



Physical Therapy Health History Form

Date: _____

Name: _____

Gender: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Email: _____ DOB: _____ Age: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

Have you ever received Physical Therapy care? Yes No If yes, by whom? _____

Is this visit the result of an auto accident? Yes No

Please note: All auto accident visits cannot be filed on your health insurance. You must be seen as a cash account.

Name of party responsible for payment: _____

Reasons we are seeing you today:

Primary Reason: _____ Date of Onset: _____

Referring Physician: _____ Phone: _____

Have you had X-rays or MRI for the condition you are being seen for? Yes No

If so, where: _____ When: _____

Previous interventions, treatments, medications, or surgery sought for this concern:

Patient Name: _____

Past Health History:

1. Any significant current or previous illnesses? _____
2. Any previous Injuries or traumas? _____
3. Any Hospitalizations? _____
4. Have you ever broken any bones? Which? _____
5. Any sprains/ Strains? _____
6. Allergies: _____
7. List of current medications? (list on back If necessary)

8. Taking any vitamins/supplements? _____
9. Please list any medical/health history of family members: (heart disease, diabetes, cancer etc)

10. Occupation: _____ Employer: _____
Recreational activities: _____ Exercise habits: _____

Does your pain Interfere with any of the following? (circle all that apply)

Sitting | Walking | Standing | Lifting | Traveling | Personal Care | Social Activities

Grade Intensity/Severity (circle one):

1 2 3 4 5 6 7 8 9 10 (Worst pain Imaginable)

Frequency of Pain (circle one): Occasional | Intermittent | Only with certain movements | Constant

Lifestyle

	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Exercise				
Sleep				
Water				
Appetite				



Appointment Reminder Consent

Complete this form and sign below to give permission for Knoxville Spine and Sports to provide automatic appointment reminder service by email or by cell phone text message*.

Send email messages to confirm appointments to: _____

Send cell phone text messages to confirm my upcoming appointments to:

Cellular provider: _____

*I recognize that normal text messaging rates may apply.

Appointment reminders will be sent 24 hours in advance of the appointment unless otherwise requested. We require a 24-hour notice for any changes to the schedule. Failure to notify the office of any appointment change without 24 hours' notice will result in a **\$25.00 charge for Chiropractic Appointments, and a \$50.00 charge for Physical Therapy Appointments.**

Patient Signature: _____ Date: _____



CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Knoxville Spine and Sports to furnish care and treatment to (patient) _____ that is considered necessary and proper in diagnosing or treating my/his/her condition.

RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Knoxville Spine and Sports may make available certain basic information about the patient in accordance with HIPAA regulations, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Knoxville Spine and Sports for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Knoxville Spine and Sports may disclose portions of the patient's record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Knoxville Spine and Sports' charges, including but not limited to government agencies (e.g. Insurance companies, health care service plans, or workers compensation carriers).

BENEFIT ASSIGNMENT: I hereby assign medical benefits to which I am entitled by private insurance and third-party payers, to Knoxville Spine and Sports. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT: The patient is responsible for providing payment at the time of service for all co pays, deductibles, coinsurance and any remaining balance due from services that are not covered by the patient's insurance carrier. I understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed including original charges, interest, collection agency fees, and attorney fees.

ASSIGNMENT OF INSURANCE BENEFITS: It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We have called your insurance company for estimated insurance benefits, and they are reflected on the "Verification of Benefits" form.

CANCELLATION AND MISSED APPOINTMENT POLICY: Failure to provide 24 hours advance notice of a cancellation or appointment change will incur a \$25.00 fee for Chiropractic visits, and a \$50.00 fee for Physical Therapy visits, automatically charged to your account. In instances of repeated non-compliance with our scheduled visits, we also reserve the right to discontinue care. In those rare cases, we will inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

WORKER'S COMPENSATION CLAUSE: The above financial policy does not apply to those patients that are considered Workers Compensation. However, be advised that if you claim Workers Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At the time, our Financial Policy will apply to you.

I have read the above information and understand my responsibilities.

Patient's Name (Print)

Patient's / Guardian Signature

Date



HIPAA RELEASE/PRIVACY FORM

Patient Name: _____ Date of Birth: _____

RELEASE of Information:

- I authorize the release of information including the diagnosis, records, examination, rendered to me and claims information

This Information may be released to :

- Knoxville Spine and Sports
 Spouse: _____
 Children: _____
 Other: _____
 Information is NOT to be released to anyone.

This release of Information will remain In effect until terminated by me In writing.

For phone messages, please call my...

- Home Phone: _____
 Cell Phone: _____
 Work Phone: _____

If unable to reach me,

- You may leave a detailed message
 Please leave a message asking me to return your call
 Do not leave a message

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health Information to carry out: treatment (including direct or Indirect treatment by other healthcare providers Involved In my treatment), obtaining payment from third party payers (i.e. insurance companies), and the day to day healthcare operation of Knoxville Spine and Sports.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, then you are bound to comply with this restriction. I understand that I may revoke this consent in writing at any time.

Patient's Name (Print)

Patient's / Guardian Signature

Date



Electronic Health Records Intake Form

In compliance with requirements for the government EHR Incentive program

First Name: _____ Last Name: _____

DOB: _____ Gender: _____ Preferred Language: _____

Please circle responses: (CMS requires providers to report both race and ethnicity)

Preferred method of communication for patient reminders: Email Phone Mail

Smoking Status: daily smoker occasional smoker former smoker never smoked

Race: American Indian or Alaska Native Asian Black or African American

White (Caucasian) Native Hawaiian or Pacific Islander Other Decline to Answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)

Medication	Dosage/ Frequency

Do you have any medication allergies?

Medication	Reaction	Onset

I choose to decline receipt of my clinical summary after every visit (these summaries are often blank because of the nature and frequency of chiropractic care)

Patient's / Guardian Signature _____ Date: _____

For office use only:

Height	Weight	Blood Pressure	Pulse R R A C
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