LAKEVIEW PHYSICAL THERAPY & SPINE

PATIENT INFORMATION

**Date**:_____

First Name:_____ Middle:_____Last:_____

DOB: _____ Gender: ☐ F ☐M ☐_____ Marital Status: ☐S ☐M ☐D ☐W

Mailing/Physical Address: _____City:_____

State:_____ Zip Code:_____

Primary Phone Number:_____ Secondary Phone Number:_____

Email:_____

Patient Employer:_____ Employer Phone Number:_____

Have you had therapy this year? ☐Y ☐N If so, where:_____

**Patient is a minor:**

Father's Name:_____ Home Address:_____

Employer:_____ Employer Phone Number:_____

Primary Phone Number:_____ Secondary Phone Number:_____

Email Address:_____

Mother's Name:_____ Home Address:_____

Employer:_____Employer Phone Number:_____

Primary Phone Number:_____ Secondary Phone Number:_____

Email Address:_____

**Emergency Contact**
Name:_____Primary Phone Number:_____
Relationship to Patient:_____

**Diagnosis/Complaint:**

_____

_____

_____

Is this diagnosis the result of an accident? ☐Y ☐N
If yes, what type of accident? ☐ Work ☐Auto ☐Other When did the date of the injury occur?_____

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## AUTHORIZATION & TREATMENT CONSENT

You,_____,hereby voluntarily authorize Lakeview Physical Therapy & Spine, LLC to perform wellness services, outpatient evaluation(s) and/or procedure(s) and to administer such outpatient therapy and/or medical treatment(s) that in the opinion of the physician and/or consulting allied health provider is/are necessary or appropriate. It has been explained to me that medical treatment/therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

## INSURANCE INFORMATION

You are responsible for providing all insurance information at the time of registration. It is also your responsibility to inform Lakeview Physical Therapy & Spine, LLC of any changes to your insurance. You are responsible to verify that your insurance company pays in a timely manner. Fulfilling this responsibility may require you to contact your insurance company. Should your insurance require authorization, it is your responsibility to verify that you have a current authorization to cover your service dates. We will help you present your claim and obtain authorization if applicable, but you must take ultimate responsibility for your account.

Primary Ins. Company: _____ Policy ID #: _____
Group #: _____ Benefits #: _____
Policy Holder: _____ Relation to Pt: _____ DOB: _____
Secondary Ins. Company: _____ Policy ID #: _____
Group #: _____ Benefits #: _____
Policy Holder: _____ Relation to Pt: _____ DOB: _____

## INSURANCE, INDEMNITY INSURANCE, AND OTHER THIRD-PARTY LIABILITY CLAIMS

As a service to you, we will call your insurance company or other third-party payer in an attempt to determine your benefits prior to your first therapy visit and prior to purchasing any medical equipment/supplies. We receive quoted benefits and they are not a guarantee of payment, and you are ultimately responsible for any expenses incurred if your insurance does not pay. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Sometimes we are quoted differently than when your claim is processed, when this occurs you will be notified. Keep in mind that some claims can take up to 60 days to process after the time of service has occurred. **If, at any time during your treatment, it is determined that your injury was due to an accident and the insurance refuses payment, you will be 100% responsible for any and all monies due to Lakeview Physical Therapy & Spine, LLC**

**Assignment of Benefits**
In the event that I am entitled to outpatient benefits of any type whatsoever, arising out of any claim or policy of insurance, said benefits are hereby irrevocably assigned to Lakeview Physical Therapy & Spine, LLC for application to my bill(s). I request that payment of benefits be made on my behalf to Lakeview Physical Therapy & Spine, LLC. _____

## AUTHORIZATION TO RELEASE INFORMATION

You,_____,hereby authorize Lakeview Physical Therapy & Spine, LLC to release medical record information by means of telephone, reproduction, email, or facsimile transmission, relative to any outpatient therapy, treatment(s), or evaluation(s) and/or medical services to referring physician for status of treatment, family physician providing follow-up care, third party payer(s) to substantiate medical necessity and charge verification, and/or case manager(s) for determining medical necessity or utilization review

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## MEDIA USE AGREEMENT

I hereby authorize Lakeview Physical Therapy & Spine, LLC to use my name, photograph, video, voice and likeness as recorded by Lakeview Physical Therapy & Spine, LLC or their representatives, with no expectations, compensation, or remuneration, now or in the future. This consent includes but is not limited to permission to use name, photographs, videos, and my voice in various publications, public affairs releases, recruitment materials, broadcast, public service, advertising, marketing materials, Lakeview Physical Therapy & Spine, LLC's website and social media. Consequently, Lakeview Physical Therapy & Spine, LLC may publish materials, use my name, photograph, and/or make reference to me in any manner Lakeview Physical Therapy & Spine, LLC deems appropriate in order to promote or publicize Lakeview Physical Therapy & Spine, LLC.

☐ Yes, I give my consent in perpetuity ☐ No, I do not give my consent

_____ DATE: _____
Signature of Patient, Parent or Guardian

## ACKNOWLEGDEMENT & AGREEMENT TO ELECTRONIC COMMUNICATION

Lakeview Physical Therapy & Spine, LLC communicates with patients through electronic communications/messages over the Internet, the World Wide Web, and other electronic networks. Examples of electronic communication/messages might include, among others, messages, initial evaluations, progress notes, discharge notes or other information sent through approved email accounts or webpages. Transmitting patient information by email or other electronic messages, however, has a number of risks. I understand that once the protected health information (PHI) is emailed from Lakeview Physical Therapy & Spine, LLC server it carries the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality laws.
I, _____, acknowledge that I have read this electronic communication disclosure. I understand the risks associated with the electronic communications/messages between and me; agree to hold Lakeview Physical Therapy & Spine, LLC harmless of any injuries, losses, or damages arising from or in connection with electronic communications; and consent to electronic communication.

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (1996) **HIPAA** NOTICE OF PRIVACY POLICY **NPP** AND PROTECTED HEALTH INFORMATION **PHI**

My signature below acknowledges that I have been informed of my rights under HIPAA and of Lakeview Physical Therapy & Spine, LLC's privacy policy concerning protected health information. Lastly, I have been informed of my right as a patient to choose any provider.

*I was offered a copy of Lakeview Physical Therapy &Spine, LLC's Notice of Privacy Practices _____

_____ DATE: _____
Signature of Patient, Parent or Guardian

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (1996) ***HIPAA***
NOTICE OF PRIVACY ***NPP*** and PRACTICE FOR PROTECTED HEALTH INFORMATION ***PHI***

*Effective April 14, 2003*

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

Please direct any questions about this Notice to Lakeview Physical Therapy and Spine, LLC, 225W Harrison Avenue, STE C, New Orleans, LA 70124.

## PURPOSE OF THIS NOTICE

Lakeview Physical Therapy & Spine, LLC understands the importance of keeping our patients' protected health information (PHI) private. We have always been careful with confidential patient health information; however, the new federal HIPAA laws require healthcare providers to provide written notice of how we may use and disclose PHI records. Please be assured of our commitment to confidentiality and privacy.

## WE COLLECT THE FOLLOWING PERSONAL HEALTH INFORMATION ***PHI***

Lakeview Physical Therapy & Spine, LLC makes a record of your visit. Typically, your electronic chart contains your initial evaluation, diagnosis, plan of treatment, recommended exercises, and modalities and frequency performed. This Protected Health Information (PHI) is referred to as your medical record or chart and serves as a basis for planning your care and treatment.

Your PHI may also include authorizations, correspondence, health insurance forms, billing information, as well as identifying information for both our patients and their parents or guarantors. Identifying information includes name, date of birth, sex, social security number, address, and numbers for home, work, or phones numbers, etc. These records may also include reports, test results, and correspondence of consultations obtained at other medical offices.

We retain this information as required by law. We limit the collection of personal information to only that which is necessary to provide quality medical care and for insurance and reimbursement purposes.

## HOW WE USE YOUR PERSONAL INFORMATION ***PHI***

We protect **PHI** by limiting access to our patient's information to only those persons who need to know that information to effectively provide treatment, and to provide required documentation for reimbursement and insurance purposes. Lakeview Physical Therapy & Spine, LLC employee must sign a Confidentiality Statement assuring that they understand their responsibilities and the importance of complying with our policies designed to protect your privacy.

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## DISCLOSURE AND USES OF PERSONAL HEALTH INFORMATION ***PHI***

We may share and or disclose any of your personal information, within the law, we collect for the purposes of treatment, reimbursement document and healthcare operations. Our therapists may share the patient's information with personnel within Lakeview Physical Therapy & Spine, LLC involved in coordinating patient medical care and treatment. An example of this would be the type and frequency of modalities to be performed. Our therapists may provide information to the referring physician and other healthcare providers so that they may assist us in treating our patients.

As a courtesy, we will bill our patient's insurance or any third party for medical services we provide. We disclose ***PHI*** in billing because the payers require diagnosis and procedure codes before they will process your claim for payment. We may disclose ***PHI*** information with affiliates such as health insurance companies with whom we are contracted, licensed and for audits.

We treat patients of all ages, we may communicate their health information to their parent or guardian, or the person acting in authority on behalf of a minor child. We may contact the patient, parent, or guardian at their phone numbers, or office numbers to relay information such as appointment reminders or referral questions. We may contact the referring physician regarding a patient's progress and plan of treatment.

We follow government regulations in instances of serious situations such as public health risk, to prevent or lessen the risk of patient or public safety, and for disaster relief efforts. We may disclose PHI as required by law to judicial or administrative proceedings, licensures or disciplinary actions and in response to a subpoena, discovery request or other lawful process. We may disclose PHI for peer review and operations assessment.

We do not disclose information to any third party without the written permission of the patient, parent or guardian. We may disclose authorized written information via copy, fax, or mail.

## YOUR RIGHTS TO YOUR PERSONAL HEALTH INFORMATION

We have procedures for our patients, their parents, or guardians to access or inspect the PHI we collect. We will make this information available to you upon written request. You have the right to request amendment or correction to the patient's health record by delivering a written request to our office. Our therapists are not required to make such amendments. If an amendment is denied, you may file a statement of disagreement and request that the request for amendment and any denial be attached in all future disclosures of your PHI.

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## YOUR RIGHT TO CHOOSE PROVIDER

Every patient has the right to choose freely among available providers and to change providers after services has begun, within the limits of health insurance, medical assistance, or other health programs.

## AMENDMENTS TO OUR PRIVACY POLICY

Lakeview Physical Therapy & Spine, LLC reserve the right to amend our privacy policy. Any revisions will be available to you upon your next office visit. Our Privacy Notice is displayed prominently in our lobby. It is also handed individually to each patient for signature. Additional copies are available at the front desk.

## SHOULD YOU WANT TO FILE A COMPLAINT

If you have any questions, need further information, or want to file a written complaint regarding the handling of your PHI, please call Lakeview Physical Therapy & Spine, LLC at 504-354-8291 or write to 225W Harrison Avenue, STE C, New Orleans, LA 70124.

If you feel the patient's rights have been violated, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the Federal Government.

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**Name:**_____ **Date:**_____ **Referring Physician:**_____

**Height:** **Weight:**

**Have you RECENTLY noted any of the following (check all that apply)?**

- ❑ changes in bowel or bladder function
- ❑ nausea/vomiting
- ❑ dizziness/lightheadedness
- ❑ difficulty maintaining balance while walking
- ❑ weight loss/gain
- ❑ shortness of breath
- ❑ headaches
- ❑ changes in appetite
- ❑ fever/chills/sweats
- ❑ pain at night
- ❑ weakness/fatigue
- ❑ difficulty swallowing

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

- ❑ cancer (type)_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ asthma
- ❑ pacemaker inserted
- ❑ osteoporosis
- ❑ chemical dependency (i.e., alcoholism)
- ❑ rheumatoid arthritis
- ❑ stroke
- ❑ depression
- ❑ anemia
- ❑ lung problems
- ❑ thyroid problems
- ❑ other_____
- ❑ diabetes
- ❑ multiple sclerosis
- ❑ kidney/liver problems
- ❑ stomach ulcers
- ❑ epilepsy
- ❑ Parkinson's disease
- ❑ other_____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
**Do you smoke? Yes**_____**pack/day No**
**FOR WOMEN:** Are you currently pregnant or think you might be pregnant? **YES NO**

**ALLERGIES:**_____ **Are you latex sensitive? YES NO**

**Please list any surgeries or other conditions for which you have been hospitalized, including dates:**
1. _____ 2._____ 3._____

**Pain at LOWEST: Rate you lowest pain level in past 24 hrs.**

0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain Imaginable

**Pain Currently: Rate your level of pain at this time.**

0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain Imaginable

**Pain at WORST: Rate your highest pain level in past 24 hrs.**

0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain Imaginable

**List 1 (one) important activity** you are unable or have difficulty performing as a result of your pain/symptoms. [Check number below]:

_____ (ex. Stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable

What is your goal for therapy at this time?_____

**Patient Signature**_____ **Date:**_____

**(for office use only) PT initials**_____ **Date**_____

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**Name:**_____

**Please List all medications:**

| Name | Frequency |
|---|---|
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| | |
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