PT DYNAMIX
CONFIDENTIAL PATIENT INTAKE FORM

All information you provide is confidential. We comply with all federal privacy standards.

Reason for Visit:			
☐ **Work Injury – Date of Injury (DOI) MM/DD/YYYY:**		**Claim #:**	
☐ **Auto Injury – Date of Injury (DOI) MM/DD/YYYY:**		**Claim #:**	
☐ **Other (describe below in referral section)**			
Today's Date (MM/DD/YYYY):	**Who referred you? How did you find out about us?**		
Full Name (Last, First, M.I.):	**Preferred Name:**	**Date of Birth (MM/DD/YYYY):**	**Age:**
Gender (for insurance*): ☐ Male ☐ Female ☐ Other (please specify):			
*While PT Dynamix recognizes a number of gender sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on your documents pertaining to insurance, billing, and correspondence. If your preferred name, gender identity, and pronouns differ from these, please let us know.			
Gender Identity (check all that apply): ☐ Male ☐ Female ☐ Transgender Male/Trans Man/FTM ☐ Transgender Female/Trans Woman/MTF ☐ Gender Queer ☐ Other (please specify): ☐ Decline to answer			
Pronoun Preference (if applicable): ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs			
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Spouse's Name:**			
Mailing Address:		**Email Address:**	
City:	**State/Province:**	**ZIP/Postal Code:**	**Cell Phone #:**
Disclaimer for E-Communication (you may opt out at any time): Our providers may communicate with you via text or email. We also provide convenient email and text appointment reminders and invoice options. Do you agree to receive? ☐ Yes ☐ No			
Emergency Contact Name:		**Relationship:**	**Phone #:**
Employment Details			
Your Occupation:		**Your Employer:**	
Work Address:			
City:	**State/Province:**	**ZIP/Postal Code:**	**Work Phone #:**
Family Doctor/Primary Care Physician (PCP) and/or Specialist Doctor (if applicable)			
Family Doctor/PCP:	**Clinic:**	**Phone #:**	**Fax #:**
Specialist:	**Clinic:**	**Phone #:**	**Fax #:**
If you would prefer us to NOT communicate with your PCP regarding care, check "No" and initial: ☐ No **Initials:**			
Insurance Information			
Insured's Name:	**Insured's Date of Birth:**	**Insured's Employer:**	
Primary Policy Holder:	**Primary's Date of Birth:**	**Relation to Insured:**	
Insurance Company:			
Member ID # (include alpha prefix):		**Group #:**	

ERISA AGREEMENT

Assignment of Health Plan Benefits and Rights as well as an appointment and/or designation as my personal representative and an ERISA/PPACA Representative and beneficiary:

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay PT Dynamix as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been or will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also herby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative s to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and behalf) to obtain and/or protect benefits and/or payments that are dude (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services supplies, test treatments, or medications that have been previously provided by healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Patient Signature **Date**

Printed Name

INFORMED CONSENT

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy on me (or the patient named below, for whom I am legally responsible) by any licensed clinicians who, now or in the future, treat me while employed by, work or are associated with, or are serving as a replacement or locum, for any PT Dynamix clinic, including those working at the center or office listed below or any other office or center. Performance of procedures may be a combination of care provided in-person, mobile or telehealth (virtual) care.

I have had an opportunity to discuss with the clinicians, and/or with other office or clinic personnel, the nature and purpose of all recommended procedures.

I understand, and am informed that in the practice of physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains, and potential exacerbation of symptoms. I do not expect the PT Dynamix clinician to be able to anticipate and explain all risks and complications, I wish to rely on the PT Dynamix clinician to exercise judgment during the course of the procedures which the PT Dynamix clinician deems necessary and, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to evaluation and treatment at PT Dynamix. I intend this consent form to cover the entire course of treatment from my present condition and for any future condition(s) for which I see treatment.

Patient Signature **Date**

Printed Name

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

Patient Signature **Date**

Printed Name

RECORDS REQUEST AUTHORIZATION

I understand and authorize all PT Dynamix clinics to request health information regarding my conditions(s) while under treatment at PT Dynamix. PT Dynamix may request any of the following, as long as it pertains to the treatment and care rendered at PT Dynamix, from the entities that I disclose.

- Records of medical history
- Examinations
- Consultations
- X-Ray reports
- Laboratory studies
- Operative and pathology reports
- Physicians' and nurses' notes
- Hospital records
- Diagnoses
- Prescription or treatment information relating to any disease, injury or other physical condition

Patient Signature **Date**

Printed Name

INSURANCE AUTHORIZATION AGREEMENT

Your health insurance plan may now require "authorization" for Physical Therapy services.

The number of annual visits for the above-mentioned services that are "allowed" by your plan may not have changed, however your insurance company now uses an outsourced (3rd party) company to decide what is "medically necessary" and, in turn, what they will pay for.

You may have received notification from your insurance company however such policies can be confusing and because we value your trust in us, we want you to be aware of the reasons and processes involved.

The Authorization Process

1. Appointment with provider: The information required by your insurance company to apply for authorization can only be gathered from a normal appointment with your provider.
2. Care Plan and Treatment: you and your provider agree on the need for care and begin treatment.
3. Submission: PT Dynamix will submit the required paperwork for your based on the information gathered at your in-office visit.
4. Authorization: When authorization is granted it will specify (1) the number of visits and (2) the time frame allowed to use those. When the allowed visits are used or the time period expires a new authorization must be submitted. NOTE: this will apply regardless of the annual limits that your plan carries

Denials and Patient Responsibility

If a submission is not immediately approved it will go to "medical review". It may take days or weeks for the insurance company to get back to us with a determination of approval or denial. If your case does go to medical review, we will inform you so that you can make a decision to continue with care or wait until we receive the response.

Should you choose to receive care:

- Any visits that your insurance deems to lack "medical necessity" will become your financial responsibility. This is standard practice for any services rendered that are not covered by insurance. We always strive to keep you informed about where we are in the process of obtaining authorization.

- Due to the time sensitive nature of this process if you do not provide us with accurate insurance information and we are unable to obtain pre=authorization on your behalf then you may be responsible for the visit if we are unable to appeal.

- You cannot have two authorizations on file at the same time. If a past office has an active authorization file you will need to contact them to add a discharge date before the date of your first visit with us. If this is not done, we will be unable to obtain pre-authorization and you will be responsible for any visits not approved.

- Please discuss with your provider if you believe you may have an authorization on file at a different clinic or have questions about this process. Any visits that your insurance does not pay for due to this issue will be your responsibility.

PT Dynamix continues to be a leader on researching and managing these new systems to get you the best care possible. Unfortunately, this new cost saving strategy by your insurance company simply makes it more difficult for you to utilize your insurance policy benefits.

Please let us know if you have any questions or concerns. We are here to hep and do our best to make sure that you receive the care you need. Thank you.

Patient Signature **Date**

Printed Name

NOTE: If you are one of the many health insurance customers who feel that this new policy is an unreasonable barrier to getting care we encourage you to make this known by contracting your employer (HR), your insurance carrier and the Insurance commissioner. All complaints to the commissioner must be investigated and will hopefully lead to a change in regulation.

Call or send your letter:
Consumer Protection Services
Office of the Washington State Ins. Commission
P.O. Box 40256
Olympia, WA 98504-0256
Tel: (800) 563-6900

HIPAA AGREEMENT

(Patient Copy)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you an exercise by presenting a written request to the Privacy Officer.

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.

- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

PATIENT COPY

HIPAA AGREEMENT

(Notice of Privacy practices Acknowledgement)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed, to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ _____

Patient Signature **Date**

_____

Printed Name

_____ _____

Representative/Guardian Signature **Date**

_____

Printed Name

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so, as documented below:

Date:

Initials:

Reasons: