INNOVATION
OCCUPATIONAL THERAPY

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innovationot.com

New Patient Information

Date: _____ **Patient's Full Name:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **E-mail:** _____

Date of Birth: _____ ☐**Male**☐**Female** **Social Security Number:** _____

☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Spouse's Name: _____ **Number of Children/Ages:** _____

☐ **Full Time Employed** ☐ **Part Time Employed** ☐ **Full Time Student** ☐ **Part Time Student** ☐ **Retired** ☐ **Unemployed**

Occupation: _____ **Employer/School:** _____

Primary Insurance Co: _____
ID# _____ Group # _____
Insured's Name: _____
Date of Birth: _____/_____/_____ Employer: _____
Relation to Insured: _____

Emergency Contact: _____ **Relationship**: _____

Phone # 1: _____ **Phone # 2:** _____

Primary Medical Physician: _____ **City:** _____ **State:** _____

Current Diagnosis/Reason for Visit: _____ **Date of Onset:** _____

Please list medications and dosages below or provide list:

Have you had any NERVE CONDUCTION studies in the past 10 years? ☐Yes ☐No

Have you had any MRI or CT studies in the past 10 years? ☐Yes ☐No

If yes, approximate date and location: _____

If yes, approximate date and location: _____

Have you had any X-RAYS in the past 10 years? ☐Yes ☐No

If yes, approximate date and location: _____

Have you had any BLOOD or LAB TESTS in the past 10 years? ☐Yes ☐No

If yes, approximate date and location: _____

If yes, who, when, and for what condition? _____

Please list any other physicians you see and for what conditions: **_____**
_____

Is today's visit due to a work-related injury? ☐Yes ☐No Date of Injury: _____
Is today's visit due to an auto accident? ☐Yes ☐No Date of Injury: _____
Referred by: **_____**

Health History

Have you ever had a stroke or issues with blood clotting? ☐Yes ☐No

If yes, when? _____
Have you recently experienced unexplained fatigue, fever, or unexplained weight loss? ☐Yes ☐No

If yes, explain: _____

Have you ever had any major illnesses, injuries, fractures, accidents, or surgeries? ☐Yes ☐No
If yes, when? _____

Illness/Injury/Fracture/Accident/Surgery:

Treatment: _____ Outcome:_____

Are you currently taking any prescription or over-the-counter medications, vitamins, or supplements? ☐Yes ☐No
Are you currently taking anti-coagulant or blood thinning medication? ☐Yes ☐No

Approximate date or year of last physical examination and health screening: _____
Females: Possibility of pregnancy? ☐Yes ☐No

Health History Continued

Do you currently, or have you ever had, any diseases, illnesses, or conditions involving the following?

☐Allergies (Food, Medication, etc.) (1) ☐Blood (2)☐Ears, Nose, Throat, Mouth (3) ☐Eyes (4)☐Heart
(5) ☐Internal Organs (6)☐Intestines/Bowels (7) ☐Joints/Bones (8)☐Lungs (9)☐Muscles (10)☐Nerves
(11) ☐Psychological/Emotional (12) ☐Skin (13)☐Urinary
(14) **Females only:** ☐Gynecological/Menstrual/Breast
(15) **Males only:** ☐Prostate/Testicular/Penile

Please explain any of the above: _____
_____
_____
_____

Social History

Recreational Activities (Hobbies): _____

Do you exercise? ☐Yes ☐No _____ /times per week.

Do you smoke? ☐Yes ☐No _____ /packs per day.

If you have quit smoking, when did you Do you use tobacco? ☐Yes ☐No

Do you consume alcohol? ☐Yes ☐No

Do you consume caffeine? ☐Yes ☐No

Do you eat a balanced diet? ☐Yes ☐No

Do you get adequate sleep? ☐Yes ☐No

Is work stressful to you? ☐Yes ☐No

Is family life stressful to you? ☐Yes ☐No

Do you use recreational drugs? ☐Yes ☐No

Review of Systems

As you review the following list, please check any problems or conditions that you are CURRENTLY experiencing or have experienced in the PAST 5 YEARS. If you do not have any of the problems listed, please check NONE.

General Health
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of appetite
- ☐ Night sweats
- ☐ Recent weight gain (6 months)
- ☐ Recent weight loss (6 months)
- ☐ *NONE*

Endocrine
- ☐ Diabetes (Type I or Type II)
- ☐ Excessive thirst or hunger
- ☐ Frequent urination
- ☐ Heat or cold sensitivity
- ☐ Sweating
- ☐ Thyroid condition: _____
- ☐ *NONE*

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Eating disorder
- ☐ Nervousness
- ☐ Other: _____
- ☐ *NONE*

Ears, Nose, Mouth, Throat
- ☐ Difficulty swallowing
- ☐ Earaches
- ☐ Loss of hearing
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Painful chewing
- ☐ Ringing in ears
- ☐ Sinus infection or discharge
- ☐ Sores in mouth
- ☐ Other: _____
- ☐ *NONE*

Gastrointestinal
- ☐ Abnormal stools
- ☐ Blood in stools
- ☐ Heart burn or indigestion
- ☐ Increasing constipation
- ☐ Nausea
- ☐ Painful bowel movements
- ☐ Persistent diarrhea
- ☐ Stomach or abdominal pain
- ☐ Ulcer
- ☐ Vomiting
- ☐ Other: _____
- ☐ *NONE*

Respiratory
- ☐ Asthma
- ☐ Blood in cough
- ☐ Chronic or frequent cough
- ☐ Pneumonia
- ☐ Other: _____
- ☐ *NONE*

Cardiovascular
- ☐ Discoloration of hands or feet
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat or palpitations
- ☐ Leg pain or cramps with walking
- ☐ Pain in chest
- ☐ Shortness of breath with activity
- ☐ Swelling in hands or feet
- ☐ Other: _____
- ☐ *NONE*

Hematologic/Lymphatic
- ☐ Bleeding disorder: _____
- ☐ Bruise easily
- ☐ Swollen or enlarged lymph nodes
- ☐ *NONE*

Eyes
- ☐ Blind spots
- ☐ Blurred vision
- ☐ Double vision
- ☐ Glasses or Contacts
- ☐ Injury
- ☐ Loss of vision
- ☐ Other: _____
- ☐ Pain
- ☐ *NONE*

Genitourinary
- ☐ Blood in urine or discoloration
- ☐ Female: irregular bleeding
- ☐ Female: irregular periods
- ☐ Female: menstrual pain
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Male: prostate disease
- ☐ Male: testicle pain or mass
- ☐ Painful or burning urination
- ☐ Sexual difficulty
- ☐ Sexually transmitted disease
- ☐ Urgency with urination
- ☐ Urine retention
- ☐ Other: _____
- ☐ *NONE*

Skin
- ☐ Breast lump or discharge
- ☐ Color changes
- ☐ Hair loss
- ☐ Itching
- ☐ Nail changes
- ☐ Rash
- ☐ Sores or lesions
- ☐ Other: _____
- ☐ *NONE*

Neurological
- ☐ Balance trouble
- ☐ Black outs/loss of consciousness
- ☐ Change in handwriting
- ☐ Clumsiness
- ☐ Difficulty speaking
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Facial drooping
- ☐ Fainting
- ☐ Head injury
- ☐ Headaches
- ☐ Light-headed
- ☐ Memory loss
- ☐ Mental confusion
- ☐ Migraines
- ☐ Mini-stroke
- ☐ Neuropathy
- ☐ Numbness (loss of sensation)
- ☐ Paralysis
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Vertigo (room spinning)
- ☐ Weakness
- ☐ Other: _____
- ☐ *NONE*

Musculoskeletal
- ☐ Arthritis
- ☐ Difficulty walking
- ☐ Grind or clench teeth
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Limp
- ☐ Muscle cramps
- ☐ Muscle pain or tenderness
- ☐ Other: _____
- ☐ *NONE*

INFORMED CONSENT FOR CARE

Occupational Therapy Examination and Treatment. On occasion, some patients experience increased discomfort following treatment and examination. Physical examination and treatment may involve bending, twisting, and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the extremities, and it can possibly lead to temporary feelings of soreness or pain. During treatment, therapists may use their hands or mechanical devices to move, adjust, or manipulate joints and mobilize soft tissues of the body. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to or refuse certain aspects of care once therapeutic options have been presented.

Permission for Physical Contact I understand that, in the course of various examination procedures and treatment methods, the therapist or other staff may have to examine and physically contact portions of my body.

Do you wish to have another staff member present during examination and treatment? **☐Yes ☐No**

Risks of Occupational Therapy Care and Treatment

I have been given information about my condition and the therapy evaluation so that I will be better informed to give or withhold my consent to my evaluation. This consent form is a written confirmation of such a discussion.

My therapist has discussed my condition with me and has proposed certain occupational therapy and treatment. The reasons for and potential risks and benefits have also been explained to me. I wish to rely on the therapist to exercise their best professional judgment during the course of the examination and treatment based upon the facts as known at the time of treatment.

I will immediately notify a member of the clinic staff of any unanticipated side effects or adverse reactions associated with treatment. I also understand that if I become concerned about any post-treatment discomfort or, if I should develop any new or unrelated symptoms, I should call Innovation Therapy (hereinafter the "Practice") for immediate attention. I also understand that if for some reason I am unable to reach or contact the Practice, that I should telephone my primary healthcare provider or present myself to the nearest hospital emergency room.

Alternative Treatments Available I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over- the-counter medication, exercise, non-treatment, treatment and evaluation by another provider, and possibly surgery. Each is associated with their own benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment, and management of my presenting condition(s) at any time. I further understand the potential consequences if no evaluation or treatment is given.

Consent By affixing my signature below, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction, **PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

I, the undersigned, hereby request, consent to, and authorize Adria Hawthorne, MSOT, OTR and the staff at the Innovation Therapy to conduct physical examinations, perform testing procedures as are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the therapist's scope of practice. I attest that the information provided regarding my, or my dependents, current and past health history has been completed to the fullest extent and to the best of my knowledge and ability, and does not contain false or misleading information, nor omission. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from any treatment rendered.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____ **Signature (Patient, Parent, or Legal Guardian)**

_____ **Print Name (Patient, Parent, or Legal Guardian)**

_____**Signature (Occupational Therapist/Staff)**

Date: _____

Privacy Protection and Authorization for Release of Protected Health Information

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payors, and conduct normal healthcare operations such as quality assessments and accreditation. This includes release of information and notification of care to my primary health care and/or referring provider. I hereby authorize the Practice to release a complete report of services rendered including diagnosis, findings and details of treatment, and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payors, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, attorney, or other intermediaries responsible for payment of my charges and hereby release the Practice from any consequences thereof. I understand that I may revoke this consent at any time by giving written notice.

Please list below the names of and your relationship to individuals whom you authorize the Practice to release your protected health information.

Name and Relationship

_____

_____

_____

_____

_____

Acknowledgement of Receipt of the Notice of Privacy Practices

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Innovation Therapy to ensure the privacy of my protected health information. I understand that this acknowledgement will be placed in my electronic file and maintained for six years. A copy of this notice is available at any time upon request.

Initial: _____

Authorization to Acquire Healthcare Information

I hereby authorize Innovation Therapy to obtain details regarding my current and/or prior health status from my primary care provider, referring provider, and/or other providers to facilitate appropriate care. All health records, diagnostic imaging results, diagnostic testing results, surgical information, and any data that are held regarding my medical and health management are applicable for release. This release does NOT allow information pertaining to drug and/or alcohol abuse, or mental health information to be included. I understand that I may revoke this consent at any time, except to the extent that action has already been taken, with written notice.

Initial: _____

Assignment of Insurance Benefits and Financial Policy

In consideration of all services provided, I hereby assign and transfer to Innovation Therapy all my rights, title, and interest to healthcare reimbursement in accordance with the terms and benefits under my insurance policy or other health benefits otherwise payable to me for those services rendered, including Medicare Part B. I certify that the health insurance information that I have provided is accurate and that I am responsible for keeping it updated.

I understand that I will be fully responsible for payment of any and all charges not paid by health insurance. I understand that the balance of my account is due in full within **30 days** of notice, unless a payment plan arrangement has been made in advance. If a bill is disputed, notification must be made within **30 days**. If I do not notify Innovation Therapy within that time, the bill will be presumed valid and due. All balances remaining unpaid after **30 days** may be reported to a collection agency, and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.

I hereby authorize Innovation Therapy to submit claims, on my or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I have provided, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Innovation Therapy directly for services rendered to me or my dependent.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Innovation Therapy are paid in full. I also understand that I am responsible for all amounts not paid by my health insurance, including co-payments, co- insurances, and deductibles.

*Innovation Therapy **ONLY** accepts personal check, debit card, Visa, Discover, American Express, and MasterCard. I understand that I will have to pay a $25.00 fee for each check that is returned to Innovation Therapy for non-sufficient funds.*

Prior balances considered delinquent must be paid prior to being seen for any further scheduled visits. Charges added to your account will be due in full when stated on the invoice.

ERISA Authorization (Employee Retirement Income Security Act)

I hereby designate, authorize, and convey to Innovation Therapy to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. (2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Innovation Therapy and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

On-Time Policy

If you are not able to keep your appointment, we would appreciate a 24-hour notice. A missed appointment without 24-hours prior notice will be assessed a **$50.00** fee. Three **(3)** missed appointments without any notice will result in being discharged as a patient.

If you are late for your appointment (more than 10 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

Initial: _____

Consent to Treat a Minor without Parent or Guardian Present

I hereby authorize and give my consent to Innovation Therapy staff to provide evaluation and treatment as needed and necessary to my minor child **in my absence** following initial consultation.

☐Yes ☐No

My child will be accompanied by (check all that apply):

☐ **Himself or Herself**
☐ **Other:**

_____

Parent or Legal Guardian Initial:

_____

Patient Communications Policy

It is the policy of Innovation Therapy to not leave messages via voicemail, e-mail, or with another party regarding your care, testing results, specific follow up instructions, or other situations involving your personal health or care provided in this clinic or elsewhere. When needed, communications will be limited in scope and nature with as little identifying or specific information as possible, often requesting a return phone call to discuss pertinent information. However, with your consent, information can be left via the following methods:

☐ *I hereby authorize that Innovation Therapy to leave detailed messages regarding my healthcare via voicemail at the following phone numbers that I have provided:* _____

☐Cell ☐Home

Authorization to Send and Receive Medical Information by E-mail/Text

Innovation Therapy (the "Practice") sends patient information by e-mail and/or text messaging. We utilize a two-way text messaging service to confirm appointments and may use e- mail to send requested information with your permission.

RISKS: Transmitting information by e-mail/text, however, has several risks that patients should consider before using e-mail/text. These include, but are not limited to, the following risks: (1) E-mail/text can be circulated, forwarded, and stored in numerous paper and electronic files. (2) E- mail/text can be immediately broadcast worldwide and be received by many intended and unintended recipients. (3) E-mail/text senders can easily misaddress an e-mail or text. (4) E-mail/text can be intercepted, altered, forwarded, or used without authorization or detection (collectively the "Risks").

CONDITIONS: Because of the Risks outlined above, the Practice cannot guarantee the security and confidentiality of e-mail/text communication and will not be liable for improper use and/or disclosure of confidential information that is not caused by the Practice's intentional misconduct. Thus, patients must consent to the use of e-mail/text for patient information. Consent to the use of e-mail/text includes agreement with the following conditions: (1) All e-mails/texts to or from the patient concerning diagnosis or treatment will be saved as part of the medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails/texts. (2) The Practice may forward e-mails internally to the Practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. The Practice will not, however, forward e-mail

to independent third parties without the patient's prior written consent, except as authorized or required by law. (3) Although the Practice will endeavor to read and respond promptly to an e-mail/text from the patient, the Practice cannot guarantee that any e-mail/text will be read and responded to within any period. Thus, the patient shall not use e-mail/text for medical emergencies or other time-sensitive matters. (4) If the patient's e-mail/text requires or invites a response from the Practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e- mail/text and when the recipient will respond. (5) The patient should not use e-mail/text for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. (6) The patient is responsible for informing the Practice of any types of information the patient does not want to be sent by e-mail/text, in addition to those set out in the preceding paragraph. (7) The patient is responsible for protecting his/her password or other means of access to e-mail/text. (8) The Practice is not liable for breaches of confidentiality caused by the patient or any third party. (9) The Practice shall not engage in e-mail/text communication that is unlawful, such as unlawfully practicing medicine across state lines. (10) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS: To communicate by e-mail/text, the patient shall: (1) Limit or avoid use of his/her employer's computer. (2) Inform the Practice of changes in his/her e-mail address or text number. (3) Put the patient's name in the body of the e-mail/text. (4) Include the category of the communication in the e-mail's subject line or body of a text message, for routing purposes (e.g., billing question). (5) Review the e-mail/text to make sure it is clear, and that all relevant information is provided before sending to the Practice. (6) Inform the Practice that the patient received an e-mail/text from the Practice. (7) Take precautions to preserve the confidentiality of e-mails/texts, such as using screen savers and safeguarding his/her computer password. (8) Withdraw consent only by written communication submitted to the Practice in-person. (9) Contact the Practice at (812) 254-2203 with any unanswered questions before communicating with the Practice via e-mail or text message.

Would you like a text message reminder of future appointments and confirmation of appointments?

☐Yes ☐No

When required or requested by you, may we communicate with you regarding your healthcare via e- mail?

☐Yes ☐No

Patient Acknowledgement and Agreement

I, the undersigned, hereby certify that I have read, fully understand, and agree to be bound by these policies, assignment, and authorizations pertaining to myself or my dependent. I understand the risks associated with the communication of e-mail and text between myself and the Practice, and consent to the conditions outlined in this document. I have asked or have declined the opportunity to ask any pertinent questions regarding this information before applying my signature. A photocopy of this document shall be considered as effective as the original. I intend this certification to cover the entire course of treatment for my, or my dependent's, present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient or Responsible Party)

_____

Print Name (Patient or Responsible Party)

_____

Date

_____

Phone number authorized for text messaging

_____

Cellular carrier

_____

E-mail authorized for sending medical records