PATIENT INFORMATION:

First Name:_____Middle Name:_____Last Name:_____

Date of Birth:_____/_____/_____Social Security Number:_____Sex_____

Address:_____Home Phone: (_____)_____

City/State/Zip:_____Mobile Phone:(_____)_____

Marital Status:_____Occupation:_____

Email: _____

EMERGENCY CONTACT INFORMATION:

First Name:_____Last Name:_____Phone: (_____)_____

REFERRING PHYSICIAN:

Name:_____Phone: (_____) _____

ADDITIONAL INFORMATION:

1. Is this a work-related injury? Yes No
2. Are you having physical therapy due to a Motor Vehicle Accident? Yes No
3. Have you had Imaging done? Xray MRI CT Ultrasound Bone scan EMG

   If yes, what provider?

   _____
4. Have you received any physical therapy for any condition this year? Yes No

   If so, what area and how many visits? _____
5. Have you had surgery for this condition? Yes No

   If so, what was the date and nature of the surgery? _____
6. How did you hear about S.T.A.R. Physical Therapy? Doctor Friend Mail Social Media

   Other: _____

PRIMARY HEALTH INSURANCE:

Primary Insurance Provider:_____Insurance ID #: _____

Policy Holder First and Last Name: _____

Policy Holder Date of Birth:_____/_____/_____ Policy Holder SSN: _____

Relationship to Patient: _____

SECONDARY HEALTH INSURANCE:

Secondary Insurance Provider:_____Insurance ID #: _____

Policy Holder First and Last Name: _____

Policy Holder Date of Birth:_____/_____/_____ Policy Holder SSN: _____

Relationship to Patient: _____

For Office Use Only:
Intake completed by:_____Date: _____

PAST MEDICAL HISTORY:

1) Please check "**Yes**" or "**No**" to all the medical conditions listed below that you are currently diagnosed with or have been previously diagnosed with:

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	HIV / AIDS
☐	☐	Bronchitis	☐	☐	Osteoarthritis
☐	☐	Bowel/Bladder Problems	☐	☐	Osteoporosis
☐	☐	Cancer	☐	☐	Pneumonia
☐	☐	Chest Pain	☐	☐	Rheumatoid Arthritis
☐	☐	Depression	☐	☐	Shingles
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Emphysema	☐	☐	Are you currently pregnant?
☐	☐	Epilepsy/Seizures	☐	☐	History of alcoholism?
☐	☐	Fibromyalgia	☐	☐	History of drug abuse?
☐	☐	Heart Disease/Attack	☐	☐	Currently have surgical implants?
☐	☐	Hepatitis	☐	☐	Currently have a pacemaker?
☐	☐	High Blood Pressure			

2) Please list all the surgeries that you have had, including the approximate date:

_____

_____

_____

3) Please list any other medical conditions, past or present, which are not listed above:

_____

_____

_____

4) Do you smoke? Yes No

If you do smoke, please refrain from smoking for 2 hours before and 2 hours after your physical therapy treatment. This will significantly improve your healing process.

5) Please list where you have been having pain:

_____

6) Please mark the number below that corresponds to the worst pain you have had in the past week:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Severe Pain

Patient Name:_____

Signature:_____ **Date:**_____

<u>MEDICATION LIST</u>: Additional sheets are available if needed.

Patient Name:_____ **Date:**_____

Medication Name	Dosage	Frequency	Route of Administration (oral, injection, nasal spray, etc.)
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			
21)			
22)			
23)			
24)			
25)			

I hereby acknowledge that I have completed this information to the best of my ability:
Signature:_____

PATIENT AUTHORIZATION:

Consent for Treatment and Authorization to Release Information

I hereby authorize S.T.A.R. Physical Therapy and Injury Rehab., to provide any physical therapy services or related services as deemednecessary by the physical therapist(s). I consent and authorize S.T.A.R. Physical Therapy and Injury Rehab, to release information contained in my medical and financial records, including diagnosis and test results to my referring physician, insurance company, or an attorney's office if applicable.

INITIALS: _____

Consent to Treat a Minor (if applicable)

I,_____the parent/ legal guardian of,_____
authorize physical therapy treatment to be administered by S.T.A.R. Physical Therapy and Injury Rehab

Assignment of Insurance Benefits

I hereby authorize any and all insurance carriers, and/or appropriate agencies to pay directly to S.T.A.R. Physical Therapy and Injury Rehab, benefits due me, if any, by reason of services described in the statement rendered.

INITIALS: _____

Acknowledgement of Review of Notice of Privacy Practices

I have been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

INITIALS: _____

Personal Valuables

I hereby release S.T.A.R. Physical Therapy and Injury Rehab, and its associates of any and all responsibility for loss or damage to personal property, including but not limited to clothing, money, or other valuables kept in my possession or brought in by me or anyone with me during my care.

INITIALS: _____

Contact Authorization

I hereby authorize S.T.A.R. Physical Therapy and Injury Rehab, to contact me and/or a minor under my guardianship via phone, text,or email in regards to my medical care.

INITIALS: _____

_____ _____
Patient/ Guardian Signature Date

_____ _____
Company Representative Signature Date

HIPPA / Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is 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.

Use and disclosure of protected information

Your health information will only be used by the doctor, our office staff and others outside of our office that are involved in your case of treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Health Operations

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, Coroners, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates. Under the law we must make disclosures to you and when required by the Secretary of the department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your Rights

You have the right to inspect and copy your protected health information other than 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 to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, **upon request**.

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

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. **We will not retaliate against you for filing a complaint.** This notice was published and becomes effective on/or before **April 14, 2003.**

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print Patient Name: _____

Patient/Guardian Signature: _____ Date Signed:_____