



**WELCOME TO MILE HIGH PHYSICAL THERAPY, PC**

Dear \_\_\_\_\_:

Welcome to Mile High Physical Therapy. We are committed to restoring you to your full functional capacity. In order to achieve that goal, we need your participation and commitment. Your doctor has prescribed a specific number of physical therapy sessions to be completed in a specific period of time. Please make every effort to keep your scheduled appointments. If you need to miss an appointment, please call us 24 hours in advance so we may offer you another convenient appointment. **There will be a \$50 fee for any appointment not cancelled within 24 hours.** If you miss two scheduled appointments and we do not hear from you, we will remove any subsequent appointments from the schedule. In that case, you will need to call to reschedule your future appointments.

Also, please initial that you have been made aware and understand your responsibility regarding insurance and payment information.

Patient: \_\_\_\_\_ Mile High Physical Therapy representative: \_\_\_\_\_

Thank you very much for your consideration in this matter.

If you should have any questions, or if we can be of any assistance to you, please do not hesitate to ask.

Sincerely,

Mile High Physical Therapy

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## MEDICAL HISTORY

Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Date of 1<sup>st</sup> doctor visit for this injury: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
 Last day worked due to this injury: \_\_\_\_\_ Date returned to work: \_\_\_\_\_  
 Is an attorney involved in this case: YES NO  
 Have you had surgery for this injury YES NO Number of Surgeries: \_\_\_\_\_  
 Type of Surgery: \_\_\_\_\_ Site: HOSPITAL SURGICAL CENTER Date: \_\_\_\_\_

Are you currently taking any medications? If so, please list:  
 \_\_\_\_\_

Are you allergic to any medications: YES NO List Medications: \_\_\_\_\_

Have you ever had any of the following medical or rehabilitative services for this injury?

	YES	NO		YES	NO
CT Scan	_____	_____	Chiropractor	_____	_____
EMG/NCV	_____	_____	General Practitioner	_____	_____
Myelogram	_____	_____	Podiatrist	_____	_____
Massage Therapy	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	MRI	_____	_____
Emergency Room Care	_____	_____	X-Rays	_____	_____
Other: _____					

Do you have or have had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema	_____	_____	Severe, frequent headaches	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Vision or Hearing Problems	_____	_____
Coronary Heart Disease/Angina	_____	_____	Numbness or Tingling	_____	_____
Do you have a Pacemaker	_____	_____	Dizziness or Fainting	_____	_____
High Blood Pressure	_____	_____	Bowel or Bladder Problems	_____	_____
Heart Attack or Surgery	_____	_____	Weakness	_____	_____
Stroke/TIA	_____	_____	Weight Loss/Energy Loss	_____	_____
Congestive Heart Disease	_____	_____	Hernia	_____	_____
Blood Clot/Emboli	_____	_____	Varicose Veins	_____	_____
Epilepsy/Seizures	_____	_____	Any Pins or Metal Implants	_____	_____
Anemia	_____	_____	Joint Replacement Surgery	_____	_____
Infectious Disease	_____	_____	Neck/Shoulder Injury/Surgery	_____	_____
Diabetes	_____	_____	Elbow/Hand Injury/Surgery	_____	_____
Arthritis	_____	_____	Back Injury/Surgery	_____	_____
Osteoporosis	_____	_____	Knee Injury/Surgery	_____	_____
Gout	_____	_____	Leg/Ankle/Foot Injury/Surgery	_____	_____
Sleeping Problems/Difficulties	_____	_____	Are you pregnant?	_____	_____
Emotional/Psychological Problems	_____	_____	Do you use tobacco?	_____	_____

Please list any other information that would assist us with your care:  
 \_\_\_\_\_

Are you aware of your diagnosis and prognosis as explained by your physician? YES NO

Based on your awareness, what are your rehabilitative goals/expectations while in this program?  
 \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT INFORMATION SHEET**

**PATIENT INFORMATION:**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
SEX M / F      MARITAL STATUS single/married/cohabitate/separated/divorced/widowed  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CELL # \_\_\_\_\_ EMAIL \_\_\_\_\_

**RESPONSIBLE PARTY:** (NAME AND INFO OF PRIMARY INS CARD HOLDER)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**PATIENT EMPLOYER INFORMATION:**

NAME OF EMPLOYER \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

**EMERGENCY CONTACT:**

NAME \_\_\_\_\_  
PHONE: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

## Consent for Care

I, the undersigned, do consent to physical therapy treatment as ordered by physician prescription and administered by Mile High Physical Therapy.

### **Consent for Use and Disclosure of Protected Health Information**

I consent to the use or disclosure of my protected health information by Mile High Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mile High Physical Therapy is not required to agree to the restrictions that I may request. However, if Mile High Physical Therapy agrees to a restriction that I request, the restriction is binding on Mile High Physical Therapy. Your request must be in writing and you must state the specific restriction requested and to whom you want the restriction to apply.

I have the right to revoke this consent, in writing, at any time, except to the extent that Mile High Physical Therapy has taken action in reliance on this consent.

My “protected health information” means health information, including demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical therapy or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Mile High Physical Therapy’s Notice of Privacy Practices prior to signing this document. Mile High Physical Therapy’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care operations of Mile High Physical Therapy. This Notice of Privacy Practices also describes my rights and Mile High Physical Therapy’s duties with respect to my protected health information.

Mile High Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please be advised that Mile High Physical Therapy practices in an open gym environment. This means that if your treating provider is discussing your private health information with you, someone in close proximity may overhear the conversation. If you are concerned with this, please bring this to the attention of your therapist.

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\_\_\_\_\_  
Patient signature (or parent if minor)

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\_\_\_\_\_  
Date

## Notice of Privacy Practices and Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

### **NOTICE OF PRIVACY**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If minor, signature of parent or guardian: \_\_\_\_\_

### **For Office Use Only**

A "good faith effort" was made to get a signature from the patient. Signature was not attained due to the following:

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