Vermont Sports Medicine Center

Today's Date: _____

APPOINTMENT DATE: _____ **TIME:** _____ **R RH C B K**

Therapist Name: _____

Name: _____ Date of Birth: _____

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

Male ☐ Female ☐ Married ☐ Single ☐

Home Phone: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Referring Physician: _____ Diagnosis: _____

Are you currently under the care of a Home Health Care (VNA)? YES or NO (circle one)

MINOR PATIENTS

Parent Name: _____ Address: _____

DOB: _____ Home Phone: _____ Work Phone: _____

**Please help us verify your insurance information.

Is your injury/issue related to any of the following: Injury/Illness_____ Work Accident_____ Auto Accident_____

Primary Ins. Co.:_____ Secondary Ins. Co.:_____

Insured:_____ DOB:_____ Insured:_____ DOB:_____

ID#:_____ ID#:_____

Group#:_____ Group#:_____

Workers' Compensation Ins. Co.:_____ Injury Date:_____

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

Employer's Name:_____ Contact Person:_____

SS#: _____

Claim #:_____ Phone #:_____

Nurse Case Manager: _____ Phone #: _____

Adjuster:_____ Phone #:_____

Auto Accident Ins. Co._____ Injury Date:_____

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

Phone:_____ Policy # _____ Policyholder:_____

Adjuster Email: _____ **Claims Sent Via: Email** _____ **Mail** _____ **Fax** _____

FRONT OFFICE VERIFICATION:

Copay: $._____ Med B Cap used: _____ Deductible Amt / Met: _____ / _____ OOP Max: _____

Pre Cert: Y N # Visits / Cal Year: _____ Verified With / Date: _____ / _____

PATIENT HISTORY

Name: _____ DOB: _____ Age: _____

Gender: M / F Height: _____ Weight: _____ Occupation: _____

Primary Care Physician: _____ Referring Physician: _____

Diagnosis: _____

How were you injured? (Gradually / Suddenly / New Injury): _____

Date of Injury: _____ Surgery for this injury? _____ Surgery Date: _____

Have you had a history of falls / balance issues?

☐ 2 or more falls in the past year
☐ Any fall in the past year that has resulted in injury
☐ No falls, or only one but without injury

Are you using an assistive device?

☐ Crutches ☐ Brace ☐ Walker ☐ Wheelchair
☐ Cane ☐ Splint ☐ Other_____

Current Level of Function / Able to perform:

Home Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Work Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Recreation Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Previous Level of Function (check all that apply):

Independent with: ☐ Daily Activities ☐ Self Care ☐ Work / Vocation ☐ Care Giving ☐ Ambulation/Mobility
☐ Community Access

Recreational Activities / Hobbies (Please list): _____

_____

_____

Functional Limits (check all that apply): ☐ Sleep ☐ Self Care ☐ Daily Activities ☐ Reaching / Pushing / Pulling
☐ Lifting / Carrying ☐ Sitting / Standing ☐ Mobility / Ambulation ☐ Community Access

Aggravating Factors (check all that apply): ☐ Sitting ☐ Standing ☐ Waking ☐ Stairs (up/down)
☐ Bending ☐ Voiding ☐ Lying Down ☐ Coughing / Sneezing

Current Work Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Light duty due to injury
☐ Not working due to injury Out of work since: _____

What date (approximately) did your present pain start? _____

PAIN: *(0 = None 5 = Moderate 10 = Extreme)*

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Do you smoke? ☐ Yes ☐ No # of packs/day _____
Are you pregnant? ☐ Yes ☐ No Due Date: _____
Latex Allergies? ☐ Yes ☐ No

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

Is your pain affecting your sleep? ☐ Yes ☐ No

What treatments have you received for this issue so far? _____

Have you had an X-Ray, MRI or other test for this issue? _____

What makes your symptoms better? _____

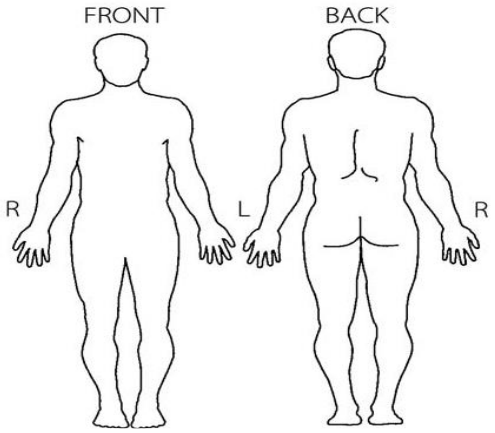
What makes your symptoms worse? _____

Is there anything else we should know about your symptoms or medical history? _____

_____

On Body Diagram: Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not include areas of pain which are not related to your present problem.

///////	XXXXXXX	0000000	======
Stabbing	Burning	Pins & Needles	Numb



Pain Frequency: ☐ Less than daily ☐ Daily ☐ Increases throughout day ☐ Constant ☐ Night

☐ Other: _____

Past Medical History: ***Check any conditions that you currently have or have had in the past.***

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Allergies/Asthma
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Arthritis
- ☐ Seizures/Epilepsy
- ☐ Fever, Chills, Sweating
- ☐ Unexplained Weight Loss
- ☐ Infectious Disease
- ☐ Thyroid Problems
- ☐ Skin Disease
- ☐ Ulcers/Stomach Issues
- ☐ Stroke
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Other_____
- ☐ Kidney Problems
- ☐ Change in Bowel/Bladder Function
- ☐ Broken Bones/Fracture
- ☐ Liver Disease
- ☐ Head Injury
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Pace Maker

Past Surgical History: _____

_____

Current Medications:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Home Layout:

☐ 1 – Story ☐ 2 – Story ☐ Condo / Apartment ☐ Stairs / Steps ☐ Shower Stall ☐ Combo Bathtub Shower ☐ W/C Accessible

Durable Medical Equipment:

☐ None ☐ Tub Bench ☐ Shower Chair ☐ Bedside Commode ☐ Raised Toilet Seat ☐ Standard Walker ☐ Rolling Walker
☐ Hemi Walker ☐ Quad Cane ☐ Straight Cane ☐ Wheelchair

Identify 3 goals that you personally would like to achieve as a result of your therapy:

1. _____
2. _____
3. _____

* Are you currently under the care of a Home Health Agency? ☐ Yes ☐ No

* Have you had any other physical, occupational or speech therapy in this calendar year? ☐ Yes ☐ No

Name: _____ Date: _____

Therapist's Signature: _____ Date: _____

Vermont Sports Medicine Center

AUTHORIZATION TO PAY BENEFITS TO VERMONT SPORTS MEDICINE CENTER

I hereby authorize payment directly to Vermont Sports Medicine Center for all medical benefits for services rendered. I understand that I am financially responsible for any and all charges NOT COVERED by my insurance**. In addition, I will pay my co-payments and co-insurance on a weekly or bi-weekly basis, as well as any deductible not met at the time of service. Any and all medical equipment prescribed by my physician or therapist, not covered by insurance, will be paid in full at the time of delivery. If I do not pay for these charges, I will be responsible for all attorneys' fees.

PATIENT RESPONSIBILITY INFORMATION

All insurance policies are not the same and therefore everyone's coverage is different. It is your responsibility to find out how much your policy covers, both in terms of number of visits and cost. You are responsible for payment of anything insurance doesn't cover. **CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT.**

****PLEASE NOTE: If there is a lapse in your insurance coverage for any reason, you are solely responsible for all services rendered and the balance will be transferred to your responsibility.**

AUTHORIZATION TO TREAT A MINOR

I hereby authorize Vermont Sports Medicine Center to render Physical Therapy to my child (under 18) as defined in my child's plan of care created by the Physical Therapist.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Vermont Sports Medicine Center to release any information acquired in the course of my examination and/or treatment to my insurance company, physician, and employer (for Workers' Compensation only.)

Please check how you would like us to send your confidential healthcare information. *Check ALL that apply.*

☐ You may email* me at (*email address*): _____

*(*Please note that the confidentiality of electronic communications cannot be guaranteed.)*

☐ You may phone me at (daytime phone #): _____

☐ You may leave a phone message:

- ☐ On my answering machine at: _____
- ☐ With another person at: _____ Name:_____

If you want VSMC to share any information with other person(s), you must list them below, including any and all legal guardians if (a minor) or (unable to consent).

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

NOTE:

WE WOULD APPRECIATE AT LEAST 24 HOURS NOTICE IF YOU NEED TO CANCEL YOUR APPOINTMENT.

Please note that a $50 charge may be applied for any scheduled appointment that is cancelled without proper notification.

We reserve the right to request you return to your physician if you should fail to attend your scheduled appointments (frequent cancels or no shows). Your treatment plan, as defined by Vermont Sports Medicine Center, will not be effective without consistent attendance. In the event this should occur, a letter will be sent to your provider.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE on pages 1 and 2 of the Authorization Form:

Patient Signature: _____ **Date:** _____

The undersigned certifies that the patient is (unable to consent) or (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible Party Signature: _____ **Date:** _____

Vermont Sports Medicine Center

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Vermont Sports Medicine Center Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Maureen Gibeault, PT – Clinical Director at 802.775.1300.

WHO WILL FOLLOW THIS NOTICE:

- Vermont Sports Medicine Center

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and service you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the way in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make certain that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for you care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- To allow oversight of the quality of healthcare we provide
- To allow Workers' Compensation claims as require by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health and safety

The full details for all these uses are contained the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding health information we maintain about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice.

Information on how to exercise these rights can be seen in the NPP or can be obtain from Maureen Gibeault, PT – Clinical Director, at 802.775.1300.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Maureen Gibeault, PT – Clinical Director. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Vermont Sports Medicine Center

HIPAA Privacy Rule

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness _____

Printed Name of Individual or Legal Representative _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____