NEW PATIENT INTAKE FORM

phynix PHYSICAL THERAPY

PATIENT INFORMATION

PATIENT'S FULL NAME (LAST, FIRST, MI)			
ADDRESS		CITY	STATE / ZIP
BIRTH SEX ( ) Male ( ) Female	SSN		DOB (MM/DD/YYYY)
HOME PHONE OK TO CALL	CELL PHONE OK TO CALL		WORK PHONE OK TO CALL
EMAIL		HOW DID YOU HEAR ABOUT US?	
REFERRING PHYSICIAN	ADDRESS		PHONE
EMERGENCY CONTACT NAME		RELATION	PHONE

INJURY/ILLNESS INFORMATION

DIAGNOSIS	DATE OF INJURY (MM/DD/YYYY)	DATE OF SURGERY (MM/DD/YYYY)
NATURE OF INJURY/ILLNESS	TYPE OF INJURY ON THE JOB MOTOR VEHICLE OTHER	

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY			PHONE NUMBER
SUBSCRIBERS NAME		SUBSCRIBERS DOB (MM/DD/YYYY)	RELATION
ID#	GROUP ID#	EMPLOYER / PHONE	
INSURANCE ADDRESS			

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY			PHONE NUMBER
SUBSCRIBERS NAME		SUBSCRIBERS DOB (MM/DD/YYYY)	RELATION
ID#	GROUP ID#	EMPLOYER / PHONE	
INSURANCE ADDRESS			

GUARANTOR INFORMATION

GUARANTOR NAME		PHONE	DOB
ADDRESS		CITY / STATE	ZIP

I acknowledge that all the information that I have supplied on these forms is true, accurate, current, and complete.

_____ _____ _____

Signature Printed Name Date

Patient Past Medical History

Patient Name: _____ **Condition Begin Date** ____ / ____ / _____

Work Status: Full Time / Part Time / Off Duty **On the job injury?** Yes / No

Rate Your Pain (0 = No Pain, 10 = Worst Pain You Can Imagine)

Symptoms at Worst: ____ Symptoms at Best: ____ Symptoms Today: ____

How much does pain limit activity? _____ %

Current Medications (include ALL known prescriptions, over the counters, herbals and vitamin/mineral/dietary/nutritional supplements) **____ List Attached**

___Not currently taking any prescribed or over the counter medications, herbals or vitamin/mineral/dietary (nutritional) supplements

Medication / Dose / Frequency / Method	Medication / Dose / Frequency / Method
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____
_____ /_____ /_____ /_____	_____ /_____ /_____ /_____

Past Surgical History

Type of Surgery	Date	Type of Surgery	Date
_____	____/____/ ____	_____	____/____/ ____
_____	____/____/ ____	_____	____/____/ ____

Have you had any of the following diagnostic, medical, or rehabilitative services for this injury/episode?

___ Chiropractor ___ Practitioner ___ EMG/NCV ___Massage Therapy

___ CT Scan ___ MRI ___ Myelogram ___Neurologist ___ Occupational Therapy

___ Orthopedist ___ Physical Therapy ___ Podiatrist ___ ER ___ X-Rays

Past Medical History: Please check any condition you currently have OR have ever had in the past.

___ Asthma ___ Cancer ___ Diabetes ___Blood Clot ___ Anemia ___Depression

___ Anxiety ___ Gout ___ Seizures ___ Stroke ___ Concussion ___Hernia

___ Fibromyalgia ___ Pacemaker ___Heart Problem ___ Infectious Diseases

___ Sleep Problems ___ Varicose Veins ___ Osteoporosis ___ Visual Dysfunction

___ Migraines/Headache ___ Pins or Metal Implants ___ Neurologic Disorder

___ High Blood Pressure ___ Rheumatoid Arthritis ___ Thyroid Trouble/Goiter

Allergies _____

Have you experienced any of these symptoms recently (please check all that apply)

___ Chest Pain ___ Pain with Meals ___ Nausea/Vomiting ___ Dizziness ___ Vision Changes

___ Memory Problems ___Unusual Weakness ___Poor Balance/Falls ___Fever/Chills/Sweats

___ Difficulty Speaking ___ Numbness/Tingling ___Change in Appetite ___Difficulty Swallowing

___ Shortness of Breath ___ Confusion/Brain Fog ___Unusual Pain w/Menstruation

___ Unexplained Weight Loss/Gain ___ Increased Pain at Night/Rest

___Change in Bowel Habits/Control ___Change in Bladder Habits/Control

Other(s) _____

Additional Information

Smoker	Yes	No	If yes, packs per day
Alcohol Use	Yes	No	If yes, drinks per day
Possibly Pregnant	Yes	No	

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

_____ _____ _____

Patient/Legal Guardian Signature **Printed Name** **Date**

Assignment of Benefits

I hereby appoint Phynix Physical Therapy, LLC as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), which I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize Phynix Physical Therapy, LLC to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to Phynix Physical Therapy, LLC and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to PPT not later than ten (10) days after my receipt.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____ _____

Witness Signature Date

phynix
PHYSICAL THERAPY

Consent to Treatment

I consent to and authorize Phynix Physical Therapy, LLC to administer rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation may have some risks. I understand that I have the right to ask about these risks and to have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____ _____

Witness Signature Date

phynix
PHYSICAL THERAPY

HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: Phynix Physical Therapy, LLC
7710 NW 71st Ct, Suite 210
Tamarac, Fl 33321

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with physical therapy services. I expressly request that the designated record custodian of all covered entities under HIPPA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits
- ☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____to_____.

phynix
PHYSICAL THERAPY

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes:

_____

_____

I understand the following: See CFR §164.508(c)(2)(i-iii)

A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
B. The information released in response to this authorization may be re-disclosed to other parties.
C. My treatment or payment for my treatment cannot be conditioned on the singing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative (See 45CFR § 164.508(c)(1)(vi)) Date

_____

Name and Relationship of Legally Authorized Representative to Patient (See 45CFR §164.508(c)(1)(iv))

_____ _____

Witness Signature Date

phynix
PHYSICAL THERAPY

HEALTH INFORMATION PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information.
Please Review This Document Carefully.

About Protected Health Information (PHI).

In this Notice, "we", "our" or "us" means Phynix Physical Therapy and our workforce of employees, contractors and volunteers. "you" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information, we call this Protected Health Information---or "PHI". In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

1. Treatment

   We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation, we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optimal care is rendered.

2. Payment Involving a Third-Party Payer

   After we treat you, we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received, and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third-party payer may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

3. Payment Exclusive of a Third-Party Payer (fully self-pay)

   If you choose to pay for your services, in full, without involving a third party (insurer, employer, etc.) you may request that we do not disclose any information regarding your services for payment purposes.

4. Health Care Operations

We also use and disclose your PHI in our health care operations. For example, our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of actual patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

5. Special Uses

We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

- Update your workers compensation case worker or employer
- *Remind you of appointments*
- *Carry out follow ups on home programs that you have been taught*
- *Release equipment and/or supplies to your designee*
- *Carry out follow ups on your home programs or discharge planning*
- *Advise you of new or updated services or home supplies via telecommunication or via a newsletter (you can choose to opt-out of receiving information of this nature from us)*
- *Carry out research that does not directly identify you*
- *Carry out marketing functions such as providing nominal promotional gifts (you can choose to opt-out of receiving any marketing information or items from us)*
- *Contact you regarding fundraising projects that we are engaged in (you can choose to opt-out of any fundraising project notification that we engage in)*

Note: If we receive direct or indirect financial remuneration from a third party for marketing a product or item or for any fundraising we are engaged in we will offer you the opportunity to 'opt out' from receiving any of these materials.

6. Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

- If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
- We may use your PHI in an emergency if you are not able to express yourself
- If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research; *FACILITYNAME* will always obtain an authorization from you even though it is 'permitted' without one

Required:

- When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
- For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
- To report neglect, abuse or domestic violence
- To the government regulators or its agents to determine whether we comply with applicable rules and regulations
- In judicial or administrative proceedings such as a response to a valid subpoena
- When properly requested by law enforcement officials or other legal requirements such as reporting gunshot wounds
- To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- Deemed necessary by appropriate military command authorities if you are in the Armed Forces
- In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

Some state regulations are more stringent than federal privacy regulations, so we comply with those laws.

7. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

8. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure

  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right

- Your Right to Confidential Communication

  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing

- Your Right to Inspect and Copy Your PHI

  You have the right to inspect and copy your PHI. If we maintain our records in paper, that will be the format utilized; however, if we maintain our records electronically you have the right to review and/or have copies made in an electronic format. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within *thirty (30) days*, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.

- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI, you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope

- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that right. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment, we must notify you and make effort to notify others who have the original record

- Your Right to Know Who Else Sees your PHI

  You have the right to request an accounting of certain disclosure that we have made over the past six years. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually. We have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.

- You have a right to be informed of a breach your protected health information

  We are required to notify the patient by first class mail or by e-mail (if indicated a preference to receive information by e-mail), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than *sixty (60) days* following the discovery of the breach. “Unsecured Protected Health Information” is information that is not secured through the use of a

technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

a) A description of the breach, including the date of the breach and the date of its discovery, if known
b) A description of the type of unsecured protected health information involved in the breach
c) Instructions regarding the measures the patient should take to protect him/her from potential harm resulting from the breach
d) Correction action Phynix Physical Therapy has/will take to investigate the breach, mitigate losses, and protect the patient from further breaches
e) Phynix Physical Therapy contact information, including a toll-free telephone number, e-mail address, Web site or postal address to allow for additional questions

- You Have a Right to Complain

  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us by contacting our HIPAA officer noted in Section 10, or to 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 if you file a complaint about us. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

- The Patient Has the Right to Receive a Copy of the Privacy Notice

  Phynix Physical Therapy is obligated to provide the patient with a copy of its Notice of Privacy Practices and to post the Notice in a conspicuous place for patients to access as well as on our website. We have the right to change the Notice to comply with policy, rules or regulatory changes; we are obligated to give new notices to current and subsequent patients as changes are made. We are required to maintain each version of a Privacy Notice for a minimum of six (6) years.

9. Some of Our Privacy Obligations and How We Perform Them

   - 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 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

If we change our Notice of Privacy Practices, we will provide our revised Notice to you when you next seek treatment from us.

10. Contact Information

    If you have questions about this Notice, or if you have a complaint or concern, please contact:

    Phynix Physical Therapy
    Attention: Shawn Morgan
    7710 NW 71st Court, Suite 210
    Tamarac, Florida 33321

11. Effective Date: This revised notice takes effect on 8/12/2021

Notice of Privacy Practice

I hereby acknowledge that I have been made aware of the Notice of Privacy Practices of Phynix Physical Therapy, LLC. I further acknowledge that a copy of the current notice is available at the front desk and online, and that I may request a copy of any amended Notice of Privacy Practices at any time.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____ _____

Witness Signature Date