REVOLUTION usa
Physical Therapy * Occupational Therapy

5860 Yadkin Road
Fayetteville, NC 28303

Main (910)-491-5164
Fax (910)-229-3227
info@revolutionptot.com

# INITIAL INTAKE FORM

_____ Date: _____
Patient's Primary Care Physician

**Patient Information:**

_____ M/F _____-_____-_____ ____/____/____
Patient's Name (Last, First, MI) Sex Social Security Number DOB

_____
Home Address

_____ (____)_____ (_____)_____
City, State Zip Code Primary Phone Secondary Phone

_____ _____
Cell Phone Carrier Company Email Address

**Insurance Information:**

Payment Method (Circle One) : Money Order Check Visa/ MasterCard Insurance Contract

_____ _____ _____
Primary Insurance Policy # / Sponsors SSN (**Tricare and Tricare for Life**) Group #

_____
Policy Holder Name/ Sponsor Name Policy Holder DOB/Sponsor DOB

_____ _____ _____
Secondary Insurance Policy # Group #

**Emergency Contact Information:**

_____ _____
Last Name First Name

_____ _____
Contact Phone Number Relationship

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# PATIENT HISTORY

## Section 1- Known Allergies

What type(s) of allergies do you have?

| | | | |
|---|---|---|---|
| ☐ Yes | ☐ No | Latex (please provide details): | |
| ☐ Yes | ☐ No | Food (please provide details): | |
| ☐ Yes | ☐ No | Other Contact Allergies (please provide details): | |
| ☐ Yes | ☐ No | Medication (please provide details): | |

## Section 2- Medical History

Do you have a history of:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Osteoarthritis | ☐ Yes | ☐ No | Heart Attack |
| ☐ Yes | ☐ No | Rheumatoid Arthritis | ☐ Yes | ☐ No | Heart Surgery |
| ☐ Yes | ☐ No | Heart Arrhythmia | ☐ Yes | ☐ No | Irritable Bowel |
| ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | Bladder Dysfunction |
| ☐ Yes | ☐ No | High Cholesterol | ☐ Yes | ☐ No | Liver Dysfunction |
| ☐ Yes | ☐ No | Blood Clots/ Phlebitis | ☐ Yes | ☐ No | Thyroid Dysfunction |
| ☐ Yes | ☐ No | Anemia | ☐ Yes | ☐ No | Hernia |
| ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Jaw Pain/ TMJ |
| ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | COPD |
| ☐ Yes | ☐ No | Kidney Dysfuction | ☐ Yes | ☐ No | TB |
| ☐ Yes | ☐ No | Fibromyalgia | ☐ Yes | ☐ No | Hepatitis |
| ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No | Influenza |
| ☐ Yes | ☐ No | Bulging Disc | ☐ Yes | ☐ No | Shingles |
| ☐ Yes | ☐ No | Leg Cramps | ☐ Yes | ☐ No | Parkinson's Disease |
| ☐ Yes | ☐ No | Stroke/ TIA | ☐ Yes | ☐ No | Multiple Sclerosis |
| ☐ Yes | ☐ No | Polio | ☐ Yes | ☐ No | Numbness/ Tingling |

*Seizures*

| | | |
|---|---|---|
| ☐ Yes | ☐ No | If yes, how often? |

*Asthma*

| | | |
|---|---|---|
| ☐ Yes | ☐ No | Asthma |
| ☐ Yes | ☐ No | Asthma is sports induced |
| ☐ Yes | ☐ No | Do you use an inhaler? |

*Head Injuries*

| | | |
|---|---|---|
| ☐ Yes | ☐ No | If yes, please describe when: |

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*Headaches*

| | | |
|---|---|---|
| ☐ Yes | ☐ No | Frequency: |

*Surgeries*

| | | |
|---|---|---|
| ☐ Yes | ☐ No | Knee |
| ☐ Yes | ☐ No | Spinal |
| ☐ Yes | ☐ No | Heart |
| ☐ Yes | ☐ No | Hand |
| ☐ Yes | ☐ No | Foot |
| ☐ Yes | ☐ No | Hip |
| ☐ Yes | ☐ No | Shoulder |
| Other: | | |

*Testing:*

Have you received any of the following testing for the issue you are seeing us today?

| | | |
|---|---|---|
| ☐ Yes | ☐ No | MRI |
| ☐ Yes | ☐ No | X-Ray |
| ☐ Yes | ☐ No | CT Scan |
| Other: | | |

*Medications:*

_____

_____

_____

_____

Do you use any of the following assistance devices?

☐ Wheelchair ☐ Walker ☐ Cane ☐None ☐Other: _____

Are you currently pregnant? ☐ Yes ☐ No

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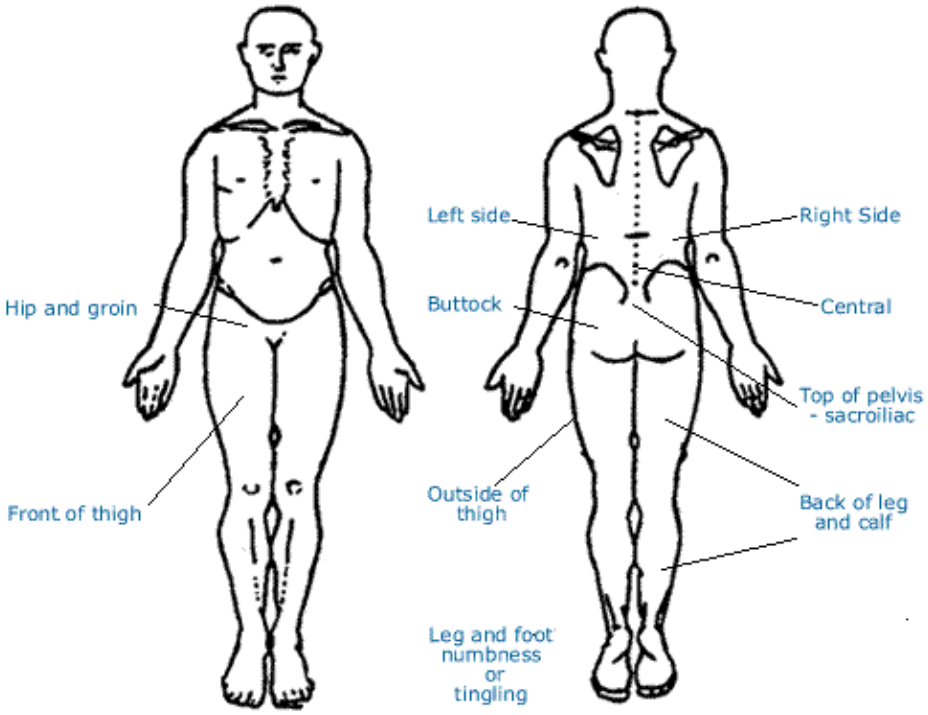
## Section 3- Current Symptoms

Please indicate where you feel pain:




Rate your pain level:
0= No Pain 10= Emergency Room

**Now:**
□ 0 □ 1 □2 □3 □4 □5 □6 □7 □8 □9 □10

**Highest in past week:**
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □7 □8 □9 □10

**Lowest in past week:**
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □7 □8 □9 □10

What is your goal for therapy?

_____

_____

At the present time, would you rate your overall general health as:

___ Excellent ___ Good ___ Fair ___ Poor

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# Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

## Uses and Disclosures

**Treatment**. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.
For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment**. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Carteret Physical Therapy Associates, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

## Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.**
Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.
www.revolutionptot.com

**Fund raising.** We will not use your name and address to support our fund-raising efforts. If you do want to participate in fund-raising please inform the Office Coordinator.

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**Individual Rights**
You have certain rights under the federal privacy standards. These include:
• the right to request restrictions on the use and disclosure of your protected health information
• the right to receive confidential communications concerning your medical condition and treatment
• the right to inspect and copy your protected health information
• the right to amend or submit corrections to your protected health information
• the right to receive an accounting of how and to whom your protected health information has been disclosed
• the right to receive a printed copy of this notice

**Revolution USA Inc. Duties**
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Requests to Inspect Protected Health Information**
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Coordinator at the clinic where you are a patient. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

**Complaints /Contact Person**
If you would like additional information or you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Tremayne Thurman, Director of Operations
Revolution USA Inc.
5860 Yadkin Rd
Fayetteville, NC 28303

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

**Effective Date**
This Notice is effective on or after November 10, 2017.

Patient Signature: _____
Name of Patient: _____
Date: _____

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# Office Policy Summary

**Please Initial All**

_____**Account Balances:** Unless other arrangements have been made, account balances are due at the time of check in for all patients.

_____**Insurance Policies:** You are responsible for understanding your insurance policy. Payments for services and/ or co-payments are due at check in. There will be a $20.00 fee for returned checks. You are responsible for any service not covered by your plan. Should any changes occur with your insurance, please be aware it is your responsibility to relay that information to our staff. Please give us a call if you have any questions.

_____**No Show Policy:** **Cancellations require 24-hour advanced notice.** In general, a **$50.00 fee** will be applied to your account if you no-show or late-cancel. You will be required to reschedule, or a no-show fee will be applied to your account. If you child becomes sick less than 24 hours before your appointment, please call to cancel your appointment. The fee will be waived if you reschedule your missed appointment for the same week. Note that only 1 reschedule a week is allowed. Nevertheless, we understand that life is dynamic, and "stuff" happens. Please give us a call if you have any questions.

_____ **Consent for Treatment:** I hereby authorize Revolution Inc. to provide physical/occupational therapy treatment and services to myself or patient named below. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I also authorize the release of such information that may be necessary for my care via mail, electronic or facsimile transmission. I further consent that by signing below I certify that all medical history has been completed in full.

_____ **Treatment of Minors:** I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

_____ _____
Signature of Patient or Responsible Party Date

_____
Name of Patient

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## APPOINTMENT AND CANCELLATION POLICY

At Revolution USA Inc., we understand that life happens. Accommodations will be made within the administration's discretion during any extenuating circumstances. To achieve maximum benefits, it is important for you and/or your loved one to attend scheduled therapy appointments. By attending the scheduled appointments, as deemed medically necessary, and by carrying over the recommended home exercises, you and/or your loved one can make progress.

## PLEASE READ THE FOLLOWING EXPECTATIONS AND ADD YOUR INTIALS

_____To cancel appointment, please call: 910.491.5164 (call at any time; 24 hours a day 365 days a year)

_____Contacting after hours (I/we) will leave name, time of appointment and detailed message of why (I/we) need to cancel appointment on voicemail

_____(I/we) are aware that CANCELLATION requires 24 hours' notice

_____A CANCELLATION within same day of the appointment time is a NO SHOW

_____TWO (2) NO SHOW appointments or THREE (3) or more cancellations will result in removal from a recurring appointment time and/or my case being reviewed for discharged

Please discuss your appointment needs with his/her therapist and the Medical Front Office Assistant. The more you communicate about you and/or your loved one's needs, the more helpful it is for the therapist to plan you and/or your loved one's individualized program. Please schedule appointments only if you are certain, you and/or your loved one will be able to attend and commit to scheduled times.

Thank you for choosing Revolution USA as your physical, occupational, and speech therapy provider.

I, _____, have read and understand the above Appointments and Cancellation Policy.

Parent/Guardian Signature: _____Date: _____

| | |
|---|---|
| ☐ Cx/NS Form Verbally Reviewed with Patient | _____PT/OT/SLP Initials _____Date |
| ☐ Cx/NS Form Verbally Reviewed for Completeness | _____PT/OT/SLP Initials _____Date |
| ☐ Cx/NS Form Uploaded into Practice Perfect | _____MFOA Initials _____Date |

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# Authorization for Release of Information

I hereby authorize Revolution Inc, to receive and release Protected Health Information (PHI) concerning history, treatment, and/or examination. I understand that I may revoke this authorization at any time by notifying Revolution Inc. in writing. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

_____ _____
Signature of Patient or Responsible Party Date

_____
Name of Patient

# Designation for Release of Information

I hereby authorize one or all the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information occurs.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**Please give a 24-hour notice if you need to cancel your therapy session. We understand that certain circumstances will not always allow this type of notice, but if all possible, please give the front desk as much notice as possible.**

**Thank you for your cooperation!**

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# Financial Policy

Thank you for choosing Revolution USA Inc as your therapy provider. We are committed to your successful treatment. Please understand that in order to provide the best treatment and meet your needs, we need you to accept total financial responsibility. We consider payment of your bill an important part of your treatment. The following is a statement of our Financial Policy that we ask that you read and sign prior to treatment.

All patients (or patient representatives) must complete our Patient Intake form before seeing a treatment provider.

- **Full payment us due at the time of service**
- **We accept checks, money orders, credit**
- **We offer an extended payment plan**

**Regarding Insurance**
Your insurance policy is a contract between you and your insurance company; we are not party to that contract. We may accept assignment of insurance benefits your second visit. However, we do require a portion of the bill to be paid at time of service. The balance is your responsibility whether the insurance pays or not. We cannot bill your insurance company unless you give us your complete insurance information. In the event we do accept assignment of benefits, we may ask that you be pre-approved on out extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to you, your credit card, or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may not be covered services and thus considered reasonable and necessary under your insurance policy.

**Regarding insurance plan where we are participating provider**
All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating provider, the provisions in the paragraph above apply.

**Adult & Minor Patients**
Adult patients are responsible for full payment at the time of service. The adult accompanying a minor and the parents or guardians of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made in advance to use an approved credit plan, check, or credit card to make payment.

**Certificate: I have read and agree to the terms of this Financial Policy.**

X_____ _____
Patient Signature or Responsible Party — Date