HOLT PHYSICAL THERAPY & PERFORMANCE TRAINING

PATIENT INFORMATION

Mr. Mrs. Ms.	First Name	Last Name	Middle Initial	Preferred Name	Social Security Number

Gender	Date of Birth	Marital Status	Employment	Student	Email Address
Male Female	MM/DD/YYYY	Married Single Divorced Separated Widow	Employed Unemployed Retired	Full-Time Part-Time None	May we send you appointment reminders via email? YES/NO

Home Phone Number	Cell Phone Number	Alternate Phone Number
May we leave messages on your answering machine? YES/NO		

Home Address	Apartment #	City	State	Zip Code

Mailing Address (If different from above)	Apartment #	City	State	Zip Code

Chief Complaint	How Did Injury Occur?	Post Operative?	If yes, date of surgery?
Right ☐ Left ☐ Both ☐		YES ☐ NO ☐	

Referring or Primary Care MD: **Date of Onset or Injury:**

Have you had any diagnostic tests: ☐ MRI ☐ Xrays ☐ CT Scan ☐ Other **Are you latex sensitive:**

EMERGENCY CONTACT

Relationship to Patient	First Name	Last Name	Middle Initial	Phone Number	This person has permission to discuss medical records for the patient? YES or NO

Address (If different from above)	Apartment #	City	State	Zip Code

INSURANCE INFORMATION

PRIMARY Insurance Company Name	Subscriber Id/Member Number	Group Number

Name of Policy Holder (If different than patient) First Name Middle Initial Last Name	Relationship to Insured:	Policy Holders Date of Birth MM/DD/YYYY	Gender Male Female	Policy Holders SS Number

Policy Holder's Home Address (If different from above)	Apartment	City	State	Zip Code

SECONDARY Insurance Company Name *INITIAL HERE IF NO Secondary Insurance* ____	Member Number	Group Number

Name of Policy Holder (If different than patient) First Name Middle Initial Last Name	Relationship to Insured:	Policy Holders Date of Birth MM/DD/YYYY	Gender Male Female	Policy Holders SS Number

Date Verified:	Verified By:	Spoke with/Ref #:
Effective Date:	Benefit Start Period:	End Date:
Deductible:	Met:	Co-Insurance:
CoPay:	Out of Pocket: Met:	Visit Limit:
Pre Authorization Required? YES NO	Dr Prescription Required? YES NO	Notes:

Verification of benefits is not a guarantee of payment. All benefits are subject to eligibility, medical necessity and the terms, conditions, limitations and exclusions of the patient's health benefit plant at the time the services are rendered. **Signature:**

Patient Name:
DOB:

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes	◯ No	Dizzy Spells	◯ Yes	◯ No	MRSA	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Emphysema/Bronchitis	◯ Yes	◯ No	Multiple Sclerosis	◯ Yes	◯ No
Anxiety	◯ Yes	◯ No	Fibromyalgia	◯ Yes	◯ No	Muscular Disease	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No	Fractures	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Gallbladder Problems	◯ Yes	◯ No	Parkinsons	◯ Yes	◯ No
Autoimmune Disorder	◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Rheumatoid Arthritis	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Hearing Impairment	◯ Yes	◯ No	Seizures	◯ Yes	◯ No
Cardiac Conditions	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Smoking	◯ Yes	◯ No
Cardiac Pacemaker	◯ Yes	◯ No	High/Low blood pressure	◯ Yes	◯ No	Speech Problems	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Strokes	◯ Yes	◯ No
Circulation Problems	◯ Yes	◯ No	HIV/AIDS	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Currently Pregnant	◯ Yes	◯ No	Incontinence	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Depression	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Vision Problems	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Metal Implants	◯ Yes	◯ No			

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

☐ Injury as a result of a fall in the past year
☐ Two or more falls in the last year

Surgical History

Body Region:_____ Surgery Type:_____ Date:_____
Body Region:_____ Surgery Type:_____ Date:_____
Body Region:_____ Surgery Type:_____ Date:_____
Body Region:_____ Surgery Type:_____ Date:_____

Current Medications

Drug:_____ Dosage:_____ Frequency:_____ Reason for Taking:_____
Drug:_____ Dosage:_____ Frequency:_____ Reason for Taking:_____
Drug:_____ Dosage:_____ Frequency:_____ Reason for Taking:_____
Drug:_____ Dosage:_____ Frequency:_____ Reason for Taking:_____

Please **read** and **initial** indicating that you are aware of and will adhere to following policies:

_____ **Patient Intake Form:** The information on the Patient Intake Form is correct**.** I will notify Holt Physical Therapy & Performance Training immediately of any insurance changes, failure of which may result in denial of coverage, the fees for which I will be responsible for.

_____ **Copays:** Copays are due at the time of service and will be collected at each visit.

_____ **Appointment Policy:** I understand that Holt Physical Therapy & Performance Training sends appointment reminders via text and/or email. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that physical therapy is an on-going process which requires regular attendance to be optimally effective, and that if I cancel or no show for three (3) consecutive appointments, Holt Physical Therapy & Performance Training has the right to discharge me from care for being non-compliant. I understand and agree that Holt Physical Therapy & Performance Training requires **24-hour advance notice of cancellation**. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $50 charge which is not covered by insurance.

_____ **Insurance/Benefit Information:** Every attempt is made to obtain accurate physical therapy benefits information. At times, insurance companies give us incorrect information. This error will not be determined until claims are processed after services are rendered. If patients overpay for services, a refund will be issued. If there is a balance not paid by the insurance company, the patient will be responsible for these charges. Patients are encouraged to verify their own benefits. It is ultimately the patient's responsibility to know and understand their benefits.

Please **read** the statement below and **sign** indicating understanding**:**

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment, if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt and Holt Physical Therapy & Performance Training, Inc. (HPT, INC.) will bill my insurance company and refund me any monies received by them from my insurance company for said supplies.

I hereby give authorization for payment of insurance benefits to be made directly to HPT, INC. for services rendered. In the event that my insurance company forwards payment directly to me, instead of HPT, INC., I will immediately deliver said payment to HPT, INC.. I authorize the release of any medical or other information necessary to verify benefits/obtain payment or complete treatment.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for HPT, INC. to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

I do hereby consent to and authorize the evaluation and all therapy treatments by Holt Physical Therapy & Performance Training, which in conjunction with the judgement of my attending physician may be considered necessary and/or advisable for diagnosis and/or treatment. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Signed (Patient and/or parent or legal guardian) _____ 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 carefully.

Holt Physical Therapy and Performance Training's Legal Duty
Holt Physical Therapy and Performance Training, hereinafter HPTPT, is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

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

HPTPT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purpose, for research studies, and for emergencies. We also provide information when required by law. In any other situation, HPTPT's policies are 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.

HPTPT may change its policies at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practice at any time.

Patient's Individual Rights
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where to have disclosed your personal health information for reasons other that treatment, payment or other related administrative purposes. You may also request in writing that we may not use or disclose your personal information for treatment, payment and administrative purposes except when specifically authorized by you. When required by law or in emergency circumstances HPTPT will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints
If you are concerned that HPTPT 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 8470 Falls of Neuse Road Suite 106 Raleigh, NC 27615. You may also send a written complaint to the US Department of Health and Human Services. For further information on HPTPT's health information practices or if you have a complaint, please contact Jaime Holt at 8470 Falls of Neuse Road Suite 106 Raleigh, NC 27615 (919) 803-0738.

Signed (Patient and/or parent or legal guardian) Date