Marino Physiotherapy **Patient Health History**

Name_____ Age _____ Height _____ Weight _____ lbs.

Date of Birth: ____ /____ /_____ Why did you choose Marino Physiotherapy?_____

Please CIRCLE* all *that apply: I am**: MALE FEMALE PREGNANT** Do you use tobacco? **YES NO**

Occupation: _____ **Retired Disabled Unemployed** Did this injury happen in an accident? **YES NO**

During the last month have you been feeling down, depressed or hopeless? **YES NO** Do you feel safe in your own home? **YES NO**

How many falls have you had in the last year? **0 1 2 >2** **None, but I often lose my balance and must catch myself**

Have you **EVER** had any of the following conditions? Date of **Next MD appointment**:_____

Cancer	Emphysema/Bronchitis	Alzheimer's	Anemia	Headaches	Balance Problems
Heart Problem/Surgery	High Blood Pressure	Hepatitis	Arthritis	Fibromyalgia	Chemical Dependency
Orthopedic Surgery	High Cholesterol	HIV/AIDs	Asthma	Incontinence	Depression
Osteoporosis/Osteopenia	Stroke/TIA	MS	Diabetes	Respiratory Problems	Fatigue
Pacemaker	Thyroid Problems	Parkinson's	Gout	Sleep Apnea/Insomnia	Other:
Corticosteroid Use	Tuberculosis	Rheumatoid	Seizures	Vision/Hearing Issues	

Have you noted any of the following in the last 3 months? Weight Loss/Gain Nausea/Vomiting Night Pain Fatigue
Fever/Chills/Sweats Numbness or Weakness Dizziness/Lightheadedness

Tell us about your condition:

I am here to address my problem with:_____

How limited are you by this condition? **Not at all 0% - 20% - 40% - 60% - 80% - 100% Completely Limited**

When did you first notice the pain/problem?_____

Describe your **PAIN**: **None = 0 1 2 3 4 5 6 7 8 9 10 =Worst** **Variable** or **Constant, Local** or **Spreading, Improving** or **Getting Worse**

What caused this pain/problem?(accident, injury, unknown)_____

What makes your problem **worse**?_____

What makes your problem **better**?_____

What have you done for this condition? MEDICINE INJECTION SURGERY EXERCISE STRETCHING REST CHIROPRACTIC ACUPUNCTURE OTHER :_____

What's your pain stopping you from doing?? _____

What do you expect to accomplish with therapy?_____

Have you had any of these tests/referrals for **this** condition? **XRay MRI CT Scan Blood Work Nerve Test Orthopedic Neurologist**

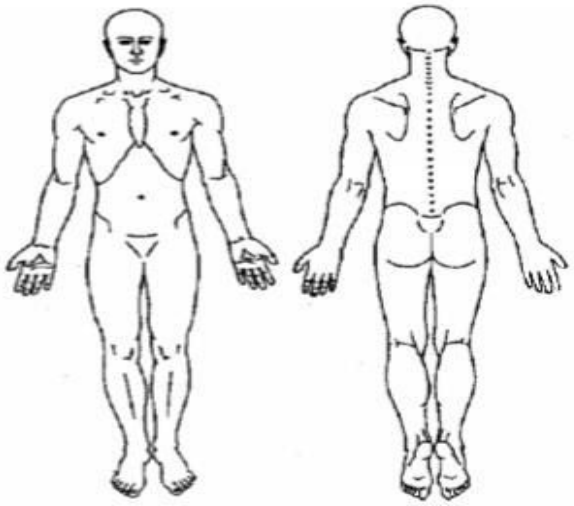
I attest that this information is thorough and correct to the best of my knowledge.

Please indicate on the body below where your symptoms are:
xx Pain ///Numbness ++ Stiffness = = Tightness

X_____ _____
Signature Date

For Clinician Use: Freq/Dur Plan:

24h - N/T toes/fingers/face- RA - Dizz - N/V - Ataxia - Severe HA - Bil/Quad/PeriOral Paresthesia - AntiCoagulant
Drop Attacks - Diplopia - Dysarthria - Cough c Radic. pain - Steroid - Tobacco - Birth Control - High Cholesterol -
HTN - Obesity - CVA / MI / CABG/ DM **0%CH 0-19%I 20-39%J 40-59%K 60-79%L 80-100%M 100%CN**
Back Index Neck Index DHI Q-Dash LEFS Tinetti TUG FOTO SCORE:



Marino Physiotherapy **Current Medication List**

SAVE TIME! **If you already have a current medications list, please allow our receptionist to photocopy it for you.**

PLEASE LIST ALL THE **PRESCRIPTION** MEDICATIONS YOUR ARE CURRENTLY TAKING

Name of Medication	Dosage (if known)	How Often You Use the Medication	Condition the Medication is for:

LIST ALL **OVER-THE -COUNTER MEDICATIONS** YOU ARE CURRENTLY TAKING

Name of Medication	Dosage (if known)	How Often You Use the Medication	Condition the Medication is for:

LIST ALL **HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS** YOU ARE CURRENTLY TAKING

Name of Medication	Dosage (if known)	How Often You Use the Medication	Condition the Medication is for:

Are you allergic to: ☐Latex ☐Adhesives ☐Other_____

☐ I am not allergic to anything

It is always a good idea to keep your medication list current. Please let us know if you have any changes or would like a copy of this list for your own records. I attest that the above information is accurate to the best of my knowledge.

Patient Signature_____ Date: _____

Full Legal Name: _____ Primary Care Physician: _____

Home Address: _____City, State, Zip _____

Phone Number: _____Social Security #_____Date of Birth: ____/____/____

Emergency Contact: _____Relationship: _____ Phone: _____

Please Circle Insurance Type: WORK COMP AUTO HEALTH PRIVATE PAY

Primary Insurance Company: _____ Secondary Insurance Company: _____

Responsible Party: _____Phone: _____Relationship: _____

Are you currently receiving home health care? **YES NO** HAVE YOU ALREADY HAD OUTPATIENT PT or OT this year? **YES NO**

Email: _____

Marino Physiotherapy Policies and Practices

Please initial each section and sign at the end

_____ **NOTICE OF PRIVACY PRACTICES** I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: * Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. * Obtain payment from third-party payers. * Conduct normal healthcare operations such as quality assessments and physician certifications. I acknowledge that **I may request a copy of Marino Physiotherapy's Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that Marino Physiotherapy has the right to change its Notice of Privacy Practices from time to time and that I may contact any of their locations at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that Marino Physiotherapy restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Marino Physiotherapy is not required to agree to my requested restrictions, but if Marino Physiotherapy does agree, then they are bound to abide by such restrictions.

_____ **ATTENDANCE POLICY** Our goal is to help you achieve your maximum rehab potential. In order for this to happen, you will need to keep your appointments. Please call as early as possible if you must cancel an appointment and we will be happy to reschedule you. We reserve the right to discharge you back to your physician if you miss 2 appointments without cancelling or are missing visits often enough to affect the progression of your care. Your physician will be notified of poor attendance. WORKERS COMPENSATION: We are required to notify your Adjuster/Case Manager of any missed/cancelled visits. It is also required all missed visits be rescheduled.

_____ **RELEASE OF INFORMATION AND CONSENT TO TREATMENT** I consent to be treated by Marino Physiotherapy. I authorize Marino Physiotherapy to request any information regarding illness, injury, medical history, treatment, or copies of medical records from other health care providers. I authorize Marino Physiotherapy to release any information requested by my insurance company or other health care providers, regarding my medical history, treatment, evaluation, or any other subjective history.

_____ **PATIENT RECORD OF DISCLOSURES** In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home. **I may to be contacted via Telephone: __ OK to leave detailed message __ Leave message with call back number only**

_____ **ASSIGNMENT OF MEDICAL BENEFITS and ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY** In order to accommodate you, (our patient), we will contact your insurance to determine your level of benefits and to obtain pre-authorizations when required. However, this is not a guarantee of payment. Therapy benefits will vary with each insurance company. WE SUGGEST THAT YOU ALSO VERIFY YOUR INSURANCE BENEFITS TO FULLY UNDERSTAND WHAT IS AND WHAT IS NOT COVERED. As a courtesy to you, (our patient), Health Insurance Claims, Auto Insurance Claims, and Workers' Compensation **Claims are filed by Marino Physiotherapy**. I authorize and instruct my insurance company to make checks payable to Marino Physiotherapy, and mail directly to Marino Physiotherapy, 8904 Cross Park Drive, Knoxville, TN 37923.. If you think your insurance company has not processed your claim correctly you should contact them directly. **If your insurance company requires a co-pay or co-insurance, you will be expected to pay this at each visit**. Should your insurance require a deductible and/or co-insurance, you will have a predetermined expected payment per session until your deductible is met. You will receive a statement each month for any remaining balance on your account, which is due upon receipt. Additional statements for unpaid balances will each incur a $5 statement fee to cover administrative costs . Our cash rate discount is only available when paid on the day that services are rendered.

_____ **FINANCIAL RESPONSIBILITY** **You are ultimately responsible for the financial resolution of your bill.** You are financially responsible for any and all charges you incur that are not covered by your insurance or Workers' Compensation. In the case that your Workers' Compensation claim is not accepted by your Work Comp carrier, and they refuse to pay, you will be responsible for payment in full. Marino Physiotherapy does not file third-party or Automotive claims, and these circumstances require either payment through private insurance or payment per cash rate at the time of service. **Co-pays and/or Co-insurances are due on the date services are rendered**. Any remaining balance will be billed to you. Should Marino Physiotherapy be required to employ an attorney to enforce payment for treatment rendered, you will be expected to pay reasonable attorney fees, court costs and interest for such enforcement. If you have questions regarding this agreement, please contact us at 865-236-0340.

_____ **MEDICARE PATIENTS** **Effective Jan 1, 2019, MEDICARE has removed the therapy cap, but does reserve the right to audit for medical necessity and claims that exceed $2,040 per patient, per calendar year.** This typically provides for about 17-23 therapy visits per calendar year before needing documentation of medical necessity. **Medicare has provided an exception process in cases of medical necessity**, ask your therapist if you qualify for this if you anticipate exceeding this cap. If you do not qualify for this exemption, then you will be financially responsible for any services beyond this capped amount. THIS IS WHY IT IS CRITICAL THAT YOU NOTIFY US OF ANY PRIOR THERAPY SERVICES THIS YEAR. I have read and understand the Medicare changes. I understand that I have financial responsibility for Medicare coinsurance, the annual deductible, and all charges exceeding the cap limit.

I hereby consent to the use and disclosure of my personal health information as stipulated in Marino Physiotherapy's Notice of Privacy Practices. I agree to abide by the Marino Physiotherapy Policies and Practices and acknowledge my financial responsibility as listed above.

Patient/Guardian Signature_____ Date _____