Therapy for Health.
Therapy for Life.

Joint Effort REHAB LLC

Joint Effort Rehab, LLC
New Patient Forms

DEMOGRAPHICS

Patient Information

First Name: MI: Last Name: Sex: M F

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

***Email** SSN#: Date of Birth:

***By providing my email address I understand and agree to allow Joint Effort Rehab, LLC and it's employees to contact me via unencrypted email.**

Referring Physician: Primary Care Physician:

Employer Name: Occupation:

Primary Insurance Subscriber Information

First Name: MI: Last Name: Sex: M F DOB:

Address: City: State: Zip:

Insurance Carrier: Member ID: Group No:

Relationship to Patient: Employer: SSN:

Secondary Insurance Subscriber Information (if applicable)

First Name: MI: Last Name: Sex: M F DOB:

Address: City: State: Zip:

Insurance Carrier: Member ID: Group No:

Relationship to Patient: Employer: SSN:

Responsible Party (if patient is minor)

First Name: MI: Last Name: Sex:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

SSN: Date of Birth: Email:

Employer Name: Patient's Relationship to Responsible Party:

Emergency Contact

First Name: Last Name: Relationship to Patient:

Home Phone: Cell Phone: Work Phone:

Communication Consent

☐ **Option A**: I give Joint Effort Rehab LLC permission to leave detailed phone messages regarding my medical and/or billing information on:

Home# ____________ ☐ Medical ☐ Billing

Cell# ____________ ☐ Medical ☐ Billing

Work# ____________ ☐ Medical ☐ Billing

I also authorize Joint Effort Rehab LLC to release ☐medical and/or ☐billing information to: ____________

☐ **Option B**: I wish to be contacted personally and do not authorize Joint Effort Rehab, LLC to leave detailed messages or discuss my care or billing account with anyone other than myself.

Patient or Responsible Party: Date:

OFFICE USE- RTNP VERIFICATION:	
Initials	Date

Revised 07/07/15

MEDICAL HISTORY

A complete medical history is necessary for a thorough evaluation. Please answer the following questions:

Your Name:				Date:
Date of Birth:	Age:	Height:	Weight:	Do you Smoke?: No Yes

Have you ever been diagnosed with any of the following?

Condition			Condition		
Tuberculosis	No	Yes	Congestive Heart Failure (CHF)	No	Yes
Hepatitis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes	Heart Attack (MI)	No	Yes
Stroke	No	Yes	Atherosclerotic Disease (CAD)	No	Yes
Chronic Respiratory Problems	No	Yes	Angioplasty	No	Yes
Epilepsy	No	Yes	Valvular Disease	No	Yes
Arthritis	No	Yes	Stents	No	Yes
Cancer	No	Yes	Arrhythmia	No	Yes
Osteoporosis / Osteopenia	No	Yes	Coronary Artery Bypass (CABG)	No	Yes
Closed Head Injury	No	Yes	Angina	No	Yes
Are you currently pregnant?	No	Yes	Pacemaker	No	Yes

Are you exercising? No Yes Describe: ______________________________

Problems with exercise? No Yes Describe: ______________________________

What do you hope to accomplish with therapy? ______________________________

Significant past or present medical diagnoses and chronic conditions not listed above:

Medications	Diagnosis	Prescribing Physician

Is there any other pertinent information you would like us to know about your condition?

____

____

Patient or Responsible Party: ______________________________ Date: ____________

OFFICE USE- RTNP VERIFICATION:	
Initials	Date

SYMPTOM DETAILS

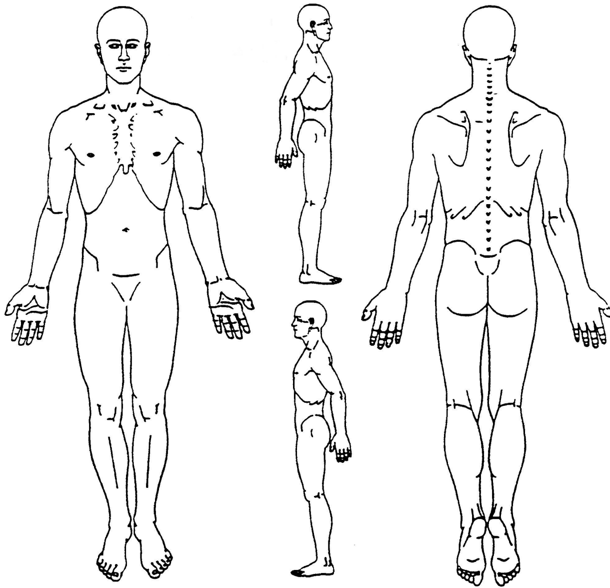
Patient Name:___________________________________

Diagnosis (if you know or have been told):______________

____

____

Body part effected? (please indicate below)



Shoulder Elbow Wrist Neck Mid-back Low-back

Hip Knee Ankle Other:______________________

Which side(s)? ☐ Right ☐ Left ☐ Both

Dominant arm? ☐ Right ☐ Left

Problem(s) (please check all that apply)

☐ Pain

☐ Weakness

☐ Instability/Giving way/Dislocation

☐ Stiffness

☐ Swelling

☐ *Other*________________________________

How severe is your pain? (0=none & 10=severe)

At rest?	0	1	2	3	4	5	6	7	8	9	10
When active?	0	1	2	3	4	5	6	7	8	9	10
At it's worst?	0	1	2	3	4	5	6	7	8	9	10
At it's best?	0	1	2	3	4	5	6	7	8	9	10

Do you have pain at night? ☐YES ☐NO

Does the pain awaken you from sleep? ☐YES ☐NO

Have you ever been seen for this issue by any other provider (ie. chiropractor, physician)? ☐YES ☐NO

In 2015 have you received any of the following treatments (related or unrelated to todays visit):

☐ Physical Therapy ______# visits

Services rendered at:__________________________

☐ Occupational Therapy ______# visits

Services rendered at:__________________________

☐ Chiropractic ______# visits

☐ Home Health ______# visits

Were you discharged from home health? ☐YES ☐NO

☐ None

Have you received any injections? ☐YES ☐NO

Are you post surgical? ☐YES ☐NO

Date of Surgery:____________________________

Type of Surgery:____________________________

List any additional surgeries you've received for this problem:____________________________

____

Other unrelated surgeries:____________________________

____

____

This is a result of... (mark all that apply)

☐ No injury – just started hurting

Date of Onset________________________

☐ Sports Injury (which sport?) ________________

☐ Motor Vehicle Related

☐ Work/Job Related

☐ 3rd Party Accident (involving insurance other than your own)

Injury :☐Current ☐Old (greater than 1 year)

Date of Injury:____________________________

Please briefly describe how your injury happened:

____

____

____

____

____

(Patient Signature) **(Date)**

SKIP THIS PAGE IF YOUR CONDITION IS *NOT* RELATED TO A WORK OR AUTO ACCIDENT

MOTOR VEHICLE INFORMATION

(Complete ONLY if your accident is MOTOR VEHICLE related)

Is there an *open* motor vehicle claim with *your* motor vehicle insurance?

☐ **YES,** please provide details below.
☐ **NO,** continue to the next page.

Were you the driver? ☐ YES ☐ NO **Were you unconscious?** ☐ YES ☐ NO
Were you wearing a seat belt? ☐ YES ☐ NO **If so, for how long?** ______________________

***Your* Motor Vehicle Insurance:**____

Address:____

Adjuster:____________________________ **Adjuster's Phone#:**______________________**x**__________

Claim#:____________________________________**Policy#:**___________________________________

Amount of Med Pay:______________ **Med Pay Remaining (if unknown please call adjuster):**______________

Is an attorney involved? **Attorney:**______________________________________

☐ **YES,** please provide attorney information. **Phone#:**______________________________________

☐ **NO,** please continue to the next page. **Fax#:**______________________________________

WORKERS COMPENSATION INFORMATION

(Complete ONLY if your accident is WORK related)

Is there an *open* claim with your employer?

☐ **YES,** please provide details below.
☐ **NO,** please continue to the next page.

Insurance:____

Address:____

Adjuster:__________________________ **Adjuster's Phone#:**______________________**x**____________

Claim#:__________________________________**Policy#:**____________________________________

Employer (at the time of the accident):____

Occupation/Job:____

I understand that if this medical condition is found to not be work related, I will be responsible for payment of medical treatment.

Patient or Responsible Party:____***Date:***______________

NOTICE OF PATIENT INFORMATION PRACTICES

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

JOINT EFFORT'S LEGAL DUTY

Joint Effort is required by law to maintain the privacy and security of your personal health information, to provide this notice about our information practices and follow the information practices that are described herein. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

USES AND DISCLOSURES OF HEALTH INFORMATION

Joint Effort uses your personal health information primarily for treatment, obtaining payment for treatment, and conducting internal administrative activities and evaluation of the quality of care that we provide; For example, Joint Effort may use your personal health information to contact you to provide appointment reminders, or for information about treatment alternatives or other health related benefits that could be of interest to you.

Joint Effort 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. We may also share information with a coroner, medical examiner or funeral director when an individual dies, for worker's compensation claims and for special functions such as military, national security, and presidential protective services. We also provide information when required by law.

In any other situation, Joint Effort'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.

Joint Effort may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. 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 electric or paper copy of your personal health information. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. You have the right to request that we correct any inaccurate or incomplete information in your records. We may say "no" to your request, but we'll tell you why in writing within 60 days.

You can ask us to contact you in a specific way (for example, home or office phone) or to send by mail to a different address. We will say "yes" to all reasonable requests.

You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You will be required to fill out and sign a written request form.

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. Joint Effort will consider all such requests on a case by case basis, but the practice is not legally required to accept them. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

OFFICE USE- RTNP VERIFICATION:	
___________ Initials	_____________ Date

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

PATIENT INDIVIDUAL CHOICES
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to share information with your family, close friends, or others involved in your care and to share information in a disaster relief situation. If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We never share your information for marketing purposes or sell your information unless you give us written permission. We may contact you for fundraising efforts, but you can tell us not to contact you again.

CONCERNS AND COMPLAINTS
If you are concerned that Joint Effort may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services, Office for Civil Rights, 200 Independence Ave, SW, Washington, DC 20201

For further information on Joint Effort's health information practices or if you have a complaint, please contact the following person:

Joint Effort Physical Therapy
Sylvia Goroski -Privacy Officer
2835 Dublin Blvd Colorado Springs, Co 80918
Telephone: 719-533-1318 Fax: 719-533-1319

PATIENT INFORMATION CONSENT

I have received, read and fully understand Joint Effort's Notice of Information Practices. I understand that Joint Effort may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Joint Effort will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Joint Effort's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_______________________________________ _______________________
Patient/Responsible Party Date

OFFICE USE- RTNP VERIFICATION:	
________ Initials	________ Date

Therapy for Health.
Therapy for Life.

PATIENT AGREEMENT

Due to limited space and potentially dangerous equipment, patients are discouraged from bringing small children to our facility. Joint Effort Physical Therapy LLC is not responsible for any injuries suffered by unsupervised children.

Authorization for Treatment
I understand that therapy evaluations and treatment may potentially cause or aggravate symptoms, and give my consent for the therapist to perform evaluations and treatment as he/she deems necessary. _________
(Initials)

Verification of Benefits
I understand that Joint Effort Rehab, LLC will attempt to obtain benefits from my insurance company; however, they will not be responsible for unauthorized services as well as any discrepancies between quoted benefits and actual benefits paid. I understand I am responsible for payment of services not covered by my insurance. I also understand and agree that I am responsible for verifying my own insurance benefits as well as knowing and understanding my plan limitations, maximum benefits available, deductibles, co-payments and coinsurance amounts. Because my insurance coverage is a contract between myself and my insurance company, I understand that I must direct questions or concerns regarding payment of benefits to them. _________
(Initials)

Authorization to Pay Benefits
I hereby authorize and instruct my insurance carrier to make payment of medical benefits to Joint Effort Physical Therapy, LLC for therapy services rendered, and that no payment be made payable to myself/insured party. If payment is made directly to the myself/insured, I understand that I will be responsible for the balance due. _________
(Initials)

Financial Liability
I understand that if billing a private health insurance, co-payments, estimated co-insurance, and deductible payments will be collected at each visit. I understand these amounts are estimates of my liability and do not necessarily represent payment in full. Final calculation of my liability will be completed after all payments have been received from said insurance carrier. Once completed, I will receive a statement for any remaining balance due, or a refund for any overpayment, whichever may apply. I understand and agree to pay all charges for myself and my family members (as shown on my statement) within 30 days after receipt, unless credit arrangements have been made. Charges are to be paid in full regardless of any arbitrary decision made by my insurance company regarding usual and customary fees. It is agreed that payment will not be delayed or withheld because of any insurance claims pending, and all proceeds of insurance are assigned to this office where applicable (a copy of this assignment is as valid as the original). In the event legal action should become necessary to collect unpaid balances due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees or other such costs as the court determines proper._________
(Initials)

Cancellation/No Show Policy
I understand that I have scheduled appointments with my therapist and that it is imperative to my recovery to keep and be on time for all appointments. I agree that if I am unable to attend my appointment, it is my responsibility to call at least 24 hours in advance, or be subject to a $25 fee. I understand if I fail to keep three appointments I will be dismissed from therapy and required to return to my physician to obtain a new prescription before resuming treatment. _________
(Initials)

Additional Fees
I understand that statements not paid by the due date shown will be assessed a $5.00 rebill fee. As well as a $20.00 fee for any and all returned checks._________
(Initials)

I, understand and agree to all the terms listed above.

____ _____________________________
Patient/Responsible Party Date

OFFICE USE- RTNP VERIFICATION:	
_______________ Initials	______________ Date