ATLAS PHYSICAL THERAPY
NEW PATIENT INFORMATION

(Upper Section for Office Use Only)
Today's Date _____/_____/_____ **Initial Evaluation Date** _____/_____/_____ **Time:** _____

Last Name _____ **First Name** _____ **MI** _____

Referring Physician _____ **Phone** _____ **Body part to be treated:** _____

Primary Care Physician _____ **Phone** _____ **Would you like reports forwarded to PCP?** ❑**Y** ❑**N**

Date of Birth _____/_____/_____ **Age** _____ **Sex: M F (please circle)** **Marital Status: S M W D P (please circle)**

Email Address _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____ **Cell Phone** (_____) _____-_____

Emergency Contact _____ **Phone** (_____) _____- _____ ❑**Hm** ❑**Wk** ❑**Cell** **Relationship** _____

How did you learn about Atlas Physical Therapy? _____

Employer _____ **Occupation** _____ **Employed:** ❑ **Full time** ❑**Part Time**

Employer's Address _____ **City** _____ **State** _____ **Zip** _____

Were you injured on the job? ❑**Y** ❑**N** **Date of Injury** _____/_____/_____ **Claim No.** _____

Name of Adjustor _____ **Phone** (_____) _____-_____

Were you injured in a car accident? ❑ **Y** ❑ **N** **Date of Injury** _____/_____/_____ **Claim No** _____

Name of Attorney _____ **Phone** (_____) _____-_____

FOR MEDICARE RECIPIENTS ONLY:

Have you had or are you currently receiving home health? ❑**Y** ❑**N** **Date of discharge:** _____

Home health agency name: _____ **Phone** (_____) _____-_____

Primary Insurance	**Secondary Insurance**
Complete blanks using *INSURED'S* information	**Complete blanks using *INSURED'S* information**
Insured's Name _____	**Insured's Name** _____
Sex: M F Birth Date ____/____/____	**Sex: M F Birth Date** ____/____/____
Patient's relationship to insured _____	**Patient's relationship to insured** _____
Employer _____	**Employer** _____
Employer's Address _____	**Employer's Address** _____
City _____ **State** _____ **Zip** _____	**City** _____ **State** _____ **Zip** _____
Insurance Company _____	**Insurance Company** _____
Phone (_____)_____-_____	**Phone** (_____)_____-_____
Address _____	**Address** _____
City _____ **State** _____ **Zip** _____	**City** _____ **State** _____ **Zip** _____
Insured's ID #: _____	**Insured's ID #:** _____
Group #: _____	**Group #:** _____

ATLAS PHYSICAL THERAPY

MEDICAL HISTORY/PAIN CHART AND ADL SCREEN

PATIENT:_____ AGE: _____

Are you on any medications? ☐YES ☐NO Please list all prescription, over the counter and herbal medicines below as well as dosage, frequency and route of administration i. e. oral or injected

_____

_____

_____

_____

Height: ____ft _____ inches Weight:_____ lbs.

2 or more falls in the past year? ___ Y ___N Any fall in the last year resulting in injury ___Y ____N

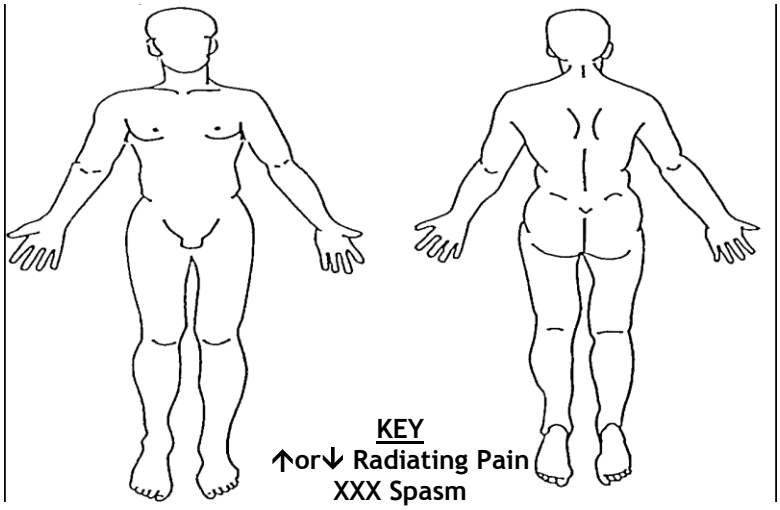
Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Dizzy Spells	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Are you currently pregnant	☐ YES	☐ NO
Seizures	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO
Osteoporosis/Osteopenia	☐ YES	☐ NO
Back injury	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Bleeding disorder	☐ YES	☐ NO
Fracture	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Pacemaker	☐ YES	☐ NO
Metalology (implants)	☐ YES	☐ NO
Respiratory problems	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO
Hepatitis A,B,C	☐ YES	☐ NO
MRSA	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO
Heart Trouble	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Bowel/bladder problems	☐ YES	☐ NO
Sudden weight loss	☐ YES	☐ NO
Allergies	☐ YES	☐ NO
List:		

Please circle all that may apply. *My pain is worse*:
In the morning/during the day/at night/constantly/
with activity/during rest.

On a scale of 0 to 10,
0 being no pain and 10 being unbearable pain requiring hospitalization,
rate your pain at its best _____ and worst _____.

Using the key provided, draw the symbol representing your pain over the area of the body as it relates to your **present** condition.



KEY
↑or↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
////// Numbness/Tingling
0000 Ache/Pain

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? **Check all that apply?**

☐Getting in/out of bed	☐Personal hygiene activities	☐Eating	☐Shaving	☐Cleaning
☐Getting in/out of car	☐Bathing/shower	☐Sleeping	☐Lifting	☐Writing
☐Getting in/out of chair	☐Brushing teeth	☐Sitting	☐Cooking	☐Shopping
☐Walking up/down stairs	☐Dressing	☐Standing	☐Laundry	☐Driving
☐Getting in/out of shower	☐Work activities	☐Walking	☐Vacuuming	

☐Other _____

✍ Patient Signature: _____ Date: _____

HEALTH INFORMATION PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Document Carefully.

1. About Protected Health Information (PHI).

   In this Notice, “we”, “our” or “us” means this FACILITY and our workforce of employees, contractors and volunteers. “you” and “your” refers to each of our patients who are entitled to a copy of this Notice.

   We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information we call this Protected Health Information---or “PHI”. In this Notice, we tell you about:

   - How we use your PHI
   - When we may disclose your PHI to others
   - Your privacy rights and how to use them
   - Our privacy duties
   - Who to contact for more information or a complaint

2. Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

   We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call “health care operations”. We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

Cont. 2. Uses and Disclosures

- Treatment

  We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optical care is rendered.

- Payment

  After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payor may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

- Health Care Operations

  We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of real patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

- Special Uses

  We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

  i. Remind you of appointments
  ii. Carry out follow ups on home programs that you have been taught
  iii. Advise you of new or updated services or home supplies

Cont 2. Uses and Disclosures

- Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

i. If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
ii. We may use your PHI in an emergency if you are not able to express yourself
iii. If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research

Required:

i. When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
ii. For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
iii. To report neglect, abuse or domestic violence
iv. To the government regulators or its agents to determine whether we comply with applicable rules and regulations
v. In judicial or administrative proceedings such as a response to a valid subpoena
vi. When properly requested by law enforcement officials or other legal requirements such as reporting gun shot wounds
vii. To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
viii. Deemed necessary by appropriate military command authorities if you are in the Armed Forces
ix. In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

We will follow any and all State regulations should they be stricter than these federal privacy regulations

3. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication
  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing
- Your Right to Inspect and Copy
  You have the right to inspect and copy your PHI. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record

Cont. 4 Your Privacy Rights and How To Exercise Them

- Your Right to Know Who Else Sees your PHI
  You have the right to request an accounting of certain disclosure that we have made over the past six years; however you may not ask for disclosures that occurred prior to April 14, 2003. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually, we have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.
- Your Right to Complain
  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint with us please contact the person identified below in this Notice. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

5. Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you Notice of our Privacy Practices. This document is our Notice. If you did not get a paper copy of this Notice, you may request one. We will abide by the privacy practices set forth in this Notice. However, we reserve the right to change this Notice and our Privacy Practices when permitted or required by law.

If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

6. Contact Information

If you have questions about this Notice, or if you have a complaint or concern, please contact:

Name:	Vicky Bledsoe
Address:	7718 Wood Hollow Dr., Suite 105
	Austin, TX 78731
Phone:	(512) 795-0053

7. Effective Date: This notice takes effect on April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Atlas Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Atlas Physical Therapy to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature