NOVA ORTHOPEDIC & SPINE CARE VILLAGE PHYSICAL THERAPY

A Division of The Centers for Advanced Orthopaedics

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Patients Last Name	First Name	MI	Today's Date:
Patients Full Address			

Patients SSN:	Patients Date of Birth:	Marital Status:	Gender:	Race and Ethnicity
Home Phone Number:	Cell Phone Number:	Work Phone Number:		
Name of Employer	**FT / PT / Retired**	Employer Address:		
May we contact you via Email	Email Address:	Primary Spoken Language:		
Emergency Contact Name:	Emergency Contact Relationship:	Emergency Contact Phone #		
If the patient is a Minor, Who is authorizing Treatment:/Accepting Financial Responsibility:	Relationship to the Child:			
Primary Care doctor / Referring Physician Name: (Medicare and HMO patients MUST list a Doctors name)				
Other Referral Source:				
Pharmacy Name and Phone Number:				

Work Related Injury	YES	NO
Work Comp Claim Filed	YES	NO
Attorney Involved	YES	NO
Approx. date you first noticed this problem / Date of injury: (*MM / DD / YY*)		

INSURANCE INFORMATION

Primary Insurance Plan		Policy Number	Group Number
Policy Holder Name	Policy Holder DOB	Policy Holder SSN	Relationship to Patient
Secondary Insurance Plan		Policy Number	Group Number
Policy Holder Name	Policy Holder DOB	Policy Holder SSN	Relationship to Patient
Worker's Comp Company Name:			
W/C Address:			
W/C Phone Number:	Adjuster Name:	Claim #:	Date of Accident:

Date Reviewed	Patient Signature (If No Change)	Staff Initials	Date Reviewed	Patient Signature (If No Change)	Staff Initials

Patient Intake Form

Patient Name:	Patient's Birthdate:	Today's Date:
Height:	Weight:	

Pain Level: Least 0 1 2 3 4 5 6 7 8 9 10 Worst

Surgeon You Are Seeing Today:

Reason For Your Appointment:

Past Medical History

Previous Surgeries:	Date

Are you pregnant or Nursing?	**YES**	**NO**
Do you have a history of Bleeding Problems?	**YES**	**NO**
Do you have problems with Anesthesia?	**YES**	**NO**

Medications (Please List Name and Reason for Taking)

Are you currently under the care of a Pain Management Doctor: YES NO Physician:_____

Drug Allergies:

Do you use Tobacco in any form: **YES** **NO**	If Yes How Much:
Do you Drink alcohol: **YES** **NO**	If Yes How Much:

Have you ever used IV drugs or other illegal substances: **YES** **NO**

Have you had any Physical Therapy for this problem: **YES** **NO**

If Yes, For how long:

Family History

Do you have a family history of arthritis, or Diseases of the muscles, bone, or nervous systems? **YES** **NO**

If yes, Please describe:

Do you have any family history of bleeding tendencies:	**YES**	**NO**
Do you have any family history of anesthesia problems:	**YES**	**NO**
Is there a family history of any other diseases you would like the Doctor to know about:	**YES**	**NO**

If Yes, Please Describe:

Date Reviewed	MD Signature	MA Signature	Date Reviewed	MD Signature	MA Signature

Are you currently working: **YES** **NO**		Occupation:
If no, when was your last day of work?		
Is your regular type of work: **HEAVY** **MEDIUM** **LIGHT** **SEDENTARY**		
Are you currently on any type of work restriction: **YES** **NO**		
If Yes, What are the restrictions:		
What regular exercise or sports do you participate in?		
What are your hobbies?		
Marital Status: **Single** **Married** **Divorced/Separated** **Widowed**		
Children: **YES** **NO**	How Many:	Ages:
Who lives at home with you:		

Current Review of Symptoms
(Circle all that Apply)

CONSTITUTIONAL	Recent Weight Loss Recent Weight Gain Fatigue Fever/Chills Night Sweats Risk Factors for HIV/Aids
HEENT	Runny Nose Itchy Eyes Hearing Loss Sinus Problems Gum/Tooth Disease Hoarsness Change In Vision Sore Throat Blurred Vision Double Vision Blind Spots Glaucoma
DERMATOLOGY	Skin Cancer Rashes Sores Moles Lumps Excessive Bleeding Acne Alopecia Dry/Sensitive Skin Raynaud's
ENDOCRINE	Diabetes Thyroid Problems Excessive Thirst Abnormal Hot or Cold
CARDIOLOGY	High Cholesterol Palpitations Chest Pain High Blood Pressure Leg Swelling Fainting Blood Clots
RESPIRATORY	Chronic Cough Wheezing Coughing Blood Emphysema Infections Chest Pain Shortness Of Breath
GASTROINTESTINAL	Nausea Heartburn Ulcers Difficulty Swallowing Abdominal Pain Constipation Diarrhea Bloody Stools
GENITOURINARY~FAMALE	Menopause Possibility of Pregnancy Incontinence Painful Urination Blood In Urine Abnormal Vaginal Bleeding Vaginal/Pelvic Infections
GENITOURINARY~MALE	Incontinence Painful Urination Blood In Urine Trouble Starting Stream Prostate Problems Impotence
MUSCULOSKELATAL	Fractures Muscle Pain Arthritis Joint Swelling Joint Pain Lower Back Pain Joint Stiffness Sciatica Neck Pain Bone Pain Leg Cramps
NEUROLOGICAL	Dizziness Headache Slurred Speech Seizures Numbness/Tingling Insomnia Memory Loss Vertigo Peripheral Neuropathy Restless Leg Syndrome Weakness Stroke Loss of Feeling on One Side
PSYCHIATRIC	Sleep Disturbance Panic Attacks Depression Anxiety Excessive Stress Considered Suicide **Are you receiving counseling or under the care of a psychiatrist? YES NO**

Patient Signature:_____ Date: _____

Date Reviewed	MD Signature	MA Signature	Date Reviewed	MD Signature	MA Signature

Financial , Payment , and General Office Policy

Insurance Patients: Providers in this office participate with most major insurance carriers. If you have an insurance we do not participate with we will verify your benefits as a courtesy to you. All copayments per your plan are required at the time of service per our contracts with the carriers. If any deductible is included in your benefits, you may be required to make a deposit towards that at the time of service. Please verify your coverage and benefits so you are aware of any costs that may be incurred.

Patient Requested Forms: There is a standard fee of $30 for the completion of all FMLA and other patient or employer requested forms. This fee will be due at the time the forms are picked up. There is no exception for this fee and forms will not be released until the fee is paid in full.

Medicaid Patients: Please be aware that Village Physical Therapy, A Division of the Centers for Advanced Orthopaedics is not a participating provider with Medicaid and there for CAN NOT bill them for ANY services. If Medicaid is secondary to Medicare, you will be billed for your 20% Medicare Coinsurance. This is due in full upon receipt of our statement and NO payment plans can be arranged.

Self Pay Patients: All fees are due at the time of service. No personal checks will be accepted for these fees. They must be paid by credit card, cashier's check, cash, or money order. This office does not set up payment plans.

Referrals: If your insurance is an HMO and requires a referral it is your responsibility to bring that to your appointment at the time of service. If you choose to come with out your referral you are risking your insurance not covering any services and you will be required to pay for your visit in full at the time of service.

Worker's Compensation: Nova Orthopedic and Spine Care and Village Physical Therapy, A Division of the Centers for Advanced Orthopaedics require that you provide this office with your workers compensation claims information and all other pertinent information prior to your visit for verification and authorization from the Workers Compensation Insurance plan. Please notify this office as soon as possible if you need assistance in filing your claim. *Failure to have appropriate authorization for the Workers Comp insurance may result in non payment of medical expenses!*

Appointments: Please contact this office 24 hours PRIOR to you scheduled appointment time if you need to reschedule or cancel an appointment. If you cancel or reschedule an appointment LESS the 24 hours PRIOR to your appointment or NO SHOW it will result in a $30.00 charge on your account and $75 charge for PT evaluations.

Phone Calls: Nova Orthopedic and Spine Care and Village Physical Therapy staff, A Division of the Centers for Advanced Orthopaedics may need to leave medical information regarding your care on your answering machine if you are not available. Should you have any restrictions to this policy please indicate:_____

Returned Check Fee: Nova Orthopedic and Spine Care and Village Physical Therapy A Division of the Centers for Advanced Orthopaedics has an agreement with the bank to collect on all returned checks after a check is returned for non-sufficient funds. You will be charged a $50 fee by the bank and no personal checks will be accepted.

Non-Payment: If your account is turned over to a collection agency or attorney for non payment, you will additionally be responsible for any and all additional fees permitted by law and a 33% collection fee will be added to your account.

Assignment of Benefits: By signing below you are authorizing Nova Orthopedic and Spine Care and Village Physical Therapy A Division of the Centers for Advanced Orthopaedics to apply for benefits on your behalf for services rendered and request that payments be made directly to Nova Orthopedic and Spine Care and Village Physical Therapy. I certify that the information I have reported regarding my health insurance coverage is correct and current. I further authorize the release of any information, including but not limited to my medical information, for this or any other related claim.

I, the undersigned, hereby authorize the payment of medical and surgical benefits to be paid directly to Nova Orthopedic and Spine Care and Village Physical Therapy A Division of the Centers for Advanced Orthopaedics. I fully understand that I am financially responsible for all charges whether or not they are paid by the insurance. I authorize the physicians and staff of Nova Orthopedic and Spine Care and Village Physical Therapy A Division of the Centers for Advanced Orthopaedics to release any information necessary to secure the payment of benefits.I, the undersigned, have read all of the above information and disclaimers and agree that all medical and surgical charges incurred by me or my dependants for services rendered by Nova Orthopedics and Spine Care and Village Physical Therapy A Division of the Centers for Advanced Orthopaedics.

I, the undersigned, acknowledge the receipt of the Statement of Privacy Practices, the Financial, Payment, and General Office Policy statements and agree to the terms of these statements.

Signature of Patient/Parent/Responsible Party	Date
Printed Name of Patient/Parent/Responsible Party	Reserved for Local Use (Staff Initials)

Authorization for the Disclosure of Private Health Information

I, _____, authorize Nova Orthopedic and Spine Care and Village Physical Therapy, A Division of the Centers for Advanced Orthopaedics to release my private health information as necessary to physicians involved in my care, my insurance company, and others necessary for the purpose of Treatment, Payment, or Operations. I further authorize Nova Orthopedic and Spine Care and Village Physical Therapy A Division of the Centers for Advanced Orthopaedics to discuss my health or my account with the following individuals:

☐ Spouse:_____

☐ Family Member:_____

☐ Other:_____

Signature of Patient/Parent/Responsible Party	Date
Printed Name of Patient/Parent/Responsible Party	Reserved for Local Use (Staff Initials)

Notice of Privacy Practices

THIS NOTICE IS REQUIRED BY FEDERAL LAW AND DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (.Notice.) describes the ways in which we may use and disclose your protected health information (PHI) and how you can get access to this information. Protected health information. is information about you that is contained in your medical and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future physical or mental health and related healthcare services.

Uses and Disclosures of Protected Health Information: We may use and disclose your protected health information for purposes of healthcare treatment, payment and healthcare operations as described below.

For Treatment: We may use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. Examples of how we will disclose information for treatment may include sharing information about you with: referring physicians, your primary care physician, a specialist, hospitals, ambulatory care centers, pharmacies or home health agencies.

For Payment: Your protected health information will be used and disclosed as required, so that we can bill and receive payment for the treatment and services you receive from us. Examples of how we will disclose information for payment include: contacting your health plan to confirm your coverage or obtain precertification of a service, or we may provide information to any other healthcare provider who requests information necessary for them to collect payment.

For Healthcare Operations: We may use and disclose your protected health information in performing business activities that we call .healthcare operations. This includes internal operations, such as for general administrative activities and to monitor the quality of care you receive at our facility. Examples include: quality of care assessments, training of medical staff, assessing certain services that we may want to offer in the future, evaluating the performance of our employees, licensing, or conducting or arranging other business activities. Other examples include: leaving messages on your answering machine; leaving messages at your place of employment or sending out recall notices. We may use or disclose your protected health information when making calls to remind you of your appointment. We will use a sign-in sheet at the receptionist's desk where you will be asked to sign your name and the name of the provider you are seeing. We will also call you by name when you are in our waiting room.

Other Uses and Disclosures We May Make Without Your Written Authorization: Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, we may use and disclose your protected health information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Risk Issues as required by Law, Communicable Diseases, Health Oversight Activities, reporting Victims of Abuse, Neglect or Domestic Violence, Legal Proceedings, Law Enforcement, (this notice continues on the back of this page) Coroners, Medical Examiners, Funeral Directors, Organ/Tissue Donation Organizations, Research; Criminal Activity; Military Activity and National Security, Inmates/Law Enforcement Custody, and Workers Compensation.

Any Other Use or Disclosure of Your Protected Health Information Requires Your Written Authorization: Will be made only with your consent, authorization or opportunity to object, unless required by law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal protected health information. Under federal law, however, you may not inspect or copy the following records; 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 Restrictions: You have the right to request a restriction on the way we use or disclose your protected health information for treatment, payment or healthcare operations. You may make this request in writing, at any time. If we do agree to the restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your emergency treatment.

You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

You Have the Right to Request that We Amend your Protected Health Information: If we deny your request, we will give you a written notice, including the reasons for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your medical record.

You Have the Right to Request an Accounting of Certain Disclosures of Your Protected Health Information. You Have the Right to Obtain a Paper Copy of This Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.

You May Issue a Complaint to our Privacy Officer (listed on the first page) or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We Reserve the Right to Change the Terms of This Notice of Privacy Practices and to make the new provisions effective for all protected health information we already have about you as well as any protected health information we create or receive in the future. If we make any changes, we will: a. Post the revised Notice in our office(s), which will contain the new effective date; and b. Make copies of the revised Notice available to you upon request.