Intake Paperwork

Name:_____

Date of Birth:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Would you like emailed or texted appointment reminders? Email Text

Emergency Contact:_____ Phone:_____

Have you had Physical Therapy this year:_____

IF YOU ARE A CITY OF CHICAGO WORKER. HAVE YOU HAD CHIROPRACTIC SERVICES THIS YEAR? IF YES HOW MANY: _____

Physician:_____

Past Medical History:

- Heart Problems
- Diabetes
- Pregnant
- Osteoporosis
- Cancer
- AIDS/HIV
- Seizures
- Metal Implants
- Dizziness
- High Blood Pressure
- Breathing Difficulty
- Allergy to Metal
- Lyme's Disease

Please give information on any issues checked above:_____

_____

Patient Signature:_____

Date:_____

Consent to Treat:

I hereby authorize and give consent to JVB PT, LLC to provide physical therapy services that fall into their scope of practice in the State of Illinois

_____

Signature

Financial Policy:

JVB PT, LLC will work with your doctor and insurance to provide you with the most effective treatment. Below are our clinic policies:

- Co-Payments are due at the time of service
- We accept cash, checks and most major credit cards as payment
- Payment plans are available upon request

_____

Initial

Insurance Policy:

JVB PT, LLC accepts most major insurances, excluding HMOs, and will work with you on submitting your claims. Please know that your insurance may deny any or all services they deem not medically necessary. They also reserve the right to limit your visit number based on their policies despite having a physician's prescription.

I hereby authorize JVB PT, LLC to charge my insurance company accordingly.

_____

Signature

Cancellation/ No Show Policy:

JVB PT, LLC reserves time slots for each patient with a specific therapist to minimize your wait and to ensure the continuity of your treatment. Your consistent attendance is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in rare instances, cancellations and no-shows decrease our ability to treat you effectively and make it difficult to accommodate the scheduling needs of other patients.

In that regard, JVB PT, LLC enforces the following cancellation/ no-show policy:

All scheduled appointments shall be cancelled no later than 24 hours in advance of the date and time of the appointment. Patients that have cancelled a scheduled appointment without such 24-hour notice, or otherwise failed to attend ("No-Shows") a scheduled appointment shall be charged a $50.00 fee per occurrence. JVB PT, LLC reserves the right to cancel appointments in the event the patient is more than 20 minutes late. JVB PT, LLC also reserves the right to suspend all remaining treatment after a patient's 3rd violation of this policy. All cancellations and No-Shows will be documented and reported to your physician, case manager, and insurance /third-party payor.

Agreed:

_____

Signature

NOTICE OF PRIVACY PRACTICES

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

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by JVB PT, LLC, and of your individual rights and JVB PT, LLC's legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health information:
I may use and disclose at my discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing mental health care and related services.
- **Payment** means activities such as obtaining payment for the mental health care services I provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.

I will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to persons or agencies even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing a I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand my operation use of your information for treatment, payment and health care operations as stated above.

Signature Date