EXCEL PHYSICAL THERAPY

Medical History Form

Name:	Date of Birth: Date:
Are you employed? YES NO If NO, last day worked? _____ Occupation: _____ Where are you employed? _____	Right Handed Left Handed Do you smoke? YES NO #of packs/day Height: Weight: Female: Are you pregnant? YES NO

Injury:

What is the problem you are here for?:
Date of injury:
Date of surgery (if applicable):
Is this the first time you have had this pain? If NO, then when:

Mechanism of Injury:

YES NO Is this injury work related?
YES NO Is this injury motor vehicle accident related?
YES NO Have you had Physical Therapy for this injury before? When: _____
YES NO Is this injury a recurrence of a previous injury?

Current Medications Please list:	Allergies: Please list

What Tests/Treatments have you had for this Injury?

YES NO CT Scan
YES NO MRI
YES NO X-rays
YES NO Chiropractor
YES NO Medication
Other: __

Previous Illnesses

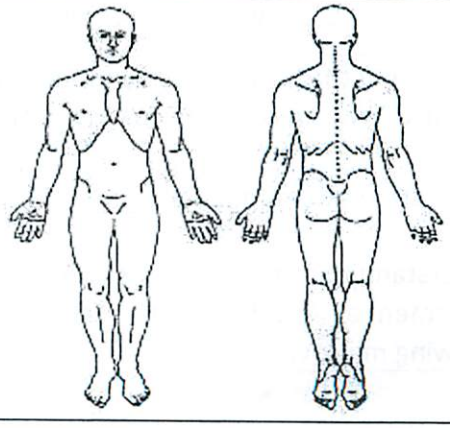
YES NO Heart Problems
YES NO Diabetes
YES NO Cancer
YES NO Endocrine
YES NO Balance Problems Dizziness Fainting
YES NO Breathing/Lung
YES NO Sleep Problems
Other: _____

PAIN AND SYMPTOMS

Is your pain Occasional Continuous
What makes your pain worse? _____
What makes your pain better? _____
What is your pain at Now? 0 1 2 3 4 5 6 7 8 9 10
What is your pain at Worst? 0 1 2 3 4 5 6 7 8 9 10
What is your pain at Best? 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain?

Please mark areas of your pain



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Medical Release:

I, _____ (print name), hereby authorize Excel Physical Therapy, Inc. to release any medical information necessary to the appropriate insurance agency to process this claim _____ (person or insurance agency responsible for this bill). I authorize direct payment of my medical benefits to Excel Physical Therapy. I understand that if insurance checks are mailed to me, I must endorse them and make them payable to Excel Physical Therapy, Inc. I understand that in case of a denial of a third party claim my primary insurance information will be kept on file and be billed.

(Patient Intitials) _____

Patient Responsibility:

I understand that it is my responsibility to understand the coverage and limits of my insurance policy. I understand that I am responsible for co-payments, deductibles, and/or patient balances as directed by my insurance policy. In the event that the party named above denies payment I understand that I am responsible for my bill. In the event that my bill is released to an outside collection agency, I understand that an additional fee of 30 – 50% will be assessed to my account. Once an account has been released to collections, we are not able to recall this additional fee on your bill.

(Patient Initials) _____

Cancellations/No Shows:

I understand that I must notify Excel Physical therapy 24 hours before my scheduled appointment when canceling an appointment. Failure to provide a 24 hour notice of cancellation will result in a $25 No Show Charge billed directly to me for each appointment missed.

(Patient Initials) _____

Acknowledgement of Receipt of Notice of Privacy Practices & Consent:

I, _____ (client), born on _____ (mm/dd/yr), acknowledge that I have received the Notice of Privacy and Practices from Excel Physical Therapy. I understand that Excel Physical Therapy will need to use and disclose confidential information including financial and health information in order to provide treatment and deliver services offered by or through Excel PT, obtain and reconcile payment of such services and manage its health care operations.

(Patient Initials) _____

I give Excel Physical Therapy permission to use and disclose my protected health information and other personal information as such uses and disclosures are described in the above mentioned Notice.

Date: _____ Signature of Individual or Representative: _____ Relationship: _____

I understand that copies of my medical records will be sent to my referring physician. If referred by a specialist, I give permission for my notes to be sent to my Primary Physician.

Yes **No** (Patient Initials): _____ Primary Care Dr.: _____

I understand that if I have questions about my bill or coverage, I may call the Excel Physical Therapy billing department at (802)893-7427. My therapist is not responsible for knowing, giving advice about or reviewing my coverage.

Signature:	**Date:**

NOTICE OF PRIVACY PRACTICES FOR CONFIDENTIAL AND PROTECTED HEALTH INFORMATION

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

EXCEL PHYSICAL THERAPY, INC. is committed to protecting the privacy of your health care information. This notice is also intended to inform you of your individual rights and of EXCEL PHYSICAL THERAPY'S legal duties with respect to such protected and confidential information.

EXCEL PHYSICAL THERAPY, INC. will notify you in the event of a breach of your unsecured PHI when it has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach.

Your Health Information Rights

Under federal regulations, you have the right to:

1. Understand how we intend to use and share your information with others.
2. Ask for restrictions on the use and sharing of your information. (Please note that while we are not required to agree to such requests, we will make an effort to accommodate you when possible.)
3. Authorize the release of your own protected health information to persons for purposes not otherwise identified here, and revoke such authorizations.
4. Restrict disclosure of PHI to a health plan for payment if patient has paid in full for the services and items provided in that visit.
5. Have our staff communicate with you in a certain way regarding your health information (e.g. have a confidential conversation without any family members, send or receive information at an alternative location). Such requests will be accommodated within reason. If EXCEL PHYSICAL THERAPY, INC. is not able to accommodate your request, you will be notified and given an opportunity to discuss other arrangements.
6. Inspect and copy most of the records containing your protected health information. Please note that certain records containing protected health information about another individual may not be available to you. You have the right to request that records held electronically be provided to you in electronic form. EXCEL PHYSICAL THERAPY, INC. has a policy and procedure to process requests and denials and will assist you with your request.
7. Request that protected health information created by EXCEL PHYSICAL THERAPY, INC. be changed, if you believe it is incorrect or incomplete.
8. Obtain a paper copy of this notice.
9. File a complaint with EXCEL PHYSICAL THERAPY, INC. or government that you believe your privacy rights have been violated.
10. Receive a list of the persons that we released protected health information for purposes other than treatment, payment or operations and without your authorization. Such requests should be made within six (6) years of when services were rendered. Please note that a record of disclosures does not have to be made when those disclosures are:

- To carry out treatment, payment and health care operations;
- To individuals of confidential information about them;
- As a result of a signed authorization;
- For the practice's directory or to persons involved in the individual's care;
- For national security or intelligence purposes; or
- To correctional institutions or law enforcement officials.

Our Responsibilities

EXCEL PHYSICAL THERAPY, INC. is required by law to maintain the privacy of your health information and to provide to you this Notice of its duties and privacy practices. We are also required to follow the terms of this Notice. We will not use or share your health information without authorization, except as described in this notice.

Routine Uses and Disclosures

EXCEL PHYSICAL THERAPY, INC. may use PHI for the purposes of payment and health care operations, in most cases without written permission. Examples of our use of PHI:

- Provide treatment – such as sharing information with your primary care physician, medical equipment suppliers, or other health care professionals, or involved family members.
- Obtain payment – such as including your diagnosis and dates of service on invoices to collect payment from third parties or in obtaining prior approval from your insurance company.
- Conduct health care operations – such as reviewing your progress charts and sharing information within EXCEL PHYSICAL THERAPY, INC. for quality assessment/improvement activities, cost containment efforts, case management, professional reviews, education and training, audits, and business planning.
- Schedule or remind you about a visit.
- Let you know about recommended possible treatment options or alternatives that may be of interest to you.

EXCEL PHYSICAL THERAPY, INC. may share information with other people who work with us to carry out our responsibilities to you. These professionals and business associates are required to appropriately safeguard your information in the same manner as we do. For example, EXCEL PHYSICAL THERAPY, INC. contracts with a third party service to collect overdue payments.

Other Uses and Disclosures

We may send you newsletters about our company and new services or programs. EXCEL PHYSICAL THERAPY, INC. will not sell or release your name, address or other health information to another person for purposes of their marketing or fundraising efforts.

Unless you object in writing, EXCEL PHYSICAL THERAPY, INC. staff, using their best judgment, may disclose to a family member, other relative, or close personal friend, health information relevant to that person's involvement in your care or payment related to your care.

Legally Required Disclosures

Occasionally, we may be legally required to share your health information because of federal, state or local laws. Examples include:

- To state officials when there are risks to public health such as a communicable disease.
- To state and local officials relating to Vital Records (such as births or deaths).
- To state officials to report abuse or neglect of a child or vulnerable adult.
- To state officials for health oversight activities.
- To state medical review boards or an Institutional Review Board for purposes of research.
- When required or court ordered in a judicial or administrative proceeding.
- For purposes of worker's compensation insurance.
- To law enforcement officials.

For More Information or Complaints

For more information, to make a request, to inspect contents or to obtain a copy of your protected health information contact: EXCEL PHYSICAL THERAPY, INC, P.O. Box 776, 184 Route 7 South, Milton, Vermont 05468. Phone: (802) 893-7427. If you believe your privacy rights have been violated, you can file a complaint with our PRIVACY OFFICER, at the above address or with the Secretary of Health & Human Services, 200 Independence Ave, Washington, D.C. 20201 or HIPAA Compliance 7500 Security Blvd. C5-24-04, Baltimore, MD 21244. You will not be retaliated against in any way for filing a complaint.

Revisions to the Notice: EXCEL PHYSICAL THERAPY, INC. reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted on our website, if we maintain one. Our patients will be offered a copy of the latest version of this Notice at their next visit or by contacting the Privacy Officer. **Revised 9/4/2013**