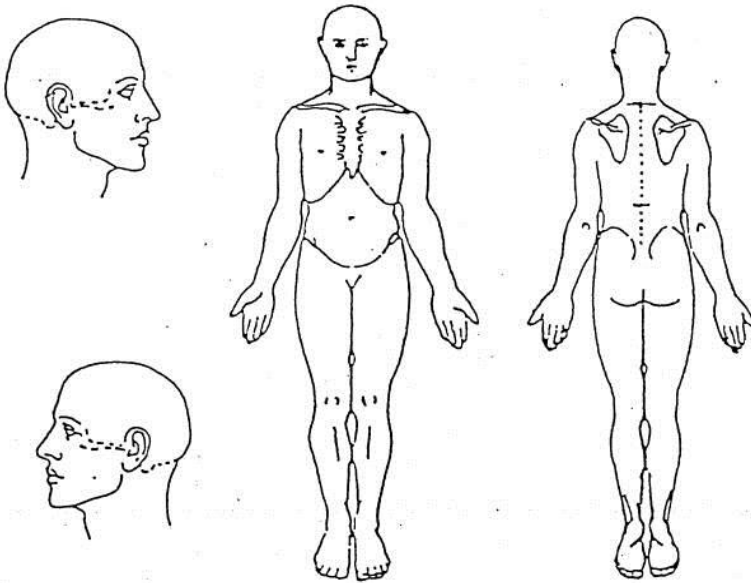


MEDICAL HISTORY FORM

Name _____ Date _____

Birth date _____ Email _____

Please mark the appropriate area of the diagram to show the location of your current symptoms:



Please describe your current symptoms:

Date of injury/surgery: __ / __ / ____
(Month / day / year)

How did your symptoms begin?

Have you used any other forms of treatment for your current problem: (i.e. chiropractor, PT, acupuncture, etc.)?

Please List All Orthopedic or Abdominal Operations/Surgeries:

Operation Performed	Year
_____	_____
_____	_____
_____	_____
_____	_____

List the medications you are now taking:

List any special tests you have had for this condition: (X-rays, MRI, CT scan, etc.):

List any allergies you have to drugs, food or other items (including latex):

Pain Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms feel better? _____

What makes your symptoms feel worse? _____

What is your general overall health? Poor Fair Good Excellent

Stress Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Do you exercise? Yes No

• **If yes, what type of exercise?** _____

• **How often?** _____

Have you had any of the following illnesses: (Please Circle)

High Blood Pressure	Multiple Chemical Sensitivity	Adrenal Fatigue
Diabetes (type I or II)	Candida (yeast allergy)	Restless Leg Syndrome
Thyroid Dysfunction	Eating Disorder	Pacemaker
High Cholesterol	Celiac Disease	Headaches, if yes, how often?
Heart Attack/Disease	Migraine Headaches	Osteoporosis
Asthma	Alcoholism	Osteopenia
Pulmonary Diseases	Anxiety	Chronic Pain
Stroke	Sleep Disorders	Fibromyalgia
Brain injury	Irritable Bowel Syndrome	Interstitial Cystitis
Blood clots	Ulcers	Chronic Pelvic Pain
Mental Illness/Depression	PTSD	Dysautonomia
Arthritis	Crohn's Disease	Sensory Processing Disorder
Cancer	Elevated Heart Rate	Other serious illnesses: (Please Explain):

Signature (parent/guardian signature if patient is a minor)

Date

PRECISION PHYSICAL THERAPY INTAKE FORM

Patient Information:					
Last Name:		First Name:		Date of Birth:	
Mailing Address:		Primary #: () Home () Cell () Other		Secondary #: () Home () Cell () Other	
City	State	Zip	Email Address:		Social Security Number:
Gender at birth:		Male ()	Female ()	Pronouns:	
Identifying Gender: () Male () Female () Trans Male () Trans Female () Non-Binary () Other () Decline to Answer					
Emergency Contact:					
Name:		Relationship to patient:		Phone Number:	
Referral Information:					
How did you hear about us? () Physician () Family () Friend () Returning Patient () Insurance () Internet () Other					
Referrals Name: (if applicable)		Referring Doctor Contact Info:		Address, City, State and Zip Code	
		Phone#:			
		Fax#:			
Primary Doctor Name:	Street Address, City, State and Zip		Phone#:	Fax#:	
Accident Information:					
Is this injury the result of an open Work Comp claim?			Is this injury the result of an open Auto claim?		
Yes No			Yes No		
Date of Accident:	Claim Number:	Adjustor's Information:			
		Name:		Phone Number:	
Insurance Information:					
Primary Insurance:		ID Number:		Group Number:	
Subscriber Name:		Subscriber Date of Birth:		Relationship to patient:	
				() Self () Spouse () Parent or Guardian	
Secondary Insurance:		ID Number:		Group Number:	
Subscriber Name:		Subscriber Date of Birth:		Relationship to patient:	
				() Self () Spouse () Parent or Guardian	
Office Policy:					
CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment plan will then be designed specifically for you using a variety of treatment techniques. I, the undersigned, do hereby agree and give my consent for Precision Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.					
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Precision Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.					
HIPAA - NOTICE OF PRIVACY PRACTICES: By my signature below, I acknowledge that I have read and understand the HIPAA privacy practices set by this clinic and the Secretary of Health and Human Services. I understand that I will be given a copy of the HIPAA notice upon my request.					
FINANCIAL POLICY: I am ultimately responsible to pay the medical bill if my insurance company does not honor the assignment of benefits in whole or in part. Payments may be arranged. I agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for the reasonable cost of collections, to include any attorney fees.					
CONSENT TO COMMUNICATE VIA TEXT AND/OR EMAIL REGARDING MEDICAL INFORMATION: () Email () Text () I DO NOT give Precision Physical Therapy to communicate with me by email/text The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.					

Patient / Guardian Signature: _____

Date: _____

Late Cancel & No-Show Policy for Precision Physical Therapy

Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a “No-Show” Appointment

Precision Physical Therapy defines a “No-show” appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than **4 hours’** notice

Impact of a “No-Show” Appointment

“No-show” appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient “no-shows” a scheduled appointment it:

- Negatively impacts access for other patients that could have been seen in the appointment slot
- Disrespects not only the provider’s time, but also the time of the entire clinic staff

Consequences of “No-Show” Appointments

If you “No-Show” Three (3) or more appointments within 12 months you may be dismissed from Precision Physical Therapy.

- Patients will be charged \$35 for the 2nd “no-show” appointment, and \$75 for the 3rd and final “no-show” appointment. Medicaid patients will be managed under the guidelines as outlined by CCHA.
- If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.

How to Avoid Getting a “No-Show”

Give 4 hours’ notice to cancel or reschedule an appointment. When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 4 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 4 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Reminder Calls or Texts

We offer reminder calls or text messaging for all appointments. This is an added service we provide. You are still responsible for your appointment even in the event you do not receive one.

I would like to receive reminder: ☐ TEXTS ☐ CALLS ☐ I DO NOT WANT REMINDERS

I have read and understood the “No Show” Policy for Precision Physical Therapy as described above.

PRINT Patient Name: _____

Signature: _____ Date: _____
(Parent/Guardian if patient is a minor)

Precision Physical Therapy, Inc • www.precisionphysicaltherapy.net

• 275 Century Circle, Suite 103, Louisville, CO 80027
• Apex Center - 13150 W. 72nd Ave, Arvada, CO 80005
• 10200 W 44th Ave, Suite 339, Wheat Ridge, CO 80033

Tel: 303-926-1444 • Fax: 303-926-0038

Precision Physical Therapy

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 01/01/2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information.** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
 - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
 - is not part of your medical or billing records;
 - is not available for inspection as set forth above; or
 - is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.

6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
 - to carry out treatment, payment and health care operations as provided above;
 - to persons involved in your care or for other notification purposes as provided by law;
 - to correctional institutions or law enforcement officials as provided by law;
 - for national security or intelligence purposes;
 - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
 - incidental to other permissible uses or disclosures;
 - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
 - made to patient or their personal representatives;
 - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officers, Elizabeth Agnew or Virginia Arnette, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Precision Physical Therapy or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
<http://www.hhs.gov/contacts>

Precision Physical Therapy
Elizabeth Agnew, PT, DPT
275 Century Circle, Suite 103
Louisville, CO 80027
303-926-1444 (p)
303-926-0038 (f)

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.