HEALTH HISTORY QUESTIONNAIRE

Date ______________

Patient Name ______________ Date Of Birth ______________ Gender ______________

Email ______________ Phone ______________

Address ______________

CURRENT CONDITION

Please describe what brings you in today ______________

How has this condition limited you or been affecting your life? ______________

Goals. What do you want to get out of physical therapy? ______________

MEDICAL HISTORY

Please mark any that may apply to you -

___ Heart Issues	___ Heart Attack	___ Cancer	___ Axiety
___ High Blood Pressure	___ Diabetes (Type 1 or Type 2)	___ Hearing Difficulty	___ Depression
___ Pacemaker	___ HIV/AIDS	___ Osteoporosis	___ Gender different than sex assigned at birth
___ Seizures	___ Urinary Incontinence	___ Osteopenia	
___ Stroke/Brian Injury	___ Currently Pregnant	___ Bone Stress Injury	

Please list previous surgeries, injuries or other health issues ______________

Are you more busy, more stressed, or getting poorer quality sleep recently? ______________

Current medications ______________

Allergies ______________

WORK HISTORY

Please circle your work status - Full time Part time Not working Retired Unemployed

What is your occupation? ______________ Who is your employer? ______________

Describe the physical requirements of your job (amount of weight you lift, time you spend sitting, standing, walking, etc)

Notice of Privacy Practices

Notice of Patient Information Practices

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

Ferrington Physical Therapy (Company), DBA Ability Physical Therapy and Boulder Run Physio at Ability Physical Therapy LEGAL DUTY

Ability Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Ability Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders and/or questions regarding missed appointments, information about your account status, or information about treatment alternatives or other health related benefits that could be of interest to you.

Ability Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies (information will not include patient names or social security numbers). You may request, in writing, to restrict disclosure of your personal health information to a health plan if you are qualified and elect to pay out-of-pocket and in full for all costs of evaluation and treatment by Ability Physical Therapy. We also provide information when required by law.
In any other situation, Ability Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop future disclosures at any time.

Ability Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our office. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain an electronic or hard copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reason other than treatment, payment, or other relate administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. As state previously, you may request, in writing, to restrict disclosure of your personal health information to a health plan if you are qualified and elect to pay out-of-pocket and in full for all costs of evaluation and treatment by Ability Physical Therapy. Ability Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.
Your signature certifies that you have read the foregoing and accept its terms

____DATE ___________________
PATIENT/GUARDIAN

____DATE___________________
RELATIONSHIP TO PATIENT

PATIENT GUIDELINES, CANCELLATION, AND ACKNOWLEDGMENT POLICY

1. Patients should arrive for their appointments on time in order to allow all patients adequate time for their therapy. Patients arriving late for a scheduled appointment may not be allocated extended treatment time.
2. Patients should come appropriately dressed in attire that will allow them comfortable movement and to perform physical activity such as gym shoes, shorts and t-shirts/tank tops.
3. All patients are required to sign in upon arrival in order to have their treating therapist notified.
4. Food, gum, and drinks other than water are not permitted in the patient treatment areas.
5. Cell phones should be turned off or on silence mode to avoid disturbing other patients or interrupt treatment.
6. Patients are required to wait in the waiting room areas until they are called in by a staff member.
7. Only the patient is permitted in the treatment area. Other adults or children are not permitted in the treatment area unless prior arrangements have been made. Children are never permitted to use any clinical equipment unless they are being treated in therapy.
8. A release for treatment must be filled out by any parent that must leave their children under the age of 18 during their therapy session. Children must be picked up promptly following therapy.
9. **If you or your child are unable to keep your appointment due to illness or any other reason, please call at least 24 hours in advance to reschedule your appointment or a cancellation/ no-show fee of $30.00 may be charged. (No charge for Medicaid patients, however, we will not reschedule after the 3rd short notice cancellation).**
10. Attending your scheduled therapy sessions is one aspect of your treatment that you can control. If you do not attend, we cannot help you reach your recovery goals. In the event of cancellation of less than 24 hours, or not attending your appointment without calling, the following policies are in effect:
    - 10.1. First offense- a verbal request that this doesn't happen again with a reminder of this policy.
    - 10.2. Second offense- your physician, and/or case manager, and/or insurance company will be notified if you cancel or do not show up for two appointments without reasonable cause.
    - 10.3. Third offense- inability to schedule again with written notification of non-compliance to physician and/or case manager, and/or insurance company.

11. **Patient Acknowledgment of Insurance Claim Processing:** We take great pride in assisting our patient's with their claims. It is a courtesy for us to bill your insurance company. We take all possible measures to try and get the insurance companies to pay on our claims. We do verify the benefits for out patients and we are only as accurate as what we are told by the insurance companies. If a circumstance arrives and the insurance will not pay, we may need you as the patient and the insured to assist in getting claims processed. If we are unable to get the claims paid in a timely matter, it then becomes patient responsibility to pay for services rendered.

Your signature certifies that you have read the foregoing and accept its terms

PATIENT/GUARDIAN _______________ DATE _______________

RELATIONSHIP TO PATIENT _______________ DATE _______________

REVISED 10/28/21