



Upright Athlete Physical Therapy

4221 Garrett Rd. Ste 1, Durham, NC 27707 Phone/Fax: (919) 493-1204

Brian Diaz, PT, CSCS - Norah Whitten, PT, DPT, CSCS - Sam Ray, PT, DPT

Physical Therapy Patient Intake Form

Please Select: Private Insurance Self-Pay Worker's Compensation Gift Certificate

**We do not accept Medicare/Medicaid insurance*

Today's Date: _____ Client File # (*office only*): _____

Last Name: _____ First Name: _____ MI: _____

(Preferred Name): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Home Email: _____

Emergency Contact Name/Relation: _____ Phone: _____

DOB: _____ SSN: _____

Sex: Male Female Marital Status: Single Married Other

Employment Status: Employed Full-Time Student Part-Time Student Retired

Occupation: _____ Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Company: _____

Subscriber's Name (if different): _____ ID #: _____

Subscriber's DOB (if different): _____ Group ID #: _____

Patient's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance Company (if applicable): _____

Secondary Subscriber's Name: _____ ID #: _____

Secondary Subscriber's DOB: _____ Group ID #: _____

Patient's Relationship to Subscriber: Self Spouse Child Other

How did you hear about us? _____

Referring Physician: _____ Phone/Fax: _____

Medical Information

Current Problem/Diagnosis: _____

When (approximately) did your symptoms start? _____

Is this related to a: Work Injury? Auto Injury? If Auto-related, State: _____

If applicable, Attorney Name: _____ Attorney Phone: _____

Is this post-surgical? Yes No Date of Surgery: _____

Have you had an x-ray, MRI, or other imaging for this problem? Yes No

If yes, please list, including date: _____

Significant past medical/injury history (*with dates*):

Allergies:

Current Medications:

Written Release of Medical Records Acknowledgement

The following authorizes the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special tests, x-rays, MRIs, or lab results to this office.

I, _____, will allow the release of all relevant medical records to Upright Athlete Physical Therapy.

Patient or Guardian Signature

Date



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Financial Policy

We are committed to providing you with the best possible care. In order to achieve these goals we need your assistance and your understanding of our payment policy.

We will be happy to submit your insurance claims for you. We will require a copayment, coinsurance, or deductible at the time of service. We will obtain a quote of benefits as a courtesy to our patients, and we are, at no time, to be held responsible for incorrect information that has been provided by your insurance company. We provide you with a summary of your benefits - not a guarantee of payment. Eligibility and benefits will be determined at the time your claims are processed. The copayment, coinsurance, or deductible due at the time of service is an approximation of the amount you are responsible for based on your insurance coverage.

If you are unable or not prepared to make a payment, please let us know before you see the physical therapist. We will be more than willing to work out an alternative payment plan. We accept cash, card, or check. Finance charges of 1.5% are automatically added monthly to accounts that are 90 days old or older. There is a charge of \$20.00 on all returned checks.

- ! **We have 12-hour cancellation policy. Physical Therapy appointments MUST call to cancel, or they will be charged a \$35 “no-show” fee.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, you must realize that:

1. Your insurance is a contract between you and your insurance company
2. Our fees are generally considered to fall within the acceptable range of most companies, and therefore are covered up to the maximum allowance determined by the insurance company
3. You are responsible for all services rendered at Upright Athlete and ActivEdge Fitness & Sports Performance if said charges are non-covered, partially-covered, or in the event you have no insurance coverage. Also, if it is necessary to collect amounts due by legal methods and/or outside agencies, you are responsible for all related costs, including attorney fees.

Auto Accident Only: If you are involved in a motor vehicle accident but we are filing with your insurance company, you will be required to make payment each visit and a monthly payment after discharge from physical therapy until balance is paid to us out of the settlement proceeds.

*We must emphasize that as medical care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, **all charges are your responsibility** for the date services are rendered. We realize that temporary financial problems may effect timely payment. If such problems arise, we encourage you to contact us for assistance in the management of your account.*

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ACTIVEEDGE FITNESS & SPORTS PERFORMANCE. I HAVE READ (OR HAVE HAD READ TO ME) THE INFORMATION ON THIS FORM AND UNDERSTAND MY RESPONSIBILITIES.

Patient or Guardian Printed Name

Patient or Guardian Signature

Date



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Notice of Privacy Practices

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.

Uses and Disclosures

Treatment

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations

Your health information may be used as necessary to support the day-to-day activities and management of ActivEdge. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement

Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Lawsuits and Similar Proceedings

Our practice may use and disclose your health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your health information in response to a discovery request, subpoena, or other lawful process by another party involved in a dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Worker's Compensation

Our practice may release your health information for worker's compensation and similar programs.

Other uses and disclosures require your authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders

Your health information will be used by our staff to send you appointment reminders.

Information about treatments

Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your protected health information

4. The right to amend or submit corrections to your protected health information
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

ActivEdge Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Administrator, ActivEdge, 4221 Garrett Rd. Ste 1-2, Durham, NC 27707

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Administrator, ActivEdge, 4221 Garrett Rd. Ste 1-2, Durham, NC
27707, (919) 493-1204

Effective Date

This Notice is effective on or after January 1, 2019