public Health activities for reporting requirement (deaths, child abuse, domestic violence, gunshots, etc.
• Reporting victims of abuse, neglect, or domestic violence.
• Health oversight activities (audits, investigations, and inspections)

• Judicial proceedings (valid Court Orders)
• Appropriate law enforcement requests
• Deceased person information (Coroners, Medical Examiners, Funeral Directors)
• Medical Research
• Emergencies or to avert a serious threat to any person or the community.
• Military Activities/National Security/Aversion of Criminal Activities
• Workers Compensation
• Correctional institutions, parole, or other law enforcement officials.
• As required by the Secretary of the Department of Health and Human Services.

How to direct use and disclose your PHI: Written Authorization.

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. YOU MAY REVOKE YOUR WRITTEN AUTHORIZATION AT ANY TIME, IN WRITING. If you revoke your written authorization, it will apply to any future actions relating to the release of your PHI. There may be cases where we have already released your PHI prior to receiving your revocation.

Your Patient Privacy Rights.

You have the right to:

• Inspect and copy your PHI. You may make a written request to our clinic and pay the copying/mailing fee to look at and receive a copy of your designated record set. The designated record set contains medical and billing records as well as other records we use to make decisions about your health care. We must respond within thirty (30) days (or sixty (60) days if extra time is need). Please contact APTC's Privacy Officer if you have any questions about the access to your medical record.
Arkadelphia Physical Therapy Center Privacy Officer: Tammy McCauley 870-246-8623.

• Request restrictions of your PHI. You may ask to limit how we use or disclose any part of your PHI as explained above, except for the typical uses and disclosures described above. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. You may request a specific restriction by writing the request and to whom the restriction applies on the authorization form. We do not have to agree to your request. In the event we agree, we will state the agreement in writing. We have the sole right to deny a request if unreasonable.

• Request to choose how we communicate with you. You have the right to ask that we send information to you in a specific manner. For example: Work address rather than home, or email rather than regular mail. We must agree to your request as long as it is not disruptive

to our operations to do so. We may condition our agreement to honor your request by asking you for specific information as to the alternative address, method of contact and the cost. We will not request an explanation from you as to the basis for the request. You must make this request in writing addressed to the Clinic Privacy Officer.

• Request your therapist amend your PHI. You may make a written request to our clinic for the therapist to consider amending the PHI in your designated medical record set to make it more accurate and complete or correct an error. You must state the reason for the request. We must respond within (60) days (or 90 days if extra time is needed). We may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. You then may have this reviewed by another provider. If we agree to make the change, we will ask you who to notify of the change. Please contact the Clinic Privacy Officer listed above if you have questions about amending your medical record.

• Receive a list of disclosures we have made of your PHI. Beginning April 14, 2003, you may make a written report for a list of all our uses and disclosures of your PHI other than for treatment, payment, clinic operations, to yourself, or those with valid authorization. We must respond in sixty (60) days (or 90 days if extra time is needed). The list will be for a 12-month period unless you ask for a shorter time. You are entitled to one (1) free accounting each year. There will be a reasonable charge for any additional accounting requests during the year. The right to receive this information is subject to certain exceptions and restrictions.

• Receive a copy of this Notice. You may receive an additional paper or electronic copy of this Notice from us.
If you want to exercise any of these rights and would like assistance, please contact our Privacy Officer in person or in writing during our normal hours.

Our Responsibilities.

We reserve the right to make changes to this Notice, which will affect the PHI we maintain at that time. Our duty, as your healthcare provider, is to maintain your privacy in accordance with law, abide by the terms of this privacy Notice, accommodate reasonable requests, or notify you if we cannot, and provide you with a revised copy of this Notice. You can obtain a copy of any revised Notice by calling our clinic or visiting our clinic and picking up a copy.

• Notices are always available in our clinic for your review.

Complaints.

If you believe your privacy rights have been violated, you may complain by providing a written statement to our clinic and to the Secretary of health and Human Services (HHS) at: Office of Civil Rights, US Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. We will not retaliate against you for filing a complaint. We will not require you to waive the right to file a complaint with HHS as a condition to receive treatment from us. You may also contact our Privacy Official if you have questions or comments about our privacy practices.

Effective Date: June 21, 2022

Thank you for allowing us to provide your physical therapy and for your confidence in the strict privacy procedures we have established to protect your PHI.

ARKADELPHIA PHYSICAL THERAPY CENTER, INC.
3030 PINE STREET
ARKADELPHIA, AR. 71923
870-246-8623

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt and explanation of the Notice of Privacy Practices of ARKADELPHIA PHYSICAL THERAPY CENTER, INC.

_____
Patient or Patient's Guardian, signature.

☐ I agree with the terms listed and all information provided is accurate.