To Our Valued Patients
Please Note:

It is your responsibility to know your health insurance benefits.
If your insurance plan includes any copays/co-insurance or deductibles, it is due at the time of service.

Please be sure to contact your insurance company to verify your physical therapy coverage before your visit (co-pays/co-insurance, deductibles, precertification requirements, visit limitations, etc.).

Please fill this packet out completely and accurately and bring it in to your appointment along with the referral from your doctor (if it was given to you), your insurance card(s), photo ID, and a list of any medications that you are currently taking.

We are located in Mariner Square Building "C" in the lower level. Take Westmoreland Street off of Point Judith Road which is near the Mariner Square sign and then take the second left which brings you to the back of Building "C". Drive to the end of the parking lot and there's a walkway to use instead of the stairs. You can see our door from the walkway.

Thank you!

Evaluation Appointment: _____
(You will be here 1 Hour)
Follow-Up Appointments: _____
(1/2 Hour) _____
_____
_____

140 Point Judith Road #47
Narragansett, RI, 02882
Phone: 401-789-2077
Fax: 401-782-4762

PATIENT AUTHORIZATION

1. I authorize use of this form on ALL of my insurance submissions.

2. I request that payment of authorized benefits be made on my behalf to ProActive Physical Therapy Inc. for any services to me by that office.

3. I understand that my signature authorized that payment be made and that my medical information be released in order to pay my medical claim(s).

4. I understand that I am responsible for ANY DEDUCTIBLE, CO-PAYMENTS, and NON-COVERED SERVICES.

5. I understand that I am responsible for any UNPAID BALANCE ON MY ACCOUNT.

6. I permit a copy of this authorization to be used in place of the original.

7. I UNDERSTAND THAT I WILL BE CHARGED $50.00 FOR ANY CANCELLED APPOINTMENTS WITHOUT 24 HOUR NOTIFICATION OR MISSED APPOINTMENTS.

_____
Printed Name of Patient of Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

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Date: _____

Patient Name: _____ D.O.B.: _____
Nickname: _____
Address: _____
City: _____ State: _____ Zip: _____
Mailing Address: _____
Home Phone: _____ May we leave a message? YES NO
Cell Phone: _____ May we leave a message? YES NO
Work Phone: _____ May we leave a message? YES NO
Employer: _____ Profession: _____
Address: _____
PRIMARY Insurance: _____ Policy #: _____
SECONDARY Insurance: _____ Policy #: _____
In case of an emergency- who should we contact?
Name: _____ Phone Number: _____
Primary Care Physician: _____
Referring Physician: _____
Chief Complaint or Problem bringing you to ProActive Physical Therapy:

_____

How long has this been a problem for you? _____

Is this injury the result of a motor vehicle accident? If yes, please provide the accident date, the state where the accident took place, and your claim information (Insurance Company, claim number, adjuster contact information).

_____

Is this a Workers Compensation injury? If yes, please provide the date of the injury, and your claim information (Insurance Company, claim number, adjuster contact information).

_____

Please list any other doctors and/or specialists that you have seen for this problem:
(Please include the date of your last appointment with them).

_____

Have you had and diagnostic testing done for this problem? (X-Ray, MRI, CT-Scan, etc.)
(If yes, please list which test, when, and where you went for the testing).

_____

Medical History: **Circle Yes/No – If yes, please explain.**

Yes	**No**	**Do you have high blood pressure?**
Yes	**No**	**Do you have any heart problems?**
Yes	**No**	**Do you have angina (chest pain)?**
Yes	**No**	**Do you experience chest pain with exertion?**
Yes	**No**	**Do you have a problem with shortness of breath?**
Yes	**No**	**Do you have a pacemaker?**
Yes	**No**	**Have you ever had a stroke? If so, when? _____**
Yes	**No**	**Do you have asthma or allergies?**
Yes	**No**	**Do you have lung problems?**
Yes	**No**	**Do you have a history of depression?**
Yes	**No**	**Have you experienced recent weight loss or gain?**
Yes	**No**	**Have you experienced night sweats or fever?**
Yes	**No**	**Do you have any bowel and/or bladder issues?**
Yes	**No**	**Do you have thyroid problems?**
Yes	**No**	**Do you have diabetes?**
Yes	**No**	**Do you have low blood sugar?**
Yes	**No**	**Do you have or have you had any cancer?**
Yes	**No**	**Do you have osteoporosis?**
Yes	**No**	**Do you have headaches?**
Yes	**No**	**Do you have frequent joint sprains/muscle strains?**
Yes	**No**	**Do you have a history of fractures?**
Yes	**No**	**Do you have metal implants?**
Yes	**No**	**Do you have a history of trauma?**
Yes	**No**	**Have you ever had a head injury?**
Yes	**No**	**Do you have a history of neck/back pain?**
Yes	**No**	**Do your arms, hands, legs, or feet swell?**
Yes	**No**	**Do you have any numbness or tingling sensations?**
Yes	**No**	**Do you have difficulty walking?**
Yes	**No**	**Do you experience dizziness with a change in position?**
Yes	**No**	**Do you experience vertigo (feeling of spinning)?**
Yes	**No**	**Do you frequently lose your balance?**
Yes	**No**	**Do you have impaired hearing?**
Yes	**No**	**Do you have pain at night?**

OB GYN (If Applicable)

Yes	**No**	**Are you pregnant or suspect pregnancy?**
Yes	**No**	**Do you have dysmenorrhea (abnormal menstrual cycles)?**

Please rate your pain on a scale from 1-10 (Circle One)

☺ **1 2 3 4 5 6 7 8 9 10** ☹

No Pain **Worst Pain**

Do you have any other medical problems? If yes, please explain.

_____

_____

Medications: (Please include dosage and purpose)

(NOTE: If you have a list of medications, please write "See attached" and bring the list with you to your appointment.)

_____

_____

_____

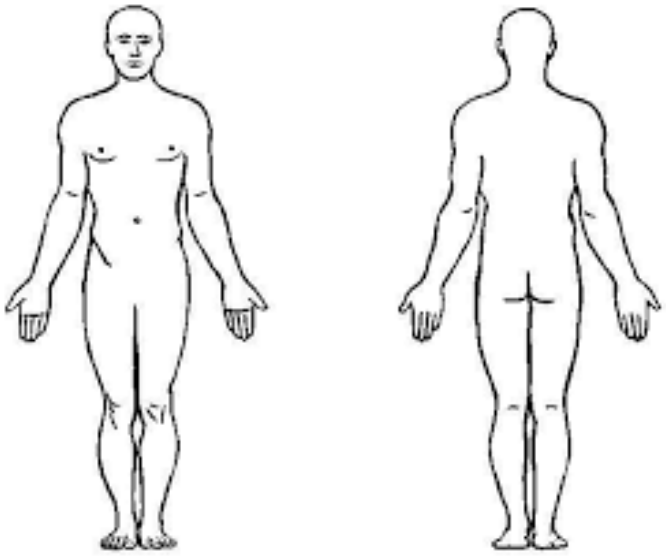
Surgeries/Dates:

(Note: If you have a list of surgery dates/medical issues, please write "See attached" and bring the list with you to your appointment)

_____

_____

_____



Please shade the symptomatic area

Patient Signature: _____Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been informed of and given the right to review and secure a copy of the ProActive Physical Therapy Inc. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by ProActive Physical Therapy, Inc. and how I may obtain access to and control this information.

_____
Printed Name of Patient of Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

(THIS SECTION MUST BE COMPLETED IF THE PATIENT REFUSES TO SIGN ABOVE)

We have made a good faith effort to obtain the above individual's acknowledgment, but the acknowledgement was not obtained for the following reason(s):

_____

_____

_____

Completed by (Printed Name) _____

Signature _____ Date _____

PROACTIVE PHYSICAL THERAPY'S NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to that information. Please review it carefully.

The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your 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 and related health care services. We are also required to share with you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 4/14/03, and will remain in effect until we replace it.

As permitted by applicable law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment: We may use or disclose your health information to obtain payment for services from your insurance company or from you. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Workers' Compensation: We may disclose your health information for Workers' Compensation or similar programs that provide benefits for work-related injuries. This also includes contacting the employer for verification of the work injury to obtain authorization to provide treatment.

Business Associates: We may disclose or share your protected health information with third party "business associates" that perform various activities for our practice. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company or an accounting law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure and only with a written certification by the party issuing the subpoena in accordance with the law.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Friends and Family: If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment of that care.

Appointment Reminders: Your health information will be used by our staff to provide you with appointment reminders, medical history questionnaire, and directions to our facility (such as voicemail messages or letters).

Information about Treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Marketing Health-Related Services: We will not use your information for marketing communication without your written authorization.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment areas may see or overhear discussion of your health information.

Authorization: Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Patient Rights:
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical conditions and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Requests to Inspect Protected Health Information:
As permitted by federal regulation, we require that request to inspect or copy protected health information by submitted in writing. *You may obtain a form to request access to your records by contacting our office.*

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can send a letter outlining your concerns to:

Privacy Officer
ProActive Physical Therapy, Inc.
140 Point Judith Road Suite 47
Narragansett, RI, 02882

140 Point Judith Road #47
Narragansett, RI, 02882
Phone: 401-789-2077
Fax: 401-782-4762

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

It is the policy of this office to closely guard our patients' Protected Health Information. Unless otherwise indicated, the sharing of medical information will be restricted to the patient themselves (or his/her parents if a patient is a minor*).

The patient may request that the people involved with their care be allowed access to his/her protected health information. Please check the appropriate boxes below and list the people in which we may share your medical information as well as adding any restrictions if necessary. **You have the right to amend this information at any time.**

☐ Spouse Name: _____

☐ Children Name: _____

☐ Parent Name: _____

☐ Other – Please Specify Name: _____

Signature: _____ Date: _____

Signature of Patient or Legal Representative

**Please note: On the minors 18th birthday, the authorized signature becomes null and void unless the patient requests in writing that their parent or legal representative remain involved with their care.*