PATIENT INFORMATION

Referring Physician:_____

Last Name:_____ **First Name:**_____ **M.I.**_____ **Date of Birth:**_____

SSN:_____ Sex: **F** or **M** Age:_____ Marital Status: M___ S___ D___ W___

Home Address:_____City:_____ State:_____ Zip:_____

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

E-mail Address:_____ Family Physician:_____

Emergency contact name:_____ Phone:_____ Relation:_____

Where did you hear about us? _____

Reason for visit or type of injury: (circle) Job Related Auto Accident Liability Situation Sports Other

Date of Onset/Injury:_____ Body Part(s) Being Treated:_____
Explanation:_____

Are you taking any medications? If so, please list below (or provide a copy): *COPY PROVIDED* *Yes* *No*

MEDICATIONS, herbs, vitamins, supplements	DOSAGE	FREQUENCY	METHOD (orally, etc)

EMPLOYMENT INFORMATION:
Employer:_____ **Occupation:**_____ **Phone:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Circle Status: FT PT Unemployed Disabled Retired Student

INSURANCE INFORMATION:
PRIMARY Insurance Company:_____ **Relation to Insured:**_____
Name of Insured:_____ Insured's Employer:_____DOB:_____

SECONDARY Insurance Company:_____**Relation to Insured:**_____
Name of Insured:_____ Insured's Employer:_____ DOB:_____
If Medicare is secondary state reason: working aged benefit_____; disabled benefit_____; veteran's admin_____;
work comp____; public health_____; other_____

I authorize the release of any medical information to process insurance claims and further authorize payment of medical benefits to HEALTHY EXPECTATIONS, INC.

Authorized Signature:_____ **Date:**_____

PATIENT HISTORY QUESTIONNAIRE

NAME: _____ **DATE**: _____

1. What is your primary problem? _____

2. How did your problem begin? _____

3. What date did your problem begin? _____

4. Have you had anything similar before? **YES** or **NO** If yes, describe: _____

_____

5. Were you free of symptoms before this onset? **YES** or **NO** _____

6. What, if any, treatment have you had for this current condition? _____

7. Please rate your pain level on a scale of 0-10, (10 = emergency room, 0 = no pain):

RIGHT NOW:_____ **BEST**:_____ **WORST**:_____

8. On a functional scale of 0-100% (100% is normal), where do you feel you are functioning? _____

9. Is your pain:

____**CONSTANT-***no change with activity* ____**INTERMITTENT** ____**CONTINUOUS-***changes with activity*

10. Do you experience pain, tingling, or numbness traveling beyond the area or dysfunction? **YES** or **NO**

If yes, where? _____

11. When is your pain level the least? _____

12. What makes the pain worse? _____

PERSONAL MEDICAL HISTORY - Do you have any of the following problems?

___ Lumps, Growths, or Tumors	___High Blood Pressure	___ Low Blood Pressure
___Gallbladder Condition	___ Respiratory/ Lung Condition	___ Epilepsy or Convulsive Condition
___ Diabetes or Hypoglycemia	___ Ear, Nose Throat, Eye Problems	___ Skin or Dermatologic Condition
___ Birth Defect or Abnormalities	___ Blood Condition	___ Liver Condition
___ Sinus Condition	___ Rheumatism, Arthritis	___ Kidney/ Bladder Condition
___ Recurrent Infections Condition	___ Circulatory/ Vascular Condition	___ Neurological Condition
___ Cancer	___ Heart Ailment	___ Depression
___ Osteoporosis	___ Stomach or Intestine Condition	___Anxiety

JOB STATUS:

1. Are you currently working? YES or NO Restrictions: _____

2. If not working, what was the last date of work? _____

3. What are your goals or expectations from receiving physical therapy? _____

FALLS: (**Definition of "Fall"** - sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.)

Have you have 2 or more falls in the past 12 months? **YES NO**

Have you had one fall with injury in the past 12 months? **YES NO**

COMMITMENT TO THERAPY

We are committed to your recovery. We have reserved a 45-60 minute one-on-one appointment with your therapist, dedicated to helping you reach goals. We are requesting the same level of commitment from you. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. To ensure optimal results it is very important for you to attend therapy consistently. If you must reschedule an appointment, we ask that you give us at least a 24-hour notice.

To cancel or reschedule your appointment, CALL us at (260) 483-9933.
DO NOT send an e-mail or text to cancel, as no one will receive them.

Cancellations/No Show Appointments:
*****Cancellations made more than 24 hours in advance of your scheduled appointment time will not be charged.
*****If an appointment is cancelled with less than 24-hour notice, or you fail to show for your appointment, you will be charged a LATE CANCEL or NO-SHOW fee of $35.00 for the missed appointment. This cancellation policy is strictly enforced. On occasion, there will be understandable reasons allowed; however, waiving this fee is solely under the discretion of your provider.
Reasons for this policy: Notifying Healthy Expectations of your intention to cancel and/or reschedule 24 hours in advance allows us the opportunity to adjust your provider's schedule to allow another person to be seen in this time frame. This is very important because others may be on a waiting list or experiencing difficulties that require a more urgent appointment. The notice will allow for this transition.

If a cancellation without a 24-hour notice or a NO-SHOW to a scheduled appointment occurs, you will be charged a $35.00 fee.

Patient Signature:_____ **Date:**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

☐ Please check the box stating you have received the Notice of Privacy Practices (HIPAA) from Healthy Expectations -- (on clipboard) If you would like a copy of this notice, please ask the front desk.

Protected Health Information (PHI)

If there is anyone who needs access to your personal medical, account, or financial information, please list their information below, authorizing our office to speak with that person.

Name & Relation:_____ Phone #_____

Name & Relation:_____ Phone #_____

Name & Relation:_____ Phone #_____

Patient Signature:_____ Date:_____

In Indiana you can be evaluated and treated in physical therapy without a doctor's referral. This process is called DIRECT ACCESS. It gives patients the ability to begin physical therapy in a timely manner, which studies have shown results in improved functional outcomes and lower cost of care. You can receive treatment for up to 42 calendar days before having to involve a physician. If you have come to Healthy Expectations through DIRECT ACCESS, and you would like a copy of your evaluation sent to a doctor of your choice, you will need to list the doctor(s) name above.

ASSIGNMENT OF MEDICAL BENEFITS AND

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

ASSIGNMENT OF BENEFITS

The undersigned hereby assign(s) to HEALTHY EXPECTATIONS, INC. ("Provider"), and all private medical insurance benefits (primary and secondary) or Medicare benefits to which the patient may be entitled for services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on the patient's behalf.

FINANCIAL RESPONSIBILITY

1. If Provider is billing your insurance, the undersigned fully understands that he/she may be financially responsible for services rendered and for any balance after insurance has processed all claims.

2. The undersigned agrees to complete other documents that may be requested by your insurance or Provider to complete the process of your treatment or claims.

3. If this claim is determined by the undersigned's workers compensation carrier to be a non-work related, the undersigned agrees to be financially responsible.

4. I further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at discharge, or within 30 days of discharge, to pay for in-office processing fees. I further agree to pay collection costs and reasonable attorney fees if this account is placed in the hands of a collection agency or attorney.

5. The undersigned agrees to call and notify Provider if unable to keep his/her scheduled appointment. Provider has the right to bill the patient a $35.00 fee if the patient cancels their appointment with less than 24 hours' notice, or is a NO SHOW for their appointment. If 2 or more appointments are **NO SHOW** or **NO CALL**, services may be discontinued due to non-compliance.

AUTHORIZATION FOR TREATMENT AND INFORMATION RELEASE

AUTHORIZATION FOR TREATMENT

1. The undersigned hereby authorizes Provider to render any and all therapy services, or other related services that Provider feels are necessary or advisable to the patient in conjunction with physician referral. The patient shall cooperate fully with all requests to Provider in connection with Provider's rendition of therapy and related services.

2. The undersigned hereby certifies that all information given by the undersigned in applying for payment under Title XVII of the Social Security Act, provided to Provider is true and correct in all respects.

RELEASE OF INFORMATION

The undersigned hereby authorizes Provider to disclose any information furnished by Provider or obtained by Provider in connection with the patient's treatment to your referring physician(s) or your insurance company.

I have read the above and fully understand the terms of this document.

_____

Patient's Printed Name

_____ _____

Patient's Signature Date Witness Date

Consent of Unencrypted E-mails and Encrypted Text Messages

We offer helpful administrative information by regular text messaging and e-mail like appointment reminders. There is some level of risk that information in a regular text message or e-mail could be read by someone besides you. Healthy Expectations will never use your protected health information (PHI) inside these messages nor sell your information to 3rd party advertisers. Please let us know if we can communicate with you by text message and/or e-mail. Check all that apply to you.

- ☐ **Yes** – Please communicate with me by unencrypted e-mail. My e-mail address is:
  _____

  (I will let Healthy Expectations know right away if my e-mail changes)

- ☐ **Yes** – Please communicate with me by encrypted text message. My cell phone number is
  _____

  (I will let Healthy Expectations know right away if my cell number changes)

- ☐ **No**-Please do not communicate with me by unencrypted e-mail

- ☐ **No**-Please do not communicate with me by encrypted text message

Appointment reminder e-mails and text messages are provided as a courtesy, given a valid cell phone number and legible e-mail address are provided. By the signing of this policy, I understand that at times these automated messages may not always work due to technical difficulties, and they should not be relied upon to remember appointments. By signing, I agree to be responsible for knowing when upcoming appointments are scheduled.

By signing below, you certify that you have read and understand the above information regarding correspondence through unencrypted e-mail or encrypted text message.

Sign _____ Date _____