25 E Washington Street, Suite 1735

PATIENT INFORMATION

Name ____ Date of Birth __________________
(First) (MI) (Last)

Address ____ Apartment # ________________

City ________________________________ State __________ Zip __________________

Gender male female Marital Status married single divorced partnered other

Phone __________________________________ E-Mail ___________________________________

Employer ________________________________ Phone (work) ______________________________

Emergency Contact Name ______________________________

Relationship_____________________________ Phone __________________________________

How did you hear about Pegasus? Doctor Friend Yelp Website Other ____________________

PHYSICIAN INFORMATION

Referring Physician: ___________________________________ Phone ________________________

INSURANCE INFORMATION

Insurance Co ______________________________ Insurance Phone __________________________

Name of Policy Holder ___________________________ Relationship: Self Spouse Child Other

Policy Holder’s DOB________________ PolicyID#______________________ Group#______________

Secondary Insurance Co ____

Name of Policy Holder ___________________________ Relationship: Self Spouse Child Other

Policy Holder’s DOB________________ PolicyID#______________________ Group#______________

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WORKERS COMPENSATION CLAIMS

Is this an approved work-related Injury? YES NO

Employer Name ___________________________________ Phone ____________________________

Job Title ____ Date of Injury _______________________

Adjuster Name ___________________________________ Company ____________________________

Adjuster Phone _________________________________ Fax ____________________________________

Case Manager Name_________________________________ Company ___________________________

Phone ____ Fax ____________________________________

Claim # ____________________________________ Last Date Worked ___________________________

AUTO ACCIDENT INFORMATION

Motor Vehicle or Personal Injury Accident YES NO

Date of Auto Accident _______________________________

Motor Vehicle Compensation Carrier ____

Claim Number _______________________________ State in which Accident Occurred ______________

ATTORNEY INFORMATION (if a lawsuit is involved)

Law Firm Name ____

Attorney Name __________________________________ Attorney Phone ____________________________

Address ____

City ___________________________________ State ________________ Zip __________________

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PATIENT SCREENING FORM

Name: ____ Age:______________

(First) (MI) (Last)

For what problem(s) are you seeking physical therapy? ______________________________________

What date did your symptoms begin? ____

What makes your symptoms **better**? ____

What makes your symptoms **worse**? ____

What treatment have you received? Physical Therapy Chiropractor Acupuncture Surgery

Injections Massage Other_______________________

Please rate your pain ***Average*** - 0 is no pain and 10 being the most painful.

1 2 3 4 5 6 7 8 9 10

Please rate the ***Highest Intensity*** of your pain over the last 24 hours.

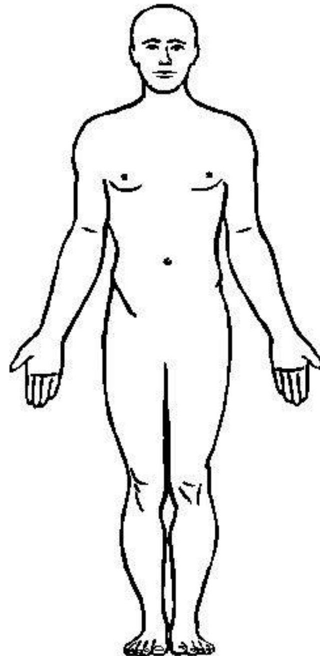
1 2 3 4 5 6 7 8 9 10

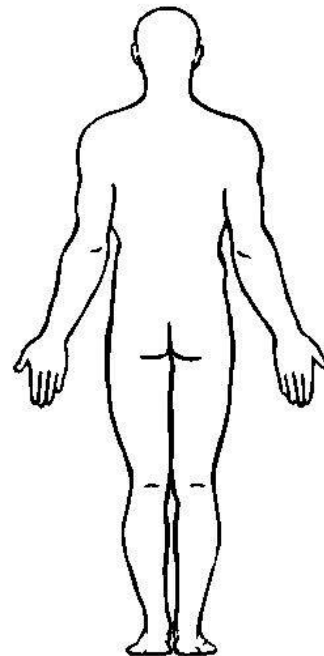
Please rate the ***Lowest Level*** of your pain over the last 24 hours.

1 2 3 4 5 6 7 8 9 10

Please use the chart below to indicate ***type*** and ***location*** of pain.

Burning: + + + + +
Stabbing: z z z z z
Numbness: / / / / /
Sharp: # # # # #
Deep Ache: o o o o o





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MEDICAL HISTORY

Have you experienced any of the following?

_____ Nausea/Vomiting	_____ Diplopia (double vision)	_____ Hypoglycemia
_____ Dizziness	_____ Diabetes	_____ Poor balance
_____ Shortness of breath	_____ Allergies to heat/cold	_____ Cancer
_____ High Blood Pressure	_____ HIV/Aids	_____ Seizures
_____ Fever/Chills/Sweats	_____ Weakness/Fatigue	_____ Chest Pain
_____ Osteoporosis	_____ Loss of balance/Falls	_____ Fainting

Past Medical History (please list all medical history and surgeries with dates):

____

Women, are you or think that you may be pregnant? **YES** Number of weeks: _______ **NO**

Medications

Please provide the name and dose of all medications, supplements, vitamins and over the counter drugs you are currently taking.

Medication (Name)	How Much (dose)	Frequency	Route of Administration
_________________________	_____________	_________	pill / patch / injection / inhaler
_________________________	_____________	_________	pill / patch / injection / inhaler
_________________________	_____________	_________	pill / patch / injection / inhaler
_________________________	_____________	_________	pill / patch / injection / inhaler

Occupation

Work Status (circle one): **Full Time** **Part Time** **Not Working**

Your typical workday consists of: Sitting Standing Walking Lifting ________ (pounds)

Exercise

Do you exercise? **YES** **NO** Typically, how many days per week do you exercise? _____________

Have you limited or avoided exercise as a result of your injury? **YES** **NO**

If so, has a lack of physical activity impacted your mood? **YES** **NO**

Please explain: ____

How would you describe your health in general? **Excellent** **Good** **Average** **Below Average** **Poor**

Is there anything else we should know about your condition?

____

I certify that the above information is complete, true and accurate to the best of my knowledge.

Patient Signature: ______________________________________ **Date:** _________________

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Consent and Statement of Financial Responsibility

CONSENT FOR TREATMENT: I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and considered necessary or advisable by my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.

RESPONSIBILITY FOR PAYMENT: I acknowledge that I am financially responsible for payment of my bill. I will provide Pegasus Physical Therapy with the most up to date insurance information. I understand health insurance coverage may cover a portion of the charges, remaining balances such as co-pays, deductibles and co-insurance are my responsibility. Should my account be turned over to a collection agency, I agree to pay all collection expenses incurred by Pegasus Physical Therapy. Please be advised that co-pays are due at the time of service.

ASSIGNMENT OF BENEFITS: I hereby assign Pegasus Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Pegasus Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Pegasus Physical Therapy's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Pegasus Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

CANCELLATION POLICY: At Pegasus, we choose not to penalize patients for canceling a physical therapy appointment, we understand that sometimes things get in the way (work, extreme weather, el mishaps). Understand that you are reserving the time of one of our clinicians, so please attend your scheduled treatments, or kindly provide 24-hour notice if you unable to keep your appointment.

HIPPA AUTHORIZATION: In compliance with HIPPA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

________________________________ ________________________________
Name/Relationship Name/Relationship

CONSENT FOR EMERGENCY CONTACT INFORMATION: Person to contact in case of an emergency.

____________________________ ____________________ ______________
Name Telephone Number Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Patient Name (Print) ____

Signature ___________________________________ Date ________________

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Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge to have received a copy of the Notice of Privacy Practices from Pegasus Physical Therapy.

Patient Name (print) ___________________________________

Signature ____ Date _______________

Office Use Only:

____ ___________________

Witness Date

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NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected health information about you is maintained as a written and/or electronic record. Specifically, it individually identifies you and relates to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare.
We are required by law maintain the privacy of your health information and provide you with a copy of this notice. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice, and make the revised or changed notice effective for all health information that we maintain. Any changes to this notice will be posted in our facility and posted on our website. Paper copies will be available upon request.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

- **Treatment** We may use your health information to coordinate, manage and provide healthcare and related services. We may disclose information to doctors, nurses, technicians or others involved in your care. For instance, if a doctor is treating you for hypertension, and we may need additional information to determine the best plan of care.
- **Payment** We may use and disclose health information, as needed, about you so the treatment and services you receive may be billed, and payment may be collected from you, an insurance company or a third party. An example may include certain activities that your health insurance plan may undertake prior to approving or paying for healthcare services that we recommend for you, such as making a determination of eligibility or coverage of health benefits.
- **Healthcare Operations** We may use or disclose, as-needed, your protected health information for day to day health care operations, to conduct quality assessments and improve our quality of care. For example, we may use or disclose PHI relating to the evaluation of patient care, business management activities, quality assessment and improvement, legal services, employee reviews, and auditing functions. All disclosures of your PHI will be limited to the minimum necessary or that which is contained in a limited data set.

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Required by Law We may use or disclose your health information when required to do so by federal or state law.

Special Notices We may contact you at the address and phone number you provide (including leaving a voice message) about scheduled or cancelled appointments, correspondence letters, marketing communications, billing and/or payment matters.

Public Health Risks We may release your health information for public health activities. For instance, the disclosure of information required for public health investigations.

Victims of Violence, Abuse or Neglect We may provide information to law enforcement if there is suspected abuse, neglect or violence relating to a child or the elderly.

Specialized Government Functions We may disclose your health information for military and veterans' affairs, or national security and intelligence activities.

Workers Compensation Both state and federal law allow, without your authorization, the disclosure of your health information that is reasonably related to a workers compensation injury. These programs may provide benefits for work related injuries or illness.

Law Enforcement We may disclose your health information for law enforcement purposes.

Others involved in your Healthcare Unless you object, we may disclose to a family member, relative, or close friend your PHI that directly relates to that person's involvement in your care. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosure of PHI.

Health Oversight Activities We may disclose your health information to health agencies authorized by law to conduct audits, investigations, licensure and inspections.

Business Associates We may disclose your health information to business associates who perform duties on our behalf or provide us services if the PHI is necessary for those functions or services. For example, we may use a shredding company to destroy paper medical records.

Judicial and Administrative Proceedings We may disclose health information in the course of a judicial or administrative proceeding in response to a court order.

To Avert a Serious Threat We may disclose health information when necessary to prevent a serious threat to your health and safety, or the health and safety of a particular person or the general public.

Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you.

Non-Custodial Parent We may disclose PHI about a minor equally to the custodial and non-custodial parent, unless a court order limits the non-custodial parent's access to the information.

USES AND DISCLOSURES THT REQUIRE YOUR AUTHORIZATION:
If you do not authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Your decision to revoke authorization will not affect or reverse any use or disclosure that occurred before you notified us of your decision.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:
Your have the following rights with respect to your protected health information.

The right to inspect and copy your protected health information.You have the right to inspect and obtain a copy of your healthcare information. This includes health and billing records. Your request to inspect and obtain a copy of your healthcare information must be made in writing. We will generally permit copying, inspection or copying of PHI.

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

The right to an electronic copy of your electronic medical records.

The right to request a restriction of your protected health information. You have the right to request a limit on the health information that we disclose about you for treatment, payment or healthcare operations (as described in this notice); in addition to family members who may be involved in your care or payment of your care. We are not required to agree to your requested restriction.

Out of pocket payments. If you paid out of pocket for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We are required to agree to your request.

The right to receive a security breach notice.

The right to request that you receive confidential communications. You have the right to request confidential communication from us by an alternate means or an alternate location.

The right to request an amendment to your protected health information. If you believe the health information we maintain about you is incorrect or incomplete, you may ask us to amend this information. This request must be made in writing, and must provide reasons to support your request. In some cases, we may deny your request.

The right to receive an accounting of certain disclosures. You have a right to receive a list of disclosures of you protected health information that we have made, except of disclosures pursuant to an authorization, for purposes of treatment, payment, healthcare operations, or required by law. Your request must state a time period which many not be long than 6 years before your request.

HOW TO EXERCISE YOUR RIGHTS:

To exercise your rights described in this notice, you must submit your request in writing to: Pegasus Physical Therapy-Medical Records Department, 25 E Washington Street, Suite 1310, Chicago, IL, 60602.

Your Legal Rights and Complaints: If you feel that your privacy or security rights have been violated, you have the right to file a complaint with our practice, or the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Pegasus Physical Therapy
Privacy Officer - Scott Johnson
25 E Washington Street, Suite 1735
Chicago, IL 60602

Secretary of the U.S. Department of Health and Human Services,
200 Independence Avenue S.W.
Washington D.C. 20201
Toll Free: 1-877-696-6775

This notice is effective as of September 22nd, 2014