Jacksonville
PHYSICAL THERAPY

Date: _____/_____/_____

PATIENT INFORMATION **Who may we thank for referring you?** _____

Name: _____

Address _____

City: _____ State: _____ Zip: _____

Date of Birth:_____ Social Security #: _____ Male or Female

Circle one: Single / Married / Widowed / Divorced Drivers License#: _____State:_____

Home Phone:_____ Cell : _____ Work: _____

Employer: _____

Employer Address: _____

Email: _____

EMERGENCY CONTACT

Name: _____ Relationship:_____

Phone#: _____ Address_____

RESPONSIBLE PARTY (if patient is a minor)

Name: _____ Relationship: _____

Date of birth:_____ Drivers License #_____ Social Security #_____

Physical Address (No P O boxes): _____

City:_____ State:_____Zip:_____

Mailing Address (if different)_____

Employer: _____ Work Number: _____

Work Address_____ City_____State_____Zip_____

Email:_____

"You agree, in order for us to service your account or to collect any amounts that you may owe us, we may call you at any phone number associated with your account, including wireless numbers, which could result in charges to you. We may also communicate with you by sending e-mails . These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that 'your office or agent' may contact me as described above.

_____ _____

Signature **Date**

JACKSONVILLE PHYSICAL THERAPY

Patient Name: _____ Date: _____

Are you presently working? ☐YES ☐NO Date of next physician visit: ___/___/___

Date of injury / onset: ___/___/___ Have you ever had these symptoms before? ☐YES ☐NO

Check which apply to your symptoms:

☐work related injury
☐motor vehicle accident
☐cause unknown
☐recurrence of previous injury
☐injury related to lifting
☐athletic/recreational injury
☐injury related to falling
☐other: _____

Have you had a related surgery? ☐YES ☐NO

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

	YES	NO		YES	NO
Diabetes	☐	☐	Allergy to Aspirin	☐	☐
Chest Pain / Angina	☐	☐	Depression	☐	☐
High Blood Pressure	☐	☐	Poor tolerance to Heat or Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitation	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness/Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	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	☐	☐	Stroke/CVA	☐	☐

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

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

Patient Health Questionnaire (PHQ-2)

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks.
The purpose of the PHQ-2 is to screen for depression in a "first-step" approach.

Over the last two weeks how often have you been bothered by the following problems	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				

Medication Record

Name: _____

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Route (i.e. orally)

No Show/Cancellation Policy

At Jacksonville Physical Therapy we are committed to providing the highest quality of care with the best possible outcomes. To achieve these outcomes, we commit to providing one on one intervention tailored to suit your individual goals. We understand that physical therapy takes time out of your busy schedule, and our promise is to make every effort to remain flexible. At your initial evaluation we ask that you partner with your physical therapist in establishing your treatment plan. In order to obtain the best possible outcomes, it is very important that you attend your therapy sessions as prescribed and scheduled.
We promise that all of our effort will go into your care, but we need all of your effort as well. We reserve time in our schedule specifically for YOU! With this in mind, we ask for your cooperation by making every effort to keep scheduled appointments.

Please read the following guidelines we have put into place to ensure that you get the most out of your experience at Jacksonville Physical Therapy.

1. **Please make every effort to provide 24-hour notice to change or cancel an appointment. If you do not give proper notice or do not show up for your visit, please understand that you may be charged a $25.00 office visit fee. We understand that emergencies arise outside of your control, and exceptions to this policy will be determined by our office Manager.**
2. **If you are over 20 minutes late for an appointment, you may be asked to reschedule your appointment as to not limit the time scheduled with other patients.**
3. **Case managers assigned to Worker's Compensation clients require our facility to maintain attendance records. Missed or cancelled appointments could affect other aspects of your care.**
4. **In the case of recurring cancellations, you may be asked to schedule your appointments on as available basis by calling daily to schedule.**

Please remember that your pain may fluctuate throughout treatment sessions. We request that you do not cancel due to a change in your symptoms but rather discuss any concerns with your physical therapist first. In the same manner, once your condition improves, we ask that you do not cancel before discussing with your physical therapist. At the completion of your care your physical therapist will obtain a reassessment which are often required by your physician and/or insurance carrier.

By signing below, you state you understand the terms of this form and agree that you, not insurance, may be financially responsible for charges incurred from cancellations or no-shows.

Print Name: _____

Patient's Signature: _____ Date:_____

Responsible Party/ Relationship to patient (if applicable):_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

To Our Patients: The therapists and staff of Jacksonville Physical Therapy have always been committed to the absolute protection of every patient's health information. HIPPA (Health Insurance Portability and Accountability Act) requires that we provide notice to each of our patients and how this information is used. We safeguard information about your health and PHI (Protected Health Information). Our medical records are stored in a secure area and are available only to designated staff.

How we may use and disclose your protected health information:

- Obtaining your medical history/treatment and recording it in your chart.
- Consulting your physician about your health care and providing him/her with medical records.
- Obtaining approval or payment from your health care insurance.
- Notifying you of test results.
- Discuss your care with the person responsible of taking care of you.
- To provide treatment to you in the event of language or communication barrier.
- **We may be required by law to use or share your PHI without your written consent for the following reasons:**
- When required by federal, state and local law
- Public Health activities for reporting requirement (Deaths, child abuse, domestic violence, gunshots, etc.)
- Health oversight activities (audits, investigations and inspections).
- Judicial proceedings (valid court orders)
- Appropriate law enforcement requests
- Deceased person information (coroners, medical examiners)
- Medical research
- Emergencies or to avert a serious threat to any person or the community.
- Military activities/National Security/aversion of criminal activities
- Workers Compensation
- Correctional institutions, parole or other law enforcement officials
- As required by the Secretary of the Department of Health and Human Services
- **How to direct use and disclose your PHI:** Written authorization, other uses and disclosures of your PHI will be made only with your written consent, unless otherwise permitted or required by law. You may revoke your written consent at any time, in writing. If you revoke your written consent, it will apply to any future actions to the release of your PHI.
- **Your Patient Privacy Rights- you have the right to:**
- Inspect and copy your PHI. You may make a written request to our clinic and pay the copying/mailing fee to look at and receive a copy of your designated record set. The designated records contain medical and billing records as well as other records we use to make decisions about your health care.
- Request restrictions of your PHI. You may ask to limit how we use or disclose any part of your PHI as explained above, except for the typical uses and disclosures described above. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. You may submit a written request, however, we may deny a request if unreasonable. In the event that we agree, we will state the agreement in writing.
- Request to choose how we communicate with you. You have the right to ask that we send information to you in a specific manner. We must agree to your request with the provision that it is not disruptive to our operations to do so. We will not request an explanation from you as to the basis for the request; however, you must make your request in writing addressed to our clinic.
- Request that your therapist amend your PHI. You may make a written request to our clinic for the therapist to consider amending the PHI in your medical record set for the purpose of accuracy and/or to correct an error. You must state the reason for the amendment, and we may deny your request, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy.
- Receive a list of disclosures we have made of your PHI. Effective April 14, 2003, you may make a written request to obtain a list of all our uses and disclosures of your PHI, other than for treatment, payment, clinic operations, to yourself or those with valid authorization. We must respond within 60 days. This list will be for a 12 month period. You are entitled to 1 free accounting each year and additional requests will incur a reasonable charge. The right to receive this information is subject to certain exceptions and restrictions.

- **Our Responsibilities:** We reserve the right to make changes to this notice, which will affect the PHI we maintain at that time. Our duty as your healthcare provider is to maintain your privacy in accordance with the law, abide by the terms of this privacy notice, accommodate reasonable requests or notify you if we cannot.
- **Complaints:** If you believe your privacy rights have been violated, you may provide a written statement to our clinic and to the Secretary of Health and Human Services at: Office of Civil Rights US Dept. of Health and Human Services 200 Independence Ave, SW Room 509F, HHH Bldg. Washington D.C. 20201.
- We will not retaliate nor require you to waive the right to file a complaint with HHS as a condition to receive treatment from us.