EXCEL PHYSICAL THERAPY:
MEDICAL HISTORY FORM

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____
Nickname: _____
Are you employed? YES NO
Presently Working? YES NO
If NO, last day worked? _____
Occupation: _____
Where are you employed? _____

Right Handed Left Handed *(circle one)*
Do you smoke? YES NO
Height: _____ Weight: _____
Are you Pregnant? YES NO
NEXT DOCTOR'S VISIT? _____

INJURY:
What is the problem you are here for today? _____
Injury Date or Date of Onset? _____
Date of Surgery? (if applicable) _____
Is this the first time you have had this pain? YES NO if NO, when: _____
Past Surgeries/Dates: _____

MECHANISM OF INJURY:
YES NO Is this injury work related?
YES NO Is this injury motor vehicle accident related?
YES NO Have you had Physical Therapy for this injury before? WHEN? _____
YES NO Is this injury a recurrence of a previous injury? If Yes, Explain _____
YES NO Have you received HOME HEALTH this year? If YES, date of last visit? _____
You must be discharged from Home Health before your insurance will pay for physical therapy with us

MEDICATIONS: *PRESCRIPTIONS / VITAMINS / DIETARY SUPPLEMENTS / HERBAL / OVER THE COUNTER:*
_____

ALLERGIES: NONE _____

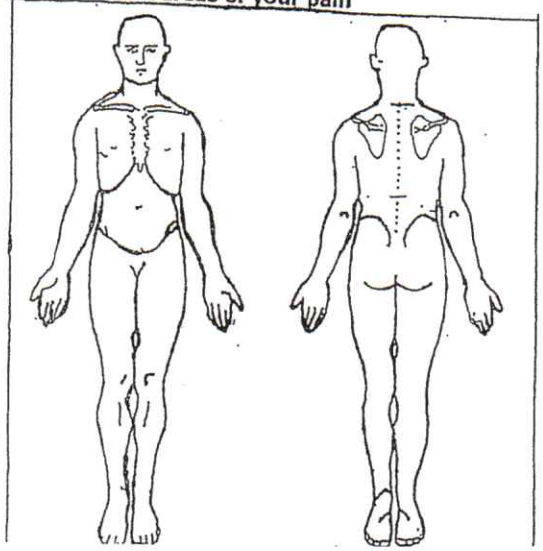
DIAGNOSTIC TESTING: CT SCAN MRI X-RAYS
DATE Performed: _____
Other: _____

MEDICAL HISTORY:
YES NO Heart Problems
YES NO Diabetes type 1 or 2
YES NO Cancer _____
YES NO Endocrine
YES NO High Blood Pressure

YES NO Balance Problems
YES NO Breathing / Lungs
YES NO Sleeping Problems
YES NO Osteoarthritis
OTHER: _____

YES NO Dizziness
YES NO Fainting
YES NO Fibromyalgia

Please mark areas of your pain



PAIN AND SYMPTIONS:
Is your pain? Occasional Or Continuous
What makes your pain worse? _____
What makes your pain better? _____

What is your pain level today? 0 1 2 3 4 5 6 7 8 9 10
What is your pain at Worst? 0 1 2 3 4 5 6 7 8 9 10
What is your pain at Best? 0 1 2 3 4 5 6 7 8 9 10

How would your describe your pain?

EXCEL PHYSICAL THERAPY: *Consent for Care and Responsibility*

Medical Release:

I, _____ ***(print your name)***, hereby authorize Excel Physical Therapy to release any medical information necessary to process this claim to _____ (person or my current insurance company). I authorize direct payment of my medical benefits to Excel Physical Therapy. I understand that if insurance checks are mailed to me, I must endorse them and make them payable to Excel Physical Therapy. I understand that in the case of denial of a third party claim my primary insurance information will be kept on file and will be billed.

Patient's Initials: _____

Patient Responsibility:

I understand that it is my responsibility to understand the coverage and limits of my insurance policy. I understand that I am responsible for co-insurances, deductibles, co-pays and or patient balances as directed by my insurance policy. In the event that the party named above denies payment I understand that I am solely responsible for my bill. In the event that my bill is released to an outside collection agency, I understand that there will be an additional collection fee or 30-50% will be assessed to my account. Once that account has been released to collections we cannot recall this fee.

Patient's Initials: _____

COPAY:

My copay is due at the time of each visit. We accept cash, check or CC. Please check your insurance card to see what your copay is and list it in the space.

My copay is: $_____

Cancellation / No Show:

I understand that I must notify Excel Physical Therapy 24 hours **before** my scheduled appointment. Failure to provide a 24 hr notice of cancellation will result in a **$50.00 fee** billed directly to me for each appointment. If you **NO SHOW** and do not call before 5 PM of your appt day all other scheduled appts will be cancelled. Workers Comp carrier will be billed the fee for WC clients.

Patient's Initials: _____

Acknowledgment of Receipt or Notice of Privacy Practices & Consent:

I acknowledge that I have received the Notice of Privacy Policy and Practices from Excel PT. I understand Excel PT will need to use and disclose confidential information including financial and health information in order to provide treatment and deliver services offered by Excel PT.

Patient's Initials: _____

I understand that copies of my medical records will be sent to my referring physician. If referred by a specialist, I give permission for my notes to be sent to my Primary Physician.

I understand that my therapist is not responsible for knowing or giving advice about my health insurance coverage. All questions about my coverage must be addressed to the billing office at: 802-893-7427.

Patient's Initials: _____

Signature: _____ ***Date:*** _____

Print Name: _____

EXCEL PHYSICAL THERAPY
MEDICATION LIST

PATIENT:
DOB:

Medication	Dose	Frequency	Mode

EXCEL PHYSICAL THERAPY:

CANCELLATION & NO SHOW POLICY

If you short notice Cancel or No Show on the day of your scheduled appointment you will be responsible for a $50.00 fee. If you NO SHOW do not call to confirm your intentions to keep future scheduled appointments before 4:30 pm that same day then all future appointments will be automatically cancelled. If you short notice Cancel or No Show on the day of your scheduled appointment 2 times (**for any reason**) within a 30 day period you will be put on same day scheduling (see below) PLUS all future appointments will be cancelled.

If you need to cancel an appointment, call (802) 893-7427 for all clinics. Our office staff can help you cancel, reschedule or relay a message to your therapist. Our Therapists are busy treating other patients and are not able to answer your calls directly or call you back.

$50.00 NO SHOW / CANCEL FEE

AVOID THE SAME DAY CANCEL OR NO SHOW FEE: please call before the day of your scheduled appointment and speak to one of our office staff or leave a message. Appointments cancelled before the day of your scheduled appointment will be deleted and will not be counted toward your total.

SAME DAY SCHEDULING: You can call by 9:00 am on the day you can attend PT and see if there is an opening. If we don't hear from you for 2 weeks after your last appointment and you make no attempt to call for same day scheduling then we will assume you no longer need physical therapy. You will be discharged and a note will be sent to your Doctor.

WORKERS COMP CLIENTS: Your Workers Compensation carrier will be notified of your Same Day Cancel or No Show and will be responsible for paying this fee each time which they may then recoup from you.

**We will strictly enforce this policy to help our clients get the appointments and health care they need. Many patients are waiting for appointments and are on waiting lists to receive care. Please respect their needs and respect your health care providers time.*

_____ _____

Signature *Date*

_____ _____

Print Full Name *DOB* *Revised 3/27/24*

Excel Physical Therapy
P.O. Box 776 Milton, VT 05468 802-893-7427 Locations in: *Milton, Essex, St. Albans*

Telemedicine Consent Form

Patient Name:_____ DOB:_____

1. I understand that my Physical Therapist/PTA wants to communicate with me through a telemedicine consultation.
2. My healthcare provider has explained to me how the video conferencing technology will be used to affect such a consultation and will not be the same as a direct patient/PT visit due to the fact that I will not be in the same room as my PT/PTA.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my PT/PTA or I can discontinue the telemedicine consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
4. I understand that others may be present during the consultation other than my PT/PTA to assist with operation of the video equipment if necessary. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical exam that are personally sensitive to me, (2) ask non-medical personnel to leave the telemedicine examination room, and/or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location under the direction of the consulting PT.
6. I understand that billing will occur for my telemedicine consultation as it would for an on-site visit/consultation.

By signing this form, I certify:

- That I have read *or* had this form read and/or explained to me
- That I fully understand its contents and have been given ample opportunity to ask questions
- That I am agreeable to participate in a telemedicine consultation with my physical therapist or physical therapy assistant

Patient or parent/guardian signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR
CONFIDENTIAL AND PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

EXCEL PHYSICAL THERAPY, INC. is committed to protecting the privacy of your health care information. This notice is also intended to inform you of your individual rights and of EXCEL PHYSICAL THERAPY'S legal duties with respect to such protected and confidential information.

EXCEL PHYSICAL THERAPY, INC. will notify you in the event of a breach of your unsecured PHI when it has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach.

Your Health Information Rights

Under federal regulations, you have the right to:

1. Understand how we intend to use and share your information with others.
2. Ask for restrictions on the use and sharing of your information. (Please note that while we are not required to agree to such requests, we will make an effort to accommodate you when possible.)
3. Authorize the release of your own protected health information to persons for purposes not otherwise identified here, and revoke such authorizations.
4. Restrict disclosure of PHI to a health plan for payment if patient has paid in full for the services and items provided in that visit.
5. Have our staff communicate with you in a certain way regarding your health information (e.g. have a confidential conversation without any family members, send or receive information at an alternative location). Such requests will be accommodated within reason. If EXCEL PHYSICAL THERAPY, INC. is not able to accommodate your request, you will be notified and given an opportunity to discuss other arrangements.
6. Inspect and copy most of the records containing your protected health information. Please note that certain records containing protected health information about another individual may not be available to you. You have the right to request that records held electronically be provided to you in electronic form. EXCEL PHYSICAL THERAPY, INC. has a policy and procedure to process requests and denials and will assist you with your request.
7. Request that protected health information created by EXCEL PHYSICAL THERAPY, INC. be changed, if you believe it is incorrect or incomplete.
8. Obtain a paper copy of this notice.
9. File a complaint with EXCEL PHYSICAL THERAPY, INC. or government that you believe your privacy rights have been violated.
10. Receive a list of the persons that we released protected health information for purposes other than treatment, payment or operations and without your authorization. Such requests should be made within six (6) years of when services were rendered. Please note that a record of disclosures does not have to be made when those disclosures are:

- To carry out treatment, payment and health care operations;
- To individuals of confidential information about them;
- As a result of a signed authorization;
- For the practice's directory or to persons involved in the individual's care;
- For national security or intelligence purposes; or
- To correctional institutions or law enforcement officials.

Our Responsibilities

EXCEL PHYSICAL THERAPY, INC. is required by law to maintain the privacy of your health information and to provide to you this Notice of its duties and privacy practices. We are also required to follow the terms of this Notice. We will not use or share your health information without authorization, except as described in this notice.

Routine Uses and Disclosures

EXCEL PHYSICAL THERAPY, INC. may use PHI for the purposes of payment and health care operations, in most cases without written permission. Examples of our use of PHI:

- Provide treatment – such as sharing information with your primary care physician, medical equipment suppliers, or other health care professionals, or involved family members.
- Obtain payment – such as including your diagnosis and dates of service on invoices to collect payment from third parties or in obtaining prior approval from your insurance company.
- Conduct health care operations – such as reviewing your progress charts and sharing information within EXCEL PHYSICAL THERAPY, INC. for quality assessment/improvement activities, cost containment efforts, case management, professional reviews, education and training, audits, and business planning.
- Schedule or remind you about a visit.
- Let you know about recommended possible treatment options or alternatives that may be of interest to you.

EXCEL PHYSICAL THERAPY, INC. may share information with other people who work with us to carry out our responsibilities to you. These professionals and business associates are required to appropriately safeguard your information in the same manner as we do. For example, EXCEL PHYSICAL THERAPY, INC. contracts with a third party service to collect overdue payments.

Other Uses and Disclosures

We may send you newsletters about our company and new services or programs. EXCEL PHYSICAL THERAPY, INC. will not sell or release your name, address or other health information to another person for purposes of their marketing or fundraising efforts.

Unless you object in writing, EXCEL PHYSICAL THERAPY, INC. staff, using their best judgment, may disclose to a family member, other relative, or close personal friend, health information relevant to that person's involvement in your care or payment related to your care.

Legally Required Disclosures

Occasionally, we may be legally required to share your health information because of federal, state or local laws. Examples include:

- To state officials when there are risks to public health such as a communicable disease.
- To state and local officials relating to Vital Records (such as births or deaths).
- To state officials to report abuse or neglect of a child or vulnerable adult.
- To state officials for health oversight activities.
- To state medical review boards or an Institutional Review Board for purposes of research.
- When required or court ordered in a judicial or administrative proceeding.
- For purposes of worker's compensation insurance.
- To law enforcement officials.

For More Information or Complaints

For more information, to make a request, to inspect contents or to obtain a copy of your protected health information contact: EXCEL PHYSICAL THERAPY, INC, P.O. Box 776, 184 Route 7 South, Milton, Vermont 05468. Phone: (802) 893-7427. If you believe your privacy rights have been violated, you can file a complaint with our PRIVACY OFFICER, at the above address or with the Secretary of Health & Human Services, 200 Independence Ave, Washington, D.C. 20201 or HIPAA Compliance 7500 Security Blvd. C5-24-04, Baltimore, MD 21244. You will not be retaliated against in any way for filing a complaint.

Revisions to the Notice: EXCEL PHYSICAL THERAPY, INC. reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted on our website, if we maintain one. Our patients will be offered a copy of the latest version of this Notice at their next visit or by contacting the Privacy Officer. **Revised 9/10/2018**