ALANTE PHYSICAL THERAPY & WELLNESS

Patient Intake Form

Date of Call/Registration:
Past Patient ☐Yes ☐No

Patient Information

Last Name/Suffix:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email Address:	
Date of Birth: SSN:	Sex: ☐M ☐F	Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Unknown	

Employer Information

Employer Name:			
Address:	City:	State:	Zip Code:
Work Phone Number:	*Patient Occupation/Job Title:* _____		

Emergency Contact Information

Contact Name:	Phone#:	Relationship to Patient: ☐Parent ☐Spouse ☐Other
Name of Referring Physician: _____	Phone: _____	Fax: _____

MEDICARE ONLY-Additional Questions

If Medicare, are you currently receiving Home Health Service? ☐Yes ☐No If yes, you **CANNOT** have both services.
If yes, what type of Home Health Services are you receiving? _____ Last Date of Service: _____
Are you currently residing in a Skilled Nursing Facility? ☐Yes ☐No If yes, Name of Facility? _____
If Yes, are you on/in the "Medicare Unit"? ☐Yes ☐No
If Medicare, have you received PT, OT, Speech Services since the first of the year? ☐Yes ☐No
*If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐Yes ☐No
*Are you aware of any partial amount used since the first of the year? $_____.
*If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

Insurance Information

Policy Holder Last Name:	First Name:	Middle Initial:	SSN:	DOB:

Patient Relationship to Primary Insurance Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____	Gender: ☐ Male ☐ Female
Employer Name:	Employer Phone #:
Primary Insurance Section	**Secondary Insurance Section** Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other
Payor/Plan: Code:	Payor/Plan Code:
Policy/ID#: Group#	Policy/ID# Group#:
Insurance Phone #:	Insurance Phone #:

ALANTE PHYSICAL THERAPY & WELLNESS

Medical History Form

Patient Name: _____ Height: ___ft ___in Weight: ____(lbs) Date of injury: _____

Diagnosis as stated to you by your physician: _____

How did this injury/exacerbation occur? _____

Have you had surgery or been hospitalized for the present condition: ☐ Yes ☐ No If Yes, date: _____

If Yes, surgery type: _____

Have you had any falls this past year? ☐ Yes ☐ No If Yes, how many? _____

Have you received previous treatment for this condition? ☐ Yes ☐ No If Yes, date: _____

If Yes, what type of treatment: _____

Have you ever had the following? ☐EMG ☐CT Scan ☐Myelogram ☐MRI ☐X-Ray ☐Other

Have you ever, or are you presently being treated for any of the following conditions?

Sudden Weight Loss	☐Yes ☐No	Allergies	☐Yes ☐No	Osteoporosis	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Heart Trouble	☐Yes ☐No	Hypoglycemic	☐Yes ☐No
Anxiety or Panic Disorders	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Arthritis (RA, OA)	☐Yes ☐No	Stroke or TIA	☐Yes ☐No	Kidney Problems	☐Yes ☐No
Liver/Gallbladder Problems	☐Yes ☐No	MRSA	☐Yes ☐No	Fracture	☐Yes ☐No
Congestive Heart Failure (CHF)	☐Yes ☐No	HIV/AIDS	☐Yes ☐No	Metal Implants	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis A, B, C	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Diabetes	☐Yes ☐No	Visual Impairment	☐Yes ☐No	Angina	☐Yes ☐No
Hearing Impairment	☐Yes ☐No	Peripheral Vascular Disease	☐Yes ☐No	Back Injury	☐Yes ☐No
Epilepsy or Seizure Disorder	☐Yes ☐No	Bowel/Bladder Problems	☐Yes ☐No	Asthma	☐Yes ☐No
Are you currently pregnant	☐Yes ☐No	Acquired Respiratory Distress Syndrome		☐Yes ☐No	
Bleeding Disorder	☐Yes ☐No	Chronic Obstructive Pulmonary Disease (COPD)		☐Yes ☐No	

Are you on any medications? ☐Yes ☐No If Yes, please list below or attach list. ☐List Attached

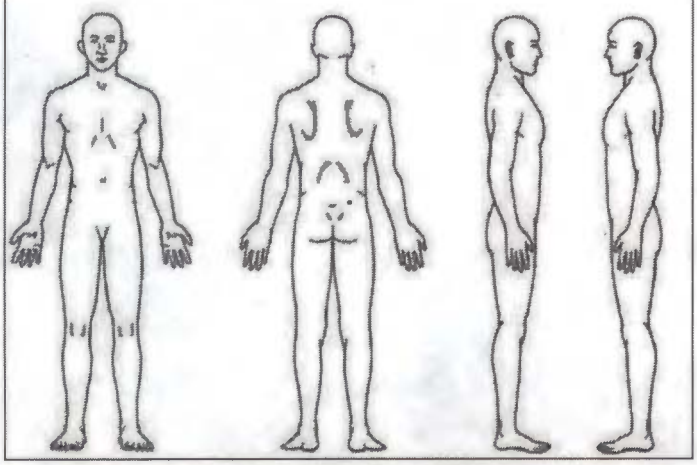
_____

_____

_____

Pain Diagram

Mark your pain over the area of the body as it relates to your present condition



On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its:
best _____ worst _____ current _____

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

_____

_____

_____

What is your goal for therapy at this time?

_____

_____

_____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

ALANTE PHYSICAL THERAPY & WELLNESS

STATEMENT OF FINANCIAL RESPONSIBILITY, CONSENT TO TREAT, AND AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ Date: _____

Alante Physical Therapy & Wellness appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of the bill.

Notification of Patient Responsibility for Co-Payments/Co-insurance % and Deductibles

Your insurance company requires Alante Physical Therapy & Wellness to collect your co-payment amount from you at the time of service. If we do not collect this amount, we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. I understand today's charge is ESTIMATED coverage information provided as a courtesy to our patients, but it is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company. Furthermore, we have an obligation to collect any co-insurance % or unmet deductible amounts from you that are determined to be your responsibility. Lymphedema bandaging supplies are generally not covered by insurance and will be billed to you when they are supplied.

If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. You will receive statements from us during and after your treatment for any outstanding amounts your insurance company indicates will be your financial responsibility. These statements will also include the amount billed to your insurance company and the payments received from both you and your insurance company. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience we accept cash, checks, and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the clinic or mailed to the address on your statement.

I have read the above policy regarding my financial responsibility to Alante Physical Therapy & Wellness for providing rehabilitative services to the above-named patient or myself. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Alante Physical Therapy & Wellness. I agree to pay Alante Physical Therapy & Wellness the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by insurance carrier.

Signature: _____ (relationship to patient_____) Date: _____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by sending text messages, emails or by using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and use of automatic dialing devices as applicable.

I/We have read this disclosure and agree that Provider and/or representative may contact me/us as described above.

Signature: _____ (relationship to patient_____) Date: _____

Notification of Authorization to Consent to Treatment

I am aware of my diagnosis and voluntarily consent to have Alante Physical Therapy & Wellness, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Alante Physical Therapy & Wellness is limited to Physical Therapy or Massage Therapy and I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature: _____ (relationship to patient_____) Date: _____

ALANTE PHYSICAL THERAPY & WELLNESS

Notification of Authorization to Release Information

I further authorize Alante Physical Therapy & Wellness to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____ (relationship to patient_____) Date: _____

Billing Disclosures to Individuals Involved in Patient's Care

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please complete this section.

I authorize Alante Physical Therapy & Wellness to disclose my health information that is directly related to my current treatment at Alante Physical Therapy & Wellness to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors, friends and colleagues.

Name	Relationship

I **DO NOT** wish to have my health information disclosed to individuals involved in my care

Name	Relationship

Signature: _____ (relationship to patient_____) Date: _____

NO CALL / NO SHOW POLICY

We ask that you *please give us the courtesy of a 24-hour* notice to cancel your appointment.
If your appointment is on a Monday please notify us by the previous Friday.
If your appointment follows a holiday on which we are closed please notify us by the previous workday.

Charge for No Show/Cancellations made ***less than*** 24 hours as detailed above: $75
This fee is not billable to insurance

We require a valid credit card to be kept on file that will **ONLY** be charged if the agreed upon policy is not adhered to. A receipt can be emailed to you through your provided email on request.

You will not be charged the $75 fee if we are able to fill your appointment time. To avoid a possible charge and give other patients the opportunity to be seen, please let us know as soon as possible if you cannot make your appointment. After three cancelled or no show appointments, you will automatically be taken off our schedule and will need to reach out to us to reschedule any further appointments.

I have read and understand the Alante Physical Therapy & Wellness Cancellation/No Show Policy.

Signature: _____ (relationship to patient_____) Date: _____

ALANTE PHYSICAL THERAPY & WELLNESS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given Notice of Privacy Practices for Alante Physical Therapy & Wellness. I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me. I recognize that outside of purposes for treatment, payment, certain healthcare operations or as permitted or required by law I must give my written authorization to Alante Physical Therapy & Wellness to release any of my protected healthcare information.

_____

Patient or Authorized Representative's **Printed Name & Date**

_____

Patient or Authorized Representative's **Signed Name & Date**

ALANTE PHYSICAL THERAPY & WELLNESS

MEDICAL RECORDS BILLING NOTICE

All medical record charges will be as stated:

Only the Primary Referring Physician will receive Medical Records free of charge. All other Physician's offices and personal requests will be as follows:

- Printed pages - will be $1.25 per page up to 20 pages and $.50 per page after the 20th page.
- Electronic pages- will be $25 for up to 500 pages or less and $50 for more than 500 pages.
- All Requests will have a $5.00 Processing Fee per case and a 3% Debit/ Credit Card Fee

These record requests will be the patient's responsibility. Insurance will not be billed for medical record charges. You may pay by Cash, Check, Credit Card or Debit Card with the 3% Fee. You may pay over the phone using a credit card. Records will be released as soon as payment is received.

Best Regards,

The Alante Physical Therapy & Wellness Team

ALANTE PHYSICAL THERAPY & WELLNESS

HEALTH INFORMATION PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Document Carefully.

1. About Protected Health Information (PHI).

In this Notice, "we", "our" or "us" means this FACILITY and our workforce of employees, contractors and volunteers. "you" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information we call this Protected Health Information---or "PHI". In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

2. Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

Cont. 2. Uses and Disclosures

- Treatment

  We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optical care is rendered.

- Payment

  After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payor may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

- Health Care Operations

  We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of real patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

- Special Uses

  We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

  i. Remind you of appointments
  ii. Carry out follow ups on home programs that you have been taught
  iii. Advise you of new or updated services or home supplies

Cont 2. Uses and Disclosures

- Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

i. If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
ii. We may use your PHI in an emergency if you are not able to express yourself
iii. If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research

Required:

i. When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
ii. For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
iii. To report neglect, abuse or domestic violence
iv. To the government regulators or its agents to determine whether we comply with applicable rules and regulations
v. In judicial or administrative proceedings such as a response to a valid subpoena
vi. When properly requested by law enforcement officials or other legal requirements such as reporting gun shot wounds
vii. To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
viii. Deemed necessary by appropriate military command authorities if you are in the Armed Forces
ix. In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

We will follow any and all State regulations should they be stricter than these federal privacy regulations

3. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication
  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing
- Your Right to Inspect and Copy
  You have the right to inspect and copy your PHI. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record

Cont. 4 Your Privacy Rights and How to Exercise Them

- Your Right to Know Who Else Sees your PHI

  You have the right to request an accounting of certain disclosures that we have made over the past six years; however, you may not ask for disclosures that occurred prior to March 5, 2018. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually, we have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year. We must advise you of any charge and you have the right to withdraw your request or to pay to proceed.

- Your Right to Complain

  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint with us please contact the person identified below in this Notice. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

5. Some of Our Privacy Obligations and How We Perform Them

   We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you Notice of our Privacy Practices. This document is our Notice. If you did not get a paper copy of this Notice, you may request one. We will abide by the privacy practices set forth in this Notice. However, we reserve the right to change this Notice and our Privacy Practices when permitted or required by law.

   If we change our Notice of Privacy Practices, we will provide our revised Notice to you when you next seek treatment from us.

6. Contact Information

   If you have questions about this Notice or if you have a complaint or concern, please contact:

Name:	Mollie Fick or Kate Obermiller
Address:	5123 North Loop 1604 W, Ste 100
	San Antonio, TX 78249
Phone:	(210) 598-1268

7. Effective Date: This notice takes effect on March 5, 2018.