Harris & Renshaw
PHYSICAL THERAPY

Date_____/_____/_____

*PATIENT INFORMATION

Name_____

Address_____SSN_____

City_____State_____Zip_____Sex M / F DOB____/___/____

Phone # Home _____ Cell_____ Marital Status S / M / W / D

Drivers License #_____ State_____

Employer _____Work Phone_____

Work Address_____City_____State_____ Zip_____

In Case of Emergency, Contact_____Phone_____

Address _____Relationship_____

*FINANCIAL POLICY

As a courtesy to you, the patient, we will bill your insurance carrier, Co-Payments set by your insurance company are due, in full, on each date when you are seen. If you do not have insurance, our initial evaluation charge is $115.00. Any visits to follow will be according to our fee schedule.

Patient Signature / or patient representative_____

Date Signed: _____

*PATIENT RESPONSIBILITY FOR MEDICAL SUPPLIES

Since many insurance companies will not cover medical supplies, it is our policy that the patient accept responsibility and pay, in full, for all medical supplies given to them by Harris & Renshaw Physical Therapy on the date of receipt of the supplies.

Patient's Signature / or patient representative: _____

Date Signed: _____

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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 requires 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 _____

Are you presently taking any medication? _____ Yes _____ No

Date	Medication	Dose Given	Frequency (2x per day)	Route Injection/orally

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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 Harris & Renshaw Rehab Center 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 relating 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 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 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.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

Harris & Renshaw Physical Therapy follows all guidelines of the **HIPPA Privacy Act**. To receive a copy, please ask the front desk.

Name any person who may receive information on your account:

_____

_____

_____

_____ _____

Signature of Patient or Guardian Date

ASSIGNMENT OF BENEFITS/CONSENT TO TREATMENT

I request and authorize my insurance company(s) or Medicare to pay directly to Harris & Renshaw Rehab Center, any proceeds payable under the terms of my policy(s). This is an irrevocable assignment: I understand and agree that any unpaid balance not covered by this policy is my obligation and will be paid by me.

I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospitals, and Physical Therapy precertifications, deductibles, co-insurance, and co-payments.

I hereby authorize and consent to treatment rendered by Harris & Renshaw Rehab Center as suggested by my physician or upon my own self referral.

_____ _____

Signature of Patient or Guardian Date

It is the policy of Harris & Renshaw Rehab Center to help the patient in obtaining full benefits from his/her insurance company. However, we are not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.

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No Show/Cancellation Policy

At Harris and Renshaw 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 Harris and Renshaw 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 15 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 canceled 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 is 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):_____

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Telemedicine/Telehealth) Patient Consent Form

Harris and Renshaw Physical Therapy offers some physical therapy consultations via a telemedicine/telehealth platform. If you elect to receive our telehealth services, you must give informed consent and agree to the following:

1. Our physical therapy telemedicine/telehealth consultations are provided through a HIPAA compliant and secure platform PTfirsApp (In Hand Health). By using this service, you agree to the terms of use and privacy policies of this telemedicine/telehealth. You will be asked to consent to the privacy and use of the company's software once you download their application.

2. The benefits to using our telemedicine/telehealth services including but not limited to not having to take time to drive to and from appointments, minimizing time off work for appointments, being able to access services at more convenient times.

3. We strive to provide telemedicine/telehealth services at the same standard of care of an in-person visit. However, you should know that there may be some limitations to what we can do through a telemedicine/telehealth connection compared to a face-to-face visit. For example, we will not have the use of other senses, such as touch and smell, or the ability to observe your body/condition in a 3-dimensional view. If the limitations of a telemedicine/telehealth consultation will interfere with our ability to properly examine or treat you, we will let you know so you can schedule a face-to-face visit with us or another provider of your choice.

4. Current Arkansas law and some health plan policies may require an initial evaluation to be provided in-person before telemedicine/telehealth visits can be provided. We will require you to see one of our therapists in our clinic for evaluation prior to your first telemedicine/telehealth visit. You are responsible for determining if your health plan requires an in-person visit for the initial evaluation as a condition of payment for our services.

5. If it would be beneficial to record our telemedicine/telehealth consultations, we will explain the reason for the need or desire to record the consultation and obtain your verbal consent in advance. If we do record the session, you may request to stop the videotaping at any time. The recording will not be stored as part of your official medical record unless we advise you that we plan to store and maintain it. If we do, it will be stored and maintained with the same privacy and security protections required by applicable state and federal laws that apply to your written medical records.

6. There are potential risks with the use of telemedicine/telehealth technology, including but not limited to: (1) interruption of the audio/video link, (2) disconnection of the audio/video link, (3) video that may not be clear enough to meet the needs of the consultation, and (4) potential of unauthorized access to the live or stored consultation. If any of these occur, the consultation may need to be stopped and/or rescheduled. Also, we are not responsible for these or other technology problems that we are not in control of.

7. Privacy and Confidentiality. The same state and federal laws that protect your privacy and the confidentiality of your medical records apply to our telemedicine/telehealth visits if the visit is for health care services. You acknowledge by signing below that you have been given an opportunity to review our Notice of Privacy Practices and had all your questions answered.

8. Some health plans may cover telemedicine/telehealth services if they are medically necessary. Some state laws require state-governed (fully insured) health plans to cover telemedicine/telehealth visits if the health plan would have covered the same interventions had they been provided in the office. However, there are frequently exceptions to these coverage laws and policies. This means that your health plan is highly likely to deny our claims for telemedicine/telehealth services. Therefore, by consenting to receive our services through a telemedicine/telehealth means, you agree to personally pay for any services your health plan does not cover even if your Explanation of Benefits (EOB) from your health plan states you owe $0 for our services.

9. Some of the services we may provide to you through our telemedicine/telehealth platform may be considered fitness or wellness services, *not* physical therapy. Fitness and wellness services may not be subject to the requirements of the physical therapy practice act or other state laws that apply to medical services.

10. If we instruct you on any exercises, balance activities or other physical procedures during the telemedicine/telehealth session, you are responsible for determining whether you can safely perform the activity without risk of falling or otherwise injuring yourself. If you do not feel safe, you must tell us. If the exercise or activity requires the assistance of a family member or caregiver (collectively "Caregivers"), you are accepting the risk of the actions of your Caregivers. We are not responsible if you fall or get injured by the actions, errors or omissions of your Caregiver.

11. Payment and Cancellations. You agree to pay for any scheduled telemedicine/telehealth consultations. You must give at least 24 hours-notice in advance if you need to cancel or reschedule an appointment. If you cancel with less notice, you will be charged per our normal cancellation/no-show policy.

I, _____ [print name], have read, understand and agree to all the above terms for my telemedicine/telehealth consultation. Understanding the limitations and risks associated with a telemedicine/telehealth consultation as described above, I consent to the examination and/or treatment through Company's telemedicine/telehealth service.

_____ _____

Patient's signature Date

_____ _____

Witness Date