Redbud Health Services
Physical Therapy

PAST MEDICAL HISTORY FORM

Patient Name: ______________________________ Date: ______________

Are you presently working? ☐ Yes Occupation: ________________ ☐ Disabled ☐ Retired ☐ Other

Date of injury / onset: ___/___/___ Date of next physician's visit: ___/___/___
Have you ever had physical therapy for these symptoms before? ☐ Yes ☐ No
Check which apply to your symptoms:
☐ work related injury ☐ recurrence of previous injury
☐ motor vehicle accident ☐ injury related to lifting ☐ injury related to falling
☐ cause unknown ☐ athletic / recreational injury ☐ other: ______________

Have you had a related surgery? ☐ Yes ☐ No Describe ______________________________

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe ______________________________

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Stroke / CVA /TIA	☐	☐
Heart problems / Angina	☐	☐	Allergies to medicine	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Peripheral Vascular Disease	☐	☐	Other Allergies	☐	☐
Low Blood Pressure	☐	☐	Hernia	☐	☐
Anti-coagulant Therapy	☐	☐	Seizures	☐	☐
Neurological Problems	☐	☐	Metal Implants	☐	☐
Eye / Ear problems	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries (list below)	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis / Osteopenia	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea/ Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other:	☐	☐	Headaches	☐	☐

If yes on any of the above, please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know about?

Please continue on the other side.

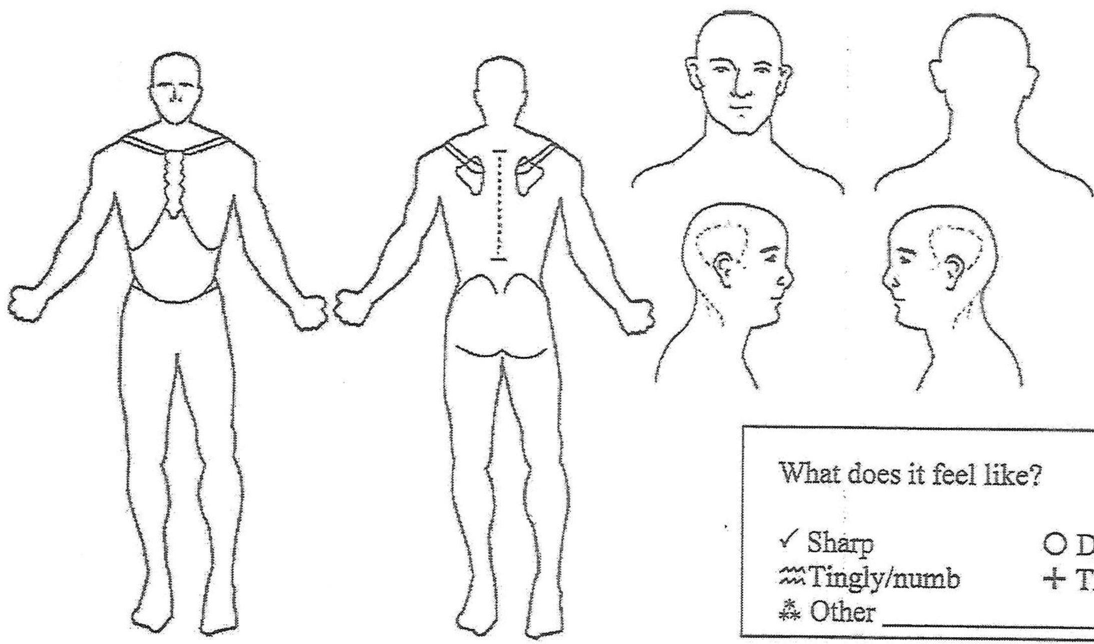
Medical History page 2

Are you presently taking Medication? ☐ Yes ☐ No

If yes, please list what medications and for what condition:

Describe your current health (circle one) Poor Fair Very Good Excellent

Please indicate below where your symptoms are located.



What does it feel like?

✓ Sharp
○ Dull/Ache
≈ Tingly/numb
+ Throbbing
⁂ Other ________________

Do these symptoms affect your sleep? ☐ No ☐ Yes Explain:________________________

If your complaint includes pain, please rate the intensity of your pain on a scale of 0 to 10.
0 = no pain and 10 = worst possible pain.

What is your current level of pain? _______
What is your AVERAGE or TYPICAL pain? _______
What is your pain at its best (How close to 0 does it get at its best)? _____
What is your pain at its WORST (How close to 10 does your pain get at its worst)? ____.

______________________________ Patient's Signature

____/____/___ Date

______________________________ Guardian (if patient has one)

Thank you for taking the time to provide this information.

INTAKE FORM

500 E 3rd Street
Buchanan MI, 49107
Phone: 269-409-8626
Fax: 269-273-8457

Last Name:	First Name:
Preferred Name:	Address:
Apts or PO Box:	Email:
City& Zip:	Cell Phone:
Home Phone:	**Sign up for Apt Reminders?** ☐ **TEXT** ☐ **EMAIL**

Emergency Contact:

Name:	Name:
Phone:	Phone:
Relationship:	Relationship:

Primary Care:

Primary Physician:	May we send updates to them? ☐ Yes ☐ No

Motor Vehicle Accident Injuries:

State and Date the accident occurred:	Claim #:
Insurance Carrier:	Address of Carrier:
Adjuster Name:	Adjuster Email:
Adjuster Phone:	Policy Holder:

Cancellation & Attendance Policy:

☐ **I acknowledge that If I am unable to keep my appointment time to call 24 hours in advance to cancel or a $60.00 cancellation fee will be added on to your account, Insurance will not cover this fee. 2 cancellations without a reschedule will result in a discharge.**

Patient Signature:______________________________ Date:______________

Name______________________

Date____________________

Redbud Health Services
500 E 3RD ST
Buchanan, MI 49107

Phone: (269) 409-8626
Fax: (269) 273-8457

Redbud Health Services
Physical Therapy Admission Consent Form
(Please initial each line)

_______**Consent to Treatment:** I Consent to rehabilitation and related medical services from Redbud Health Services Physical Therapy Clinic.

______ **Release of Information:** I allow Redbud Health Services to give information related to me and any third-party payer or insurance company which may be responsible in whole or in part for paying my bill to companies hired by these third parties to monitor utilization or rehabilitation service, and to any health care facility or physician by which I am referred or who I have identified and my primary care provider.

______**Acknowledgment of Participation :** I hereby release Redbud Health Services/ Redbud Lifestyle and Fitness Center from any responsibility or liability due to my participation in physical therapy. I am fully aware that I am participating in these sessions at my own risk and will not hold those named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions. If I have any medical conditions, I have consulted with my physician to make sure that physical therapy is appropriate for me to participate in.

______ **Authorization of Payment:** I hereby assign all benefits directly to Redbud Health Services and authorize release of any medical record necessary to facilitate my treatment to process medical claims and as otherwise permitted or required by Notice of Privacy Practices. I understand that in the event my insurance company or financial responsible party does not pay for the services I receive, I will be fully responsible for payment.

_____ **Financial Agreement:** I have read and understand the financial agreement attached to this clipboard. (copies available upon request)

______ **Notice of Privacy Practice:** I acknowledge that I have been provided with and offered a copy of the Notice of Privacy Practice. (attached)

Financial Agreement

As a courtesy to you, Redbud Health Services will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information provided to our office is accurate and current. If there is a change in your insurance information, please notify us **immediately.**

Co-payments are constant and due at the time your services are rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan.

Medical Insurance coverage is a contract between you and your insurance company. <u>WE ARE NOT</u> a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are ultimately responsible for the timely payment of your account and any outstanding or uncovered services.

<u>NO INSURANCE / CASH RATE:</u> We believe that no one should be denied physical therapy services secondary to lack of insurance coverage. Our clinic offers a discounted cash rate to those who do not have appropriate insurance coverage. Payment will be required at the time of service unless arrangements are made in advance. Please inquire about our current cash pay rate if it is applicable to your situation.

<u>COLLECTIONS:</u> If your account is more than 30 days past due, without an established payment plan on file, we will begin immediate collection actions. We will begin assessing your account a 5% finance charge, based on your remaining balance, unless you have a payment plan in place. If you do not pay your bill following our internal collection efforts, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

<u>PAYMENT METHODS AND OTHER INFORMATION:</u>

• We accept cash, check and VISA or Mastercard
• Accounts that are past due will be turned over to a collection agency and a collection fee will be assessed
• Home supplies are not covered by insurance and must be collected at the time they are received.

- **WE DO HAVE THE OPTION OF KEEPING A CARD ON FILE, IF YOU WOULD LIKE TO GIVE US PERMISSION TO RUN YOUR CARD AS CLAIMS COME THROUGH PLEASE FILL OUT THE "Card on File" Form**

<u>Flip →</u>

Redbud Health Services is committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please do not hesitate to ask if you have any questions about our fees, financial policy or your financial responsibility.

****I acknowledge that I have read and agree to the above Financial Policy.****

AUTHORIZATION FOR TREATMENT & FINANCIAL AGREEMENT

- I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received within 30 days of statement date. I agree to pay all charges within 30 days of the statement date, unless prior arrangements have been made with the billing office. I agree to assign my insurance benefits to Redbud Health Services, if applicable.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

- I authorize Redbud Health Services to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize my healthcare providers to release personal health information as it pertains to my rehabilitative care if any is requested by Redbud Health Services

Notice of Privacy Practices
Redbud health Center

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ *See page 2 for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ *See pages 3 and 4 for more information on these uses and disclosures*

Notice of Privacy Practices
Redbud health Center

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

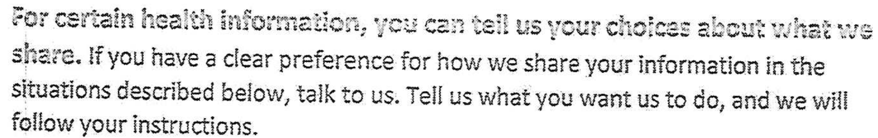
Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Notice of Privacy Practices
Redbud health Center

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint



For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

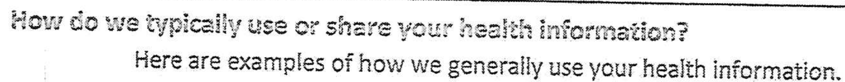
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes



How do we typically use or share your health information?
Here are examples of how we generally use your health information.

Continued on next page.

Notice of Privacy Practices
Redbud health Center

Treat you	We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	We can use and share your health information to run our practice, improve and contact you when necessary.	*Example: We use health information about you to manage your treatment and your care services.*
Bill for your services	We can use and share your health information to bill and get payment from health plans or other entities	*Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	◦ We can share health information about you for certain situations such as: Preventing disease ◦ Helping with product recalls ◦ Reporting adverse reactions to medications ◦ Reporting suspected abuse, neglect, or domestic violence ◦ Preventing or reducing a serious threat to anyone's health or safety
Do research	◦ We can use or share your information for health research.

Comply with the law	◦ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	◦ We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	◦ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	◦ We can use or share health information about you: ◦ For workers' compensation claims ◦ For law enforcement purposes or with a law enforcement official ◦ With health oversight agencies for activities authorized by law ◦ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	◦ We can share health information about you in response to a court or administrative order, or in response to a subpoena.

In Summary

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you
- The new notice will be available upon request, in our office, and on our web site.

Cancellation / 2 Strike Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family Please advise us if you need to cancel or reschedule an appointment as soon as possible, oftentimes there is a waiting list for patients that could use the same time slot.

- **Appointments must be canceled within 24-hour notice. If we do not receive a 24-hour notice, you will be charged a $60.00 dollar fee. This fee will not be covered by your insurance.**

- **2 cancels without a reschedule will result in a discharge from therapy.**

We do offer text and email reminders, please check the box on the intake form if you're interested in receiving those.

Thank you for your understanding in this matter.