DAY ONE
PHYSICAL THERAPY & WELLNESS

FIRST Name _____ Middle _____ LAST _____

MALE / FEMALE DOB _____ SS# _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

Primary Phone _____ Email _____

Emergency Contact **NAME** _____ Relationship _____ Phone _____

Appointment reminder preference: EMAIL TEXT MESSAGE VOICE CALL

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you receiving therapy at home or does a nurse go to your home for blood pressure, blood sugar or any other check-up? (Does NOT include having a provider) ___YES ____ NO

Have you been enrolled in hospice care in the last 3 months? ___ YES ____ NO

IS THERE AN ATTORNEY INVOLVED IN YOUR CASE/INJURY? ___ YES ____NO

IF YES, NAME OF ATTORNEY AND PHONE NUMBER _____
Please note: If an attorney is obtained at a later date, the balance/difference will be billed to the attorney and any balances not covered, will be your responsibility.

PLEASE FILL OUT THE FOLLOWING ONLY IF YOU ARE HERE UNDER WORKER'S COMPENSATION:

Employer Name & Adress:_____

Employer Phone:_____ Date of Injury:_____ Claim#_____

PLEASE ANSWER THE FOLLOWING:

When did pain/difficulty begin: _____ Affected body part/area:_____

Briefly describe the history/symptoms of your present illness or injury such as pain, numbness, tingling, etc.

_____

_____

If you suffered an injury, where did your injury occur?(**circle one**):

Home Work School Motor Vehicle Accident Business establishment

Have you ever had physical therapy for your current condition? (CIRCLE ONE) Yes No

CONTINUES ON NEXT PAGE ⇨

OFFICE USE ONLY

CARDS SCANNED YES NO

ENTERED BY _____

MEDICAL HISTORY

Have you ever had OR currently have any of the following conditions?

High Blood Pressure	Yes	No	Kidney/Liver Problems	Yes	No
Heart Attack	Yes	No	Glaucoma/Cataracts	Yes	No
Circulation Problems	Yes	No	Claustrophobia	Yes	No
Seizures	Yes	No	Dizzy Spells	Yes	No
Cholesterol	Yes	No	Diabetes	Yes	No
Allergies	Yes	No	Nervous Disorders	Yes	No
Fractures	Yes	No	Osteoporosis	Yes	No
Arthritis	Yes	No	Metal Implants	Yes	No
Speech Problems	Yes	No	Sensitivity to heat/cold	Yes	No
Stroke	Yes	No	Asthma	Yes	No
Cancer	Yes	No	Dialysis	Yes	No
Currently Pregnant	Yes	No	Pacemaker, Catheters or Ports	Yes	No

List **ALL** Surgeries _____

_____

Current Medications _____

_____

_____

INITIAL the following:

_____ I hereby agree and give my consent for Day One Physical Therapy & Wellness to provide physical therapy treatment. I authorize Day One Physical Therapy & Wellness to release and obtain all information necessary from my referring physician, other physician, insurance carriers, or third party payers. I hereby assign Day One all payments for services rendered to myself or my dependents and understand that I may be responsible for any uncovered charges.

_____ I have been notified of this office's ***Notice of Privacy Practices (HIPAA) *** on clipboard ******

Please give name(s) of relative, friend or other representative who may have access to your medical records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature (Patient/Guardian): _____ Date: _____

HIPAA Privacy Policies

It is the policy of Day One Physical Therapy and Wellness, LLP that all providers and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its providers and staff have the necessary medical and PHI to provide the highest quality physical therapy care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should be confident to provide information to our practice and its providers and staff for purposes of treatment, payment and healthcare operation (HCO), knowing that our practice and its providers and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its providers and staff will not use or disclose PHI for uses outside of the practice's HCO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only with their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed.

Our practice and its providers and staff will:

- Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its providers and staff respect the patient's individual dignity at all times. Our practice and its providers and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential.

Consequently, our practice and its providers and staff will:

- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
- Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete.

Our practice will:

- Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All providers and staff of our practice will maintain a list of all disclosures of PHI for purposes other than HCO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

All providers and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All providers and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Day One Physical Therapy & Wellness
No-Show / Cancellation Policy
EFFECTIVE JUNE 22, 2020

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. This is especially important during this pandemic when strategic scheduling and staffing is imperative to helping the clinic run safely and efficiently.

Following is our new cancellation and no show policy:

1. Please provide our office with 24-hour notice to change or cancel an appointment. **Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be responsible for a $10.00 late cancellation charge.** This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. Each patient will be allowed 1 same day cancel/no show that the fee will be waived. After the 1st same day cancel/no show a $10 fee will be charged from that point forward for any missed appointment without proper notice as described below.

2. 24 notice means that you must call and notify the front office **by 5:00 pm on the business day prior** to your scheduled appointment. If for some reason you are unable to speak to a person upon calling you can leave a voicemail and the time will be recorded. Calling the day or morning of your appointment will still result in a $10 charge.

3. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim or further authorizations. Missing appointments hinders that process and may end up prolonging recovery.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

Signature of Patient_____ Date _____

PRINT NAME:_____

Signature of Responsible Party (if applicable) _____Date_____