New Patient Paperwork

Welcome to Evolution Physical Therapy! Thank you for choosing us to assist you in achieving your goals. We take pride in being the premier sports and orthopedic physical therapy company in the region and we are confident you will experience great outcomes while having fun doing it!

At Evolution Physical Therapy, our mission is to help all of our patients and clients perform at their highest potential. Our mission is to completely redefine the profession of physical therapy to provide the community with exceptional rehabilitation services, fitness and performance training, prevention and wellness. Our Physical Therapists have the best skills, are equipped with the most state-of-the-art equipment, and have an unparalleled drive to help you get better.

This packet is meant to make your first visit to Evolution as seamless as possible. Please arrive 15 minutes before your first session to complete any necessary paperwork. This can be expedited by completing the paperwork in this packet. Your session will last approximately 1 hour.

Remember to bring the following items with you:

- Government-issued photo ID
- Prescription or Doctor's Orders for physical therapy (if issued)
- Insurance card(s)
- Form of Payment
- Loose, comfortable clothing that allows your therapist to access your injured body part and allows you to move!

PLEASE NOTE - We strictly enforce a 24-hours' notice cancellation policy

It is the responsibility of each patient to verify your physical therapy benefits with your insurance carrier(s) prior to initiating care. As a courtesy, we will do our best to confirm coverage with each patient's insurance plan, but that is an estimate only and is not a guarantee of payment by your insurance carrier.

Evolution Physical Therapy NEW PATIENT FORM

PLEASE PRINT CLEARLY

Legal Name (First) ____________________ (M.I.) ______ (Last) ________________________________

Preferred Name ________________________________ Date of Birth __________________ Age ________

Mailing Address ____

City ____ State ____________ ZIP __________________

Mobile Phone __________________ Work Phone __________________ Other Phone __________________

Driver's License Number ______________________ Email Address __________________________________

Gender ☐ Male ☐ Female

Emergency Contact:

Name ____________________________ Relationship __________________ Phone __________________

Referring Physician ____ Phone __________________

Who may we thank for your referral other than your Doctor? ____

Employer ____________________________________ **Employment Status** Full / Part-time / Unemployed / Retired

Address ____ Phone __________________

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other ______________________ Injury Date ______________

Attorney Involved? Yes / No Attorney/Firm Name ____

Address ____ Phone __________________

I attest that the above information is complete and true to the best of my ability.

Patient Signature:____ **Date:** __________________

Evolution Physical Therapy MEDICAL HISTORY

Patient Name ______________________________ Age __________

Type of Injury / Condition ______________________________

Onset / Injury Date ______________________________

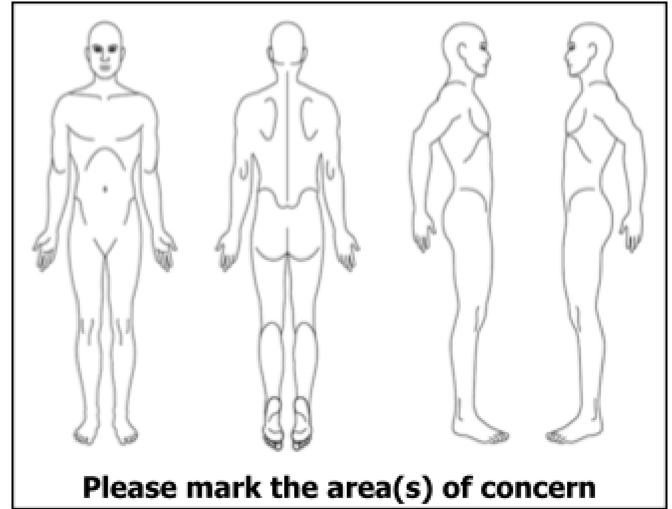
Type of Surgery & Date ______________________________

Next Doctor's Appointment? ______________________________

Describe previous treatment for this condition______________________________

____

Have you received chiropractic treatment this year? ☐ Yes ☐ No



Have you had any imaging performed:

☐ X-Ray ☐ CT Scan
☐ MRI ☐ Doppler ☐ Ultrasound

Have you recently noted:

☐ Weight Loss /Gain ☐ Nausea / Vomiting ☐ Fatigue
☐ Weakness ☐ Fever / Chills / Sweats ☐ Numbness / Tingling
☐ Pregnant / IUD ☐ Headaches ☐ Change In Vision Or Hearing
☐ Pain At Night ☐ Cramps In Legs When Walking ☐ Insomnia

Do you have now or have you ever had any of the following?

☐ Surgeries ☐ Loss of Consciousness ☐ Fractures
☐ Sprains / Strains ☐ Diabetes ☐ Blood Pressure Problems
☐ Heart Problems ☐ Cancer ☐ Motor Vehicle Accident
☐ Circulation Problems / Clots ☐ Asthma / Breathing Problems ☐ Lung Disease
☐ Easy Bruising / Bleeding ☐ Leg / Ankle Swelling ☐ Urinary Problems / Infections
☐ Indigestion / Heartburn ☐ Fainting ☐ Allergies / Skin Sensitivity
☐ Osteoporosis/Osteopenia ☐ Depression ☐ Emotional/Psychological Disorder
☐ Other: ______________________________

Any previous injury that may affect current care? ______________________________

List Current Medications ______________________________

Type Of Pain: ☐ Sharp ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness ☐ Other ______________

Rate your pain (1=minimal 10=extreme): At its worst: 1 2 3 4 5 6 7 8 9 10 / At its best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? ______________________________

What are your physical or fitness goals? ______________________________

Is there anything else you would like to include or ask your physical therapist? ______________________________

X______________________________ ______________

Patient or Personal Representative Signature **Date**

Office Policies

Patient Name: ____________________________

______ Initial **HIPAA Privacy Practices Notice:** I acknowledge the receipt of a copy of the Notice of Privacy Practices. I understand that non-identifying patient data may be used in research and/or publication and consent to such use. I understand that I may obtain a paper copy of the Evolution PT Privacy Practices at any time by asking at the Front Desk.

______ Initial **Consent for Care and Treatment:** I, the undersigned, do hereby agree and give my consent for Evolution Physical Therapy and/or its affiliates to provide the treatment and care considered necessary and proper in diagnosing and treating my physical condition. I hereby acknowledge the inherent danger and risks involved in my participation in physical therapy provided by Evolution Physical Therapy. I agree that I assume all risks and responsibilities involved in participating in physical therapy through Evolution, and waive, release, and forever discharge Evolution and their owners, directors, officers, employees, agents, or any person acting on their behalf, from any and all claims, demands, liability, and damages relating to, arising out of, or resulting from my participation in physical therapy provided by Evolution.

______ Initial **Social Media Disclosure:** I understand that while in Evolution facilities I may be a background to a subject in social media platforms. If I am to be the subject, verbal consent will be obtained in order to produce content.

______ Initial **Release of Information and Assignment of Insurance Benefits:** I authorize Evolution or its legal representatives to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or evaluation rendered to me during the period of such care. I hereby authorize payment of medical benefits to which I am entitled to Evolution for medical services rendered.

______ Initial **Workers' Compensation Claims:** If you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

______ Initial **Cancellation and No-show Policy:** We require at least *24 hours' notice by telephone* for cancellations. Cancellations under 24 hours are considered no-shows, and you will be charged a **$75 no-show fee**. If you have no-showed three or more times, Evolution reserves the right to discharge you from our care. These charges will not be covered by insurance and must be paid before receiving additional treatment.

______ Initial **Supply Charges:** We may provide treatments for which supplies *are not covered* by insurance. We will not bill insurance for these supplies, and the patient is responsible for related supply charges.

______ Initial **Visit Limit/Therapy Cap:** Most insurance plans have limits on the number of visits or a specific dollar amount that are covered during the plan year. It is the patient's responsibility to know what limits the insurance policy imposes, and how many visits have been met or amount applied toward the therapy cap to date. Visits that exceed the allowed amount will be charged at our *Self Pay* rates.

______ Initial **Credit Card on File:** It is the practice of Evolution to keep a valid, current credit card on file for all patients. This card is stored in a secure, HIPAA-compliant manner through our Electronic Medical Records (EMR) software. The card will be charged upon check-in for copays, deductible or coinsurance payments; supply charges; and for late cancellation and no-show fees. The card will **not** be charged if no fees are payable.

I acknowledge that I have read and accept the above conditions.

______________________________________ ______________________

Patient/Guardian Signature Date

Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights: This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. We may charge a reasonable, cost-based fee.
Request confidential communications	You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. 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.
Get a list of those with whom we've shared information	You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	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.
File a complaint if you feel your rights are violated	You can complain if you feel we have violated your rights by contacting us using the information at the bottom of this notice. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. 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 • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, 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.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: We typically use or share your health information in the following ways.

Treat you	We can use your health information and share it with other professionals who are treating you.
Run our organization	We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Bill for your services	We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date of Notice: December 1, 2021

This Notice of Privacy Practices applies to all Evolution Physical Therapy locations in the United States.

Privacy Officers: **Mountain Region**
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(303) 370-2670

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