Mount Nittany Health Fit for Play: Patient Intake Form

GENERAL INFO

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

Address: _____

City: _____ **State:** _____ **Zip:** _____

CONTACT INFO:

Phone (Home): _____ **Phone (Work):** _____

Phone (Mobile): _____ ** Preferred Phone: ☐ Home ☐ Work ☐ Mobile

Email: _____

☐ Do NOT email me important information about the facility or free events held at Fit For Play

Emergency Contact: _____ **Phone:** _____

PHYSICIAN(S):

Referring Physician: _____

Family Physician: _____

INSURANCE INFO:

Insurance Company: _____

Policy Holder (Name): _____ **Date of Birth:** _____

Relation to Patient: _____

Secondary Insurance (if any)**:** _____

Policy Holder (Name): _____ **Date of Birth:** _____

Relation to Patient: _____

SCHEDULING:

Preferred Appointment Days: ☐ M ☐ T ☐ W ☐ Th ☐ F **Pref Appointment Time:** ☐ AM ☐ PM

We will make every effort to accommodate your preferences, but cannot guarantee these days and times will be available.

Appointment Reminders:

Please choose only 1 of the following options below
At this time our software will only allow for 1 method of appointment reminder

I prefer to receive my appointment reminders via:

☐ Phone (please indicate preferred number) _____

☐ Text Message (please indicate preferred number) _____

** May we text message you about appointment openings? ☐ YES ☐ NO

** May we email you about appointment openings? ☐ YES ☐ NO

Mount Nittany Health Fit for Play: Patient Intake Form - Current Medical Symptoms

Age: _____ **Height:** _____ Feet _____ Inches **Weight:** _____

Please describe the main problem you are having: _____

Please list any other forms of treatment you have had for this problem?
(examples: chiropractic, physical therapy, massage therapy…. etc)

Please list any tests pertaining to current problem? (examples: x-rays, MRI, bone scan ….etc)

Are you currently? (check all that apply)
☐ Pregnant ☐ Have a Pacemaker ☐ Depressed ☐ Under Stress

I currently have difficulty: (check all that apply)
☐ Driving ☐ Getting up from a chair ☐ Bending at the waist ☐ Sleeping through the night

Are your symptoms? ☐ Getting Worse ☐ The Same ☐ Getting better

Please rate the severity of your pain by checking a number on the scale below:

NO PAIN ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **UNBEARABLE PAIN**

Please use the information below to provide our therapists' with details about your current symptoms

****Please fill out the information below after you print out the forms / or during your first visit****

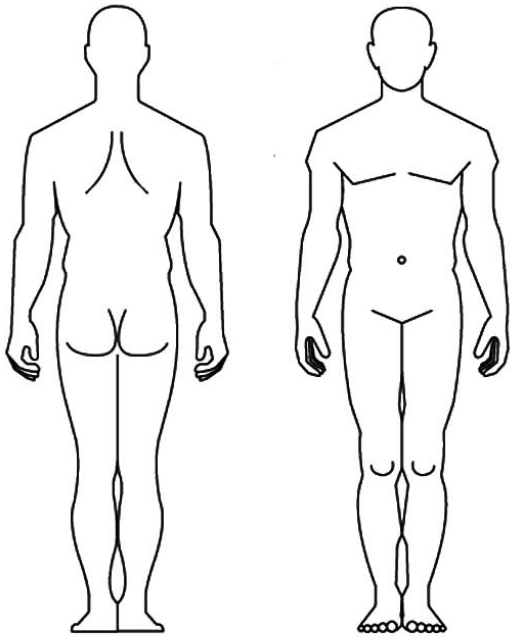
Instructions:
1. Place a circle on each area of your pain or symptoms
2. Choose the letter(s) from List 1 below to indicate the frequency of your pain / symptoms
3. Choose the number(s) from List 2 below to indicate the type of pain / symptoms

LIST 1

A. Constant (never goes away)
B. Intermittent (relieved with position change or rest)
C. Occassionally (daily or less frequent)
D. Infrequent (once a week)
E. Variable (comes and goes)

LIST 2

1. Sharp
2. Shooting
3. Burning
4. Dull
5. Throbbing
6. Pulling
7. Ache
8. Tingling
9. Numb
10. Heavy
11. Tight
12. Stabbing



Mount Nittany Health Fit for Play: Patient Intake Form - Medical History Questionnaire

Have you or an immediate family member ever been diagnosed with:

	SELF		FAMILY	
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No

	SELF		FAMILY	
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid Condition	☐ Yes	☐ No	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No

Do you personally have a history of:

Allergies/Asthma	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No

Headaches	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

Bronchitis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

In the past 3 months have you had or do you experience:

Change in your Health	☐ Yes	☐ No
Fever/chills/sweats	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Urinary tract infection	☐ Yes	☐ No

Nausea/Vomiting	☐ Yes	☐ No
Unexplained weight change	☐ Yes	☐ No
Changes in appetite	☐ Yes	☐ No
Changes in bowel	☐ Yes	☐ No
Changes in bladder function	☐ Yes	☐ No
Upper respiratory infection	☐ Yes	☐ No

PLEASE LIST ALL MEDICATIONS YOU TAKE:

Medication Name	Dosage (Typically Mg)	Times per day	How Taken (Example: Orally)

Please list any surgeries (please include year): _____

_____

Please list any allergies you have: _____

Do you currently use tobacco? (please choose one) Yes ☐ No ☐

Do you currently use alcohol? (please choose one) Yes ☐ No ☐

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

_____

Signature Date

Mount Nittany Health Fit for Play: Patient Intake Form - Consent to Treat

Patient Consent to Participate in Treatment

● The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All material risks and/or side effects of a proposed procedure, as well as the probability of success with such procedure, shall be disclosed to the patient by his/her attending physical therapist.

● The patient shall not be subjected to any procedure without his/her voluntary and competent consent, or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

● The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures.

● The patient shall be advised if Mount Nittany Health Fit for Play proposes to engage in or perform experimental therapies, for the purpose of research, affecting their care. The patient has the right to refuse to participate in experimental therapies for research use.

● The undersigned patient acknowledges and agrees that all material risks and alternatives have been explained to the satisfaction of the patient, that the patient has had a full opportunity to ask questions, and that any and all questions asked have been answered to the patient's satisfaction.

● **The patient acknowledges that no guarantees have been made to the patient as to the results of any procedure, therapy, or other services.**

After reading the above, I consent to receive physical therapy treatment at Mount Nittany Health Fit for Play, terminating when determined by myself, my physician or my physical therapist.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Assignment and Release of Insurance Benefits and Payments

I, the undersigned, assign to **Mount Nittany Health Fit for Play** all authorized medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to my attending physician for consultation; my attorney for legal purposes; my insurance carrier or other responsible party to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Mount Nittany Health Fit for Play** for any services furnished by that provider. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

I understand my signature requests that payment be made and athorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in box 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Print Name: _____ **Date:** _____

Signature: _____

Exhibit C - Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Mount Nittany Health Fit for Play (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: Mount Nittany Health Fit for Play 2160 Sandy Drive STE A, State College, PA 16803, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information **(leave blank if no restrictions):** _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

Signature of Patient or Representative	Date
Patients Name	Patients Date of Birth
Name of Personal Representative (if applicable)	Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

☐ Accepted ☐ Denied ☐ Not Applicable

☐ Other (explain) _____

Signature of Authorized Practice Representative	Date

Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes Mount Nittany Health Fit for Play. (the "Practice") to obtain, use and disclose the personally identifiable health information specifically referenced in this Authorization.

Please read the following information carefully:

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information:

2. I authorize the following person(s) or class of persons to receive the information:

3. The following is a description of the information that I authorize to be used and/or disclosed:

4. The information will be used and/or disclosed only for the following purposes:

5. I understand and acknowledge that if the person or entity that receives the information is not a health care provider, health plan, or other entity covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. **(If applicable)** I understand that the Practice will receive compensation for its use and/or disclosure of the information.

7. I understand and acknowledge that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that I may inspect or copy any information used and/or disclosed under this Authorization.

8. I understand and acknowledge that I may revoke this Authorization at any time by sending a written revocation to the Practice at the following address: Mount Nittany Health Fit for Play, 2160 Sandy Drive STE A, State College, PA 16803, Attention: Compliance Officer. However, I also understand and acknowledge that if I revoke this Authorization, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Authorization.

9. This Authorization expires _____ (insert applicable date or event).

I understand all of the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

By signing this form, I acknowledge that I have reviewed this Authorization and agree to the Practice's use and disclosure of my protected health information for the purposes set forth within this authorization

Signature of Patient or Representative

Date

Patients Name

Patients Date of Birth

Name of Personal Representative (if applicable)

Relationship to Patient

To Be Completed by the Practice

A copy of the completed and signed Authorization form has been provided to the patient or representative:

☐ Yes ☐ No

Signature of Authorized Practice Representative

Date