PATIENT INFORMATION

Patient Demographic Information

Last Name | First Name | Middle Initial
Address | City | State | Zip
Home Phone | Appointment Reminder Contact Method ☐ Text ☐ Call (mobile or home) ☐ Email ☐ No reminder (Choose method of choice)
Mobile Phone | Email address ☐ Declined email ☐ No email
Date of Birth | SSN | Sex ☐ F ☐ M | Status ☐ Single ☐ Married ☐ Other

Employer Information

Employer | Employment Status ☐ FT ☐ PT ☐ None ☐ Homemaker ☐ Retired ☐ Student
Address | City | State | Zip
Work Phone | Occupation/Position
Authorized person(s) we may speak to on your behalf:

Emergency Contact Information

Contact Name | Phone | Relationship

Physician Information

Referring Physician | Phone

Additional Questions

Injury/Onset Date | Post-Surgical ☐ Yes ☐ No | If yes, Surgery Date
Accident Related ☐ Yes ☐ No | Work Related ☐ Yes ☐ No | Auto Related ☐ Yes ☐ No | Attorney Involved ☐ Yes ☐ No

If you answered yes to any of the above, please fill out the related section(s).

Have you had prior therapy this year? (PT/OT/Chiro) ☐ Yes ☐ No | How did you hear about us?

Primary Insurance Section

Insurance/Plan
Policy ID#
Group #
Insurance Phone
Policy Holder/DOB
Patient relationship to policy holder ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Section

Insurance/Plan
Policy ID#
Group #
Insurance Phone
Policy Holder/DOB
Patient relationship to policy holder ☐ Self ☐ Spouse ☐ Child

Motor Vehicle Accident Information

Primary Insurance Information: (Your vehicle)
Name | Claim #
Phone | Claim Manager

Secondary Insurance Information: (Other vehicle involved in accident)
Name | Claim #
Phone | Claim Manager

Workman's Compensation Insurance Information

Name | Claim #
Phone | Claim Manager

Attorney Information (please complete Lien and Authorization form)

Name | Phone
Law Firm Name
Address

The above information is correct to the best of my knowledge. I agree that monies received from my insurance company over and above my indebtedness will be refunded when my bill is paid in full. I understand that I am financially responsible for all charges not covered by my insurance. I also understand that I am financially responsible for all cost of collection, including reasonable attorney's fees and court costs. I authorize payment from my insurance companies directly to Achieve Physical Therapy. I hereby authorize Achieve Physical Therapy to release information necessary to secure payment of benefits. A monthly bookkeeping charge will be added to accounts reflecting a 60-day-old balance.

Patient or Guardian Signature (if patient is a minor) ____________________

Date ____________________

MEDICAL HISTORY

ACHIEVE Physical Therapy
Boise, Meridian, Garden Valley, Horseshoe Bend

Patient Name ______________________ Preferred Name ____________ DOB __________

Referring Physician ______________________ Primary Physician ______________________

Was this injury work related? ☐ Yes ☐ No

Date of onset of symptoms: ______________

Please explain your current problem: ______________________

Since the initiation of your problem, has it gotten: ☐ Worse ☐ Better ☐ Stayed the same

What activities increase your symptoms/pain? ______________________

What activities decrease your symptoms/pain? ______________________

Have you had any falls in the past year? ☐ Yes ☐ No

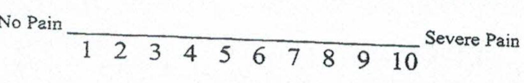
If yes, how often and were you injured? ______________________

Current medications (over-the-counter/prescriptions) or vitamins/supplements: ______________________

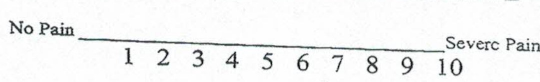
List injuries, surgeries, accidents, or current medical problems: ______________________

Nature of pain/symptoms (please circle): sharp dull throbbing aching periodic occasional constant other

Place an X on your pain level while at **REST**:



Place an X on your pain level when **ACTIVE**



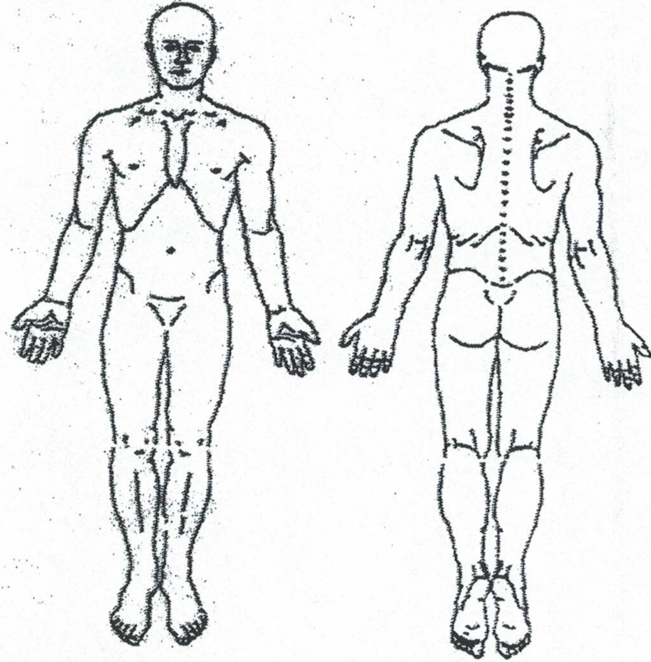
Pain Range (on a scale of 1-10):

Best __________

Worst __________

Right Now __________

Pain Diagram: Please mark the area of pain or discomfort on the chart below.



Please check the functional activities you are currently having difficulty with:

- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Bending
- ☐ Twisting
- ☐ Kneeling
- ☐ Squatting
- ☐ Lifting
- ☐ Driving
- ☐ Self care
- ☐ Overhead activities
- ☐ Talking/chewing/yawning/swallowing
- ☐ Climbing stairs
- ☐ Work requirements
- ☐ Household/yardwork/gardening
- ☐ Lying down/sleeping
- ☐ Caring for children
- ☐ Recreational/sports activities
- ☐ Repetitive activities
- ☐ Shopping

What are your physical therapy goals?

____

Living Environment: (check all that apply)

- ☐ Live alone
- ☐ Live with family or roommates
- ☐ Retirement or assisted living complex
- ☐ House/condo/apartment
- ☐ No stairs
- ☐ Ramp
- ☐ Stairs with railing
- ☐ Stairs with NO railing
- ☐ Elevator
- ☐ Uneven ground

Have you ever had/been diagnosed with any of the following conditions? (check all that apply)

- ☐ No diseases or conditions
- ☐ Cancer ____________________
- ☐ Cardiac problems ______________
- ☐ Pacemaker
- ☐ Circulation/vascular issues
- ☐ Diabetes
- ☐ Stroke/CVA/TIA
- ☐ High blood pressure/cholesterol
- ☐ Depression
- ☐ Parkinson's disease
- ☐ Muscle, joint, or bone problems
- ☐ Headaches/migraines
- ☐ Arthritis ____________________
- ☐ Osteoporosis/osteopenia
- ☐ Dental problems/TMJ
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney/bladder issues
- ☐ Pulmonary/lung issues/asthma
- ☐ Alzheimer's/dementia
- ☐ Other: ____________________

Since the onset of your current symptoms have you had: (check any that apply)

- ☐ Any difficulty with bladder/bowel function
- ☐ Malaise (vague feeling of bodily discomfort)
- ☐ Numbness (location) ________________
- ☐ Problems with vision/hearing
- ☐ Dizziness/vertigo, loss of balance or fainting
- ☐ Fever/chills
- ☐ Unexplained weakness
- ☐ Night pain/sweats
- ☐ Rapid weight loss or gain
- ☐ Other: ____________________

In what position(s) do you sleep?

- ☐ Back, sides, & stomach
- ☐ Stomach only
- ☐ Back & sides
- ☐ Back only
- ☐ Sides only
- ☐ Left-side only
- ☐ Right-side only
- ☐ Chair/recliner, cannot sleep in a bed

Does the pain wake you up at night? ☐ YES ☐ NO

Are you stiff in the morning? ☐ YES ☐ NO

Does the pain come at the same time each day/night? ______________________________

The above information is correct to the best of my knowledge. I give my consent to Achieve Physical Therapy to administer physical therapy outlined by my physician or recommended by my physical therapist.

____
Signature or Patient or Guardian (if patient is a minor)

____
Date

Notice of Privacy Practices - HIPAA

Boise, Meridian, Garden Valley, Horseshoe Bend

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

EFFECTIVE DATE: APRIL 21, 2008
UPDATED: OCTOBER 15, 2019

PLEASE REVIEW CAREFULLY

This notice describes the procedures and practices that this clinic and its professional, support, and administrative staff follow to protect the privacy of your health information.

YOUR HEALTH INFORMATION: This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, it may be in the form of written or electronic records or spoken words, and it may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, the doctor who referred you for physical therapy may be treating you for a medical or orthopedic condition and we may need to know about that and any other health problems that could complicate your treatment. We may use your medical history to decide what treatment is best for you. We will consult with your doctor and send reports about your treatment to the doctor. We do this to provide the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as telephoning your doctor and getting needed information. Family members and other health care providers may be part of your physical therapy outside this office and that may require us to provide information about you.

For Payment: We may need to disclose health information about you in order to bill your health plan or insurance company or other third party for your treatment in this clinic. We may also need to tell your health plan or insurance company about a treatment you are going to receive in order to obtain prior approval, or to determine whether your plan will pay for the treatment.

For Health Care Operations: We may use and disclose health information about you in order to manage the clinic and ensure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain treatments are effective for certain problems. We may also disclose your health information to your health plan and other health care providers that care for you in order to help these plans and providers evaluate or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

Appointment Reminders: We may contact you to remind you of your appointment.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may interest you.

Health-Related Products and Services: We may tell you about health-related products or services that may interest you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-products and services. If you advise us in writing that you do not wish to receive these communications, we will not use or disclose your information for these purposes.

OTHER CIRCUMSTANCES

We may use or disclose health information about you for the following purposes, in accordance with the requirements and limitations of stand and other law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security, and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report suspected abuse or neglect, non-accidental physical injuries or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigation, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may also release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (due to incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Medical Power of Attorney: If you have chosen someone to act on your behalf as Medical Power of Attorney or if someone is your legal guardian, that person can exercise your right and make choices, decisions regarding your health information. Our office will make sure that person has said authority before taking action.

OTHER USES AND DISCLOSURES PURSUANT TO YOUR SIGNED AUTHORIZATION

We will not use or disclose your health information for any purposes other than those identified in the previous sections without your specific, written Authorization. If you sign an Authorization for us to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of, or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Correct: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request a correction as long as this office keeps the information.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a record of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operation, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The record may also exclude any disclosures we have made based on your written Authorization. To obtain this accounting, you must submit your request in writing. It must state the time period for which you want an accounting. The time period may not be longer than six years and may not include dates before April 21, 2008. Your request should indicate in what form you want the list (paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you for someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. *We are not required to agree to your request*. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

CHANGE TO THIS NOTICE

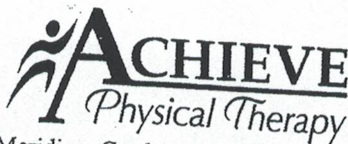
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice or a summary of the current notice in the office with its effective date at the top of the document. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the US Department of Health and Human Services. To file a complaint with the US Department of Health and Human Services you may send a letter to 200 Independence Ave. SW, Washington DC 20201, or call 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. You will not be penalized or retaliated against for filing a complaint.

I have read and understand this document, and hereby acknowledge this clinic's efforts to maintain my privacy.

Patient Signature ______________________________ **Date:** ____________________



Boise, Meridian, Garden Valley, Horseshoe Bend

PAYMENT POLICY

PRIVATE INSURANCE: We will verify your insurance benefits as a courtesy to you. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Please provide the most current insurance cards to ensure proper claims processing. We will bill your primary and/or secondary insurance. Any remaining balance after insurance(s) has paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your insurance carrier(s). Due to the variety of treatment types, it is required by state law that physical therapy procedure codes are billed in 15-minute increments called "units". Insurance companies will not guarantee payment until claims have processed.

MEDICARE: We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges after the deductible. We will also bill your secondary insurance for you, if you have one, or the balance will be billed to you. Please provide the most current Medicare and secondary insurance cards to ensure proper claims processing.

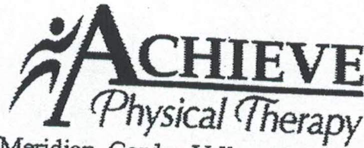
MEDICAID: All patients must provide a current Medicaid card and photo identification prior to being seen. We will verify your eligibility with Medicaid. Claims could be denied if you are not eligible at the time of treatment. If you have cost share, it is due the day of your appointment.

SELF-PAY: Please pay the balance in full at the time of service. These services CANNOT be billed to any insurance company. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Achieve Physical Therapy is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit cards are accepted for payment on accounts.

WORKER'S COMPENSATION: We will bill your Worker's Compensation carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage. We can bill your private insurance for these services if they are denied. At that point you would be responsible for any deductible copays/co-insurance.

MOTOR VEHICLE ACCIDENT: We will bill your insurance as a courtesy to you. A signed lien will be required to assure Achieve Physical Therapy is included in the settlement. Billing will go to your insurance, if denied we will then bill the other party's insurance and/or your private health insurance. Please be aware that you will remain financially responsible for all of your charges if your carrier denies coverage. Achieve Physical Therapy is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection of payment. Credit cards are accepted for payment on accounts.

____ ____________________
Patient Signature / Parent Signature (if minor) Date



Boise, Meridian, Garden Valley, Horseshoe Bend

PHYSICAL THERAPY CANCELLATION / NO-SHOW POLICY

Achieve Physical Therapy will be providing you with the highest quality of care and will attempt to arrange your therapy sessions to accommodate your schedule. Due to our one-on-one, 60-minute treatments, missed appointments are a significant inconvenience to your physical therapist, the clinic and other patients. This policy is in place out of respect for our therapist AND our clients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 service charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.
2. We reserve your one-hour appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to offer that time to a wait-listed patient.
3. Illnesses and emergencies are addressed on an individual basis.
4. Certain accident claims adjusters (Auto and Worker's Comp) expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioner(s) to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

NOTE: You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time. If you arrange a time to "make-up" this appointment, the cancellation fee will be waived. All cancellations and no-shows are recorded in your medical records and reported to your physician and/or insurance company.

*Appointment reminders are available via a voice call, a text message, or email. Please indicate if you would like to receive an appointment reminder by selecting your preferred contact method and writing down the number or address you would like your reminder sent to:

Voice Call ___________ Text Message ___________ Email ______________________

This policy is necessary for the benefit of each patient and will enable us to better serve you.

Patient Signature: ______________________________ Date: ________________