ATHLETICO PHYSICAL THERAPY | PIVOT PHYSICAL THERAPY

Patient Intake Paperwork

Date _____ Legal Name _____
(First) (Middle) (Last)

Preferred Pronoun: He/ Him ○ She/Her ○ They/Them ○ Only My Name ○ No Preference ○ Pronoun not listed: _____

Chosen Name or Nickname _____ Date of Birth _____ Age _____

Sex listed on Insurance Male ☐ Female ☐

Address: _____
(Street) (City) (State) (Zip Code)

Preferred method of communication: Cell Phone ☐ Home Phone ☐ Day Phone ☐ Email ☐

Preferred Phone # _____ **To receive messages related to appointment reminders, insurance and billing information via telephone, SMS text messaging, and/or email, please check here*** ☐

*By checking the box above, I authorize Athletico Physical Therapy to send me information about my appointments, appointment reminders, and insurance, account or billing items via email, SMS text message, or my preferred phone, or any other phone number that I provide to Athletico. I also authorize Athletico personnel to leave a voice mail with information related to my appointments, appointment reminders, insurance, account or billing items. I also represent that I understand that there is some level of privacy risk associated with each of these forms of communication.

Consent to Email Communication

I agree to receive email communication regarding appointment updates and marketing communication from Athletico Physical Therapy at the following email address: _____

What is your primary language? _____ Do you need an interpreter? Yes ☐ No ☐

You have the right to an interpreter at no cost. If you need these services, notify your Clinician or Office Coordinator.

Employer Name _____ Employer phone _____

Employer Local Address _____

HR Department Contact _____ HR Dept. phone _____

How did you hear of Athletico? (Please choose one below)

Advertisement ☐ Internet ☐ Athletico Website ☐ School ☐ Club Sport ☐ Performing Arts ☐ Insurance ☐

Professional Sports Team ☐ Race ☐ Endurance Training Group ☐ Athletico Location/Signage ☐ Physician Referral ☐

Other ☐ Please specify name/organization: _____

Consent to Verbal Communication

I give permission to the following person(s) to receive detailed verbal information regarding my appointments, medical care, billing and payment information. I understand this **DOES NOT** authorize the disclosure of my written health information.

Name _____ Relationship _____

Name _____ Relationship _____

Emergency Contact Information

Person to contact in case of an emergency:

_____ _____ _____
Name Telephone Number Relationship

Physician Information

Referring Physician _____ Phone _____

Address _____

Next physician appointment: **Date** _____ **Time** _____

Do you have a Primary Care Physician? Yes ☐ No ☐

If yes, would like us to send copies of correspondence to your primary care physician? Please complete:

Primary Care Physician _____ Phone _____

Address _____

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Insurance

Have you verified your therapy benefits with your insurance? Yes ☐ No ☐

Have you had Physical/Occupational therapy this calendar year? Yes ☐ No ☐

How many treatments (include Chiropractic) have you received this calendar year? _____Former Patient? Yes ☐ No ☐

Health Insurance

Primary Insurance Company _____ID#_____Group #_____

Policyholder name _____Relationship _____DOB _____

Secondary Insurance Company _____ID# _____Group # _____

Policyholder name _____Relationship _____DOB _____

Auto Accident / Personal Injury

Is this an Auto Accident? Yes ☐ No ☐ Is this a Personal Injury? Yes ☐ No ☐

Date of Accident _____

In what City and State did this occur? _____ Is this a lawsuit? Yes ☐ No ☐

Attorney/Firm Name _____Attorney Phone _____

Work Comp (ONLY complete this section if you experienced a work-related injury)

Please make sure Employer information is filled out on previous page.

Is this an approved Workers Comp Injury? Yes ☐ No ☐ Date of Injury _____

In what City and State did the injury occur? _____

Have you engaged an attorney for legal representation with regards to this work injury? Yes ☐ No ☐

Attorney/Firm Name _____ Attorney Phone _____

Job Title _____ Length of Service with Employer _____

Current work status for the job with which you were injured? Full Duty ☐ Modified Duty ☐ Not Working ☐

Have you recently been seen in the emergency room (ER) for pain as a result of this work injury? Yes ☐ No ☐

Have you recently had surgery or been admitted for a hospital stay? Yes ☐ No ☐

Have you experienced an onset of pain, tingling, burning, and/or weakness in your buttock, thigh, or foot (back injury), or shoulder, arm, or hand (neck injury)? Yes ☐ No ☐

Do you now or have you ever you ever had: Diabetes? Yes ☐ No ☐ Depression? Yes ☐ No ☐

Anxiety? Yes ☐ No ☐ High Blood Pressure? Yes ☐ No ☐

Are you presently taking narcotics or opioids for pain management? Yes ☐ No ☐

Are you currently taking blood thinners? Yes ☐ No ☐

Do you feel that you have ever had a substance abuse problem? Yes ☐ No ☐ Sometimes ☐

Have you experienced an absence from work in the past due to a work injury? Yes ☐ No ☐

Do you have the ability to elect to work overtime? Yes ☐ No ☐ Are you required to work overtime? Yes ☐ No ☐

Medical History

What problem(s) are you being treated for today? Describe type and location of symptoms _____

_____

What date (roughly) did your present symptoms start? _____

My symptoms are currently: Getting Better ☐ Getting Worse ☐ Staying the Same ☐

My symptoms currently: Come and go ☐ Are Constant ☐ Constant, but change with activity ☐

What makes your symptoms better? _____

What makes your symptoms worse? _____

What time of the day are your symptoms worse?: Morning ☐ Afternoon ☐ Evening ☐ Overnight ☐

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Have you recently noted any of the following? (Check all that apply)

- ☐ Changes in bowel or bladder function
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Weakness/fatigue
- ☐ Headaches
- ☐ Difficulty maintaining balance while walking
- ☐ Difficulty swallowing
- ☐ Weight loss/gain
- ☐ Numbness/tingling
- ☐ Fever/chills/sweats
- ☐ Pain at night
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Changes in appetite

Treatment received so far for this problem: Chiropractic ☐ Acupuncture ☐ Injections ☐

Physical/Occupational therapy Other _____

Special Tests done: X-Ray ☐ Bone Scan ☐ CT Scan ☐ MRI ☐

List past Medical History (i.e. falls, surgeries, pacemaker) including dates (indicate if for current condition) _____

_____

_____

Are you pregnant? If yes, how many weeks? _____

If pregnant, have you experienced pregnancy related pain? _____

MIPS

BMI Screening: Height _____ Weight _____

Depression Screening: Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things: Not at all ☐ Several Days ☐ More than one half of days ☐ Nearly every day ☐
- Feeling down, depressed, or hopeless: Not at all ☐ Several Days ☐ More than one half of days ☐ Nearly every day ☐

Medications: Are you currently taking/using any medications, herbals, vitamins, supplements, or cannabis products? Yes ☐ No ☐
If Yes, please list below.

Medication Name	How much (dose)	How often	How taken (circle one)
_____	_____	_____	ointment ☐ pill ☐ drop ☐ patch ☐ injection ☐ inhaler ☐
_____	_____	_____	ointment ☐ pill ☐ drop ☐ patch ☐ injection ☐ inhaler ☐
_____	_____	_____	ointment ☐ pill ☐ drop ☐ patch ☐ injection ☐ inhaler ☐
_____	_____	_____	ointment ☐ pill ☐ drop ☐ patch ☐ injection ☐ inhaler ☐

List any allergies (i.e., medications, latex, adhesives) _____

Falls Screening:

- Number of falls within the last year? 0 ☐ 1 ☐ 2+ ☐
- Did a fall result in injury? Yes ☐ No ☐

Abuse/Maltreatment Screening: Are you suffering from abuse (ex: physical, emotional, psychological), neglect, abandonment, material exploitation, or unwarranted control? Yes ☐ No ☐

Alcohol Screening: How many times in the last year have you had 5 (for men) or 4 (for women and all adults over 65 years old) drinks in a day? _____

Tobacco Screening (12+ years old): Have you utilized tobacco in the last 6 months? (Check one) Yes ☐ No ☐

Pelvic Health Screening:

- Do you have an active diagnosis of urinary incontinence from a physician? Yes ☐ No ☐
- Regardless of active diagnosis, are you presently experiencing urinary incontinence? Yes ☐ No ☐
- Are you experiencing any other pelvic health symptoms or concerns (i.e., pelvic floor heaviness, pelvic/bladder or abdominal pain, irregular bowel movements)? Yes ☐ No ☐

Social History/Leisure Activities/Exercise Routine

Home ☐ House ☐ Condo/Apartment ☐ Group Residence ☐ Nursing Home ☐

Do you live alone: Yes ☐ No ☐

Are you currently working: Full Duty ☐ Light Duty ☐ Not working ☐ If not working, date last worked _____

Athletico Physical Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, age, religion, sex, national origin, socioeconomic status, sexual orientation, gender identity or expression, disability, veteran status, or source of payment. You will be treated with dignity, compassion, and respect as an individual.

If you have any questions, please contact: 1-877-ATHLETICO | email: info@athletico.com

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Consent and Statement of Financial Responsibility

1. CONSENT FOR TREATMENT: I hereby consent to, and authorize my physical therapist, occupational therapist and other health care professionals and assistants who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist, occupational therapist or other healthcare professionals. .I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin, soreness after treatment and hematoma, including, without limitation, myofascial decompression and blood flow restriction, Assisted Soft Tissue M obilization, Asytm ® or Graston Technique®, Video Throwing Analysis and Video Gait Analysis. I understand that it is my responsibility to inform my physical therapist, occupational therapist or other health care professional if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and I understand that cancellation of, or failing to keep, an appointment with less than 24 hours' notice will result in a cancel/no show fee of $30 or $60 depending on appointment type.

WORKER'S COMPENSATION PATIENTS: I understand that Athletico is required to inform my Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. I understand that any missed visits must be rescheduled.

3. RESPONSIBILITY FOR PAYMENT: All co-payments and self –pay services (i.e., Astym, Graston, VGA, VTA, etc.) are due at the time of service. I acknowledge that in consideration of the services provided to me by Athletico, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Athletico with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I agree to pay any such amounts which are my responsibility. I understand that Athletico will bill my personal insurance carrier as a courtesy, but that I am ultimately responsible for any amounts owed. If formal collection procedures become necessary, I am responsible for any additional costs incurred as a result of such collection procedures.

If I pay any amount with a check, I hereby authorize Athletico to use the information from the check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from my account. I understand that if my payment is processed as an EFT, funds may be withdrawn from my account as soon as the same day and I will not receive my check back from my financial institution.

Please note that refusal to sign this form does not change responsibility for payment in any way.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Athletico all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with Athletico and to provide such information as is needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Athletico may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Athletico's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Athletico's *Notice of Privacy Practices* and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

☐ I acknowledge that I have received Athletico's *Notice of Privacy Practices* and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information. *(Please check box)*

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____ _____
Printed Name of Patient

_____ _____
Signature of Patient or Legally Responsible Person Date

_____
Printed Name of above (if not the Patient) Date

Athletico complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you have any questions, please contact: 1-877-ATHLETICO | email: info@athletico.com

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Your information. Your rights. Our responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and how to exercise them.

Receive an electronic or paper copy of your medical record

- You can ask to see or receive an electronic or paper copy of your medical record. You may submit your request in writing.
- We will provide a copy or a summary of your health information within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct or amend your medical record

- You can ask us in writing to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we will tell you why in writing.

Request confidential communications

- You can ask us to contact you in a specific way (for example, cell phone) or to send mail to a different address. We will accommodate all reasonable requests.

Ask us to restrict or limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Notification of a breach

- We will notify you if there is a breach of your health information.

Ask for a list of certain disclosures with whom we've shared information

- You may ask for a list of certain disclosures of your health information made by us, if any. This list will not include disclosures, about treatment, payment, or health care operations and certain other disclosures you may have asked us to make.
- We will include all disclosures of health information for six years prior to the date you ask.
- We will provide this to you once per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Obtain a copy of this privacy notice

- You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Protecting your health information is important to us

- We are required by law to maintain the privacy and security of your protected health information. We must follow the duties and privacy practices described in this notice.
- If you are concerned that we have violated your privacy rights, you may contact our Privacy Officer by calling 630-575-1962 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.
- If you wish to exercise any of your rights above, you may submit a written request. Forms will be available upon request at any of our facilities, or by calling the contact number at the end of this Notice.

Our Uses and Disclosures

We may, without your written authorization use and disclose your health information for the following purposes:

Help manage the health care treatment you receive

- We may use your health information in the provision and coordination of your health care. For example, your physical therapist may disclose your health information when consulting with your primary care physician regarding your medical condition.

Health care operations

- We may use or disclose your health information to monitor and support the operation of our facilities.
  For example, evaluating the quality of services provided, performing licensing and credentialing activities and other administrative functions.

Payment

- We can use and disclose your health information to bill and receive payment for your healthcare services.
  For example, we may contact your insurer to get paid for services that we delivered to you.

Patient contact

- We may contact you to set up or remind you about future appointments, billing, or payment matters.

Our Uses and Disclosures cont'd:

Family members and others involved in your care

- Unless you object, we may disclose relevant health information to a family member, relative or close friend who is involved in your care or in payment of your care.
  For example, we may share information with a family member to help you understand your care, handle your bills, or schedule appointments.

Workers' compensation

- We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law. These programs provide benefits for work-related injuries or illnesses.

As required by law

- We may disclose health information about you when required by federal, state, or local law.

Health oversight activities

- We may use or disclose health information about you with health oversight agencies for activities authorized by law.
  For example, oversight activities may include audits, investigations, and inspections necessary for the government to monitor the health care system.

Marketing communications

- We may use and disclose your health information to contact you with information about treatment services, products, or new locations that we believe might be of interest to you.

Research

- We may use your health information for research purposes in certain circumstances with your authorization.

Public health and safety issues

- We may share your health information for certain situations such as, preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing, or reducing a serious threat to anyone's health or safety.

Law enforcement and specialized government functions

- We may disclose your health information for law enforcement purposes as permitted by law. Under certain circumstances, we may disclose health information to units of the government with specialized functions

Respond to lawsuits and legal actions

- We may share health information about you in response to a court or administrative order, or in response to a subpoena or similar legal request.

To business associates

- We may disclose your health information to our "business associates" - individuals or companies that provide services for Athletico.
  For example, a business associate would include the company that administers the billing claims for Athletico. In all cases, we require business associates to appropriately safeguard the privacy of your information.

To Parents and legal guardians of minors

- As permitted by federal and state law, we may disclose health information about minors to their parents or guardians.

Highly confidential information

- Federal and state laws provide additional privacy protection for certain confidential health information. This includes information dealing with mental health, HIV/AIDS, alcohol, and drug abuse treatment.

For State of Maryland Residents with Medicare Part B Only:

We have chosen to participate in the Chesapeake Regional Information System for our patients ("CRISP"), a regional health information exchange ("HIEs") serving Maryland. CRIPS is also affiliated with and shares data with other HEIs including those, in Alaska, Connecticut, D.C., Maryland and West Virginia. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by main, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances Information, as part of the Maryland Prescription Drug Monitoring Program ("PDMP"), will still be available to providers.

Uses and disclosures pursuant to an authorization

Other uses and disclosures of your protected health information, not described above, will be made only with your written authorization. You may revoke your authorization, in writing, at any time, except that a revocation will not affect any uses or disclosures we have made in reliance on such authorization.

Changes to the terms of this notice

We can change the terms of this Notice and the changes will apply to all information we have about you. The new Notice will be available upon request, posted at each of our facilities and our web site at athletico.com.

This Notice of Privacy Practices applies to Athletico Holdings, LLC and its subsidiaries and controlled affiliates (including, without limitation, Athletico, Ltd. and its subsidiaries) (collectively, "Athletico"). Please visit our website for a full listing of all Athletico locations.

If you have any questions, or would like to discuss this Notice in more detail, please contact the privacy officer at 630-575-1962 or compliance@athletico.com. This Notice is effective as of January 1, 2024.