INTEGRATIVE

MANUAL THERAPY & WELLNESS

NEW PATIENT PACKET

1. Patient information
2. Pain diagram
3. Medical history questionnaire
4. Financial Agreement/HIPPA

Norfolk Integrative Manual Therapy
NEW PATIENT INFORMATION

Patient Name (Last, First, MI) _____ DOB_____ Age_____

SS# _____ Referred by _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Sex: (please circle) M F

Marital Status: (please circle) Single Married Divorced Separated Widowed

Employer _____

Employer's Address _____ City, State, Zip _____

Employer's Phone _____

Primary Care Physician _____

FOR TRICARE PATIENTS ONLY: Sponsor's SS# _____ Military ID#_____

Branch of Service _____ Active or Retired (circle one) Rank_____

PRIMARY INSURANCE INFORMATION:

Insured/Responsible Person's Name (Last, First, MI)_____

DOB _____ Age _____ SS# _____

Insurance Company Name _____

Insured ID# _____Group # _____

Insurance Company Address _____

Circle Patient's Relationship to Insured/Responsible Person: Self Spouse Child Other

SECONDARY INSURANCE INFORMATION:

Insured/Responsible Person's Name (Last, First, MI)_____

DOB _____ Age _____ SS# _____

Insurance Company Name _____

Insured ID# _____Group # _____

Insurance Company Address _____

Circle Patient's Relationship to Insured/Responsible Person: Self Spouse Child Other

DO NOT WRITE BELOW THIS LINE

THIS PORTION TO BE COMPLETED BY THERAPIST AFTER INITIAL VISIT

DX _____ ONSET DATE _____

FEE ARRANGEMENT: PATIENT PORTION _____ INSURANCE PORTION _____

NEW PATIENT INFORMATION

Integrative Manual Therapy and Wellness

Name:_____

Date:_____ Age:_____

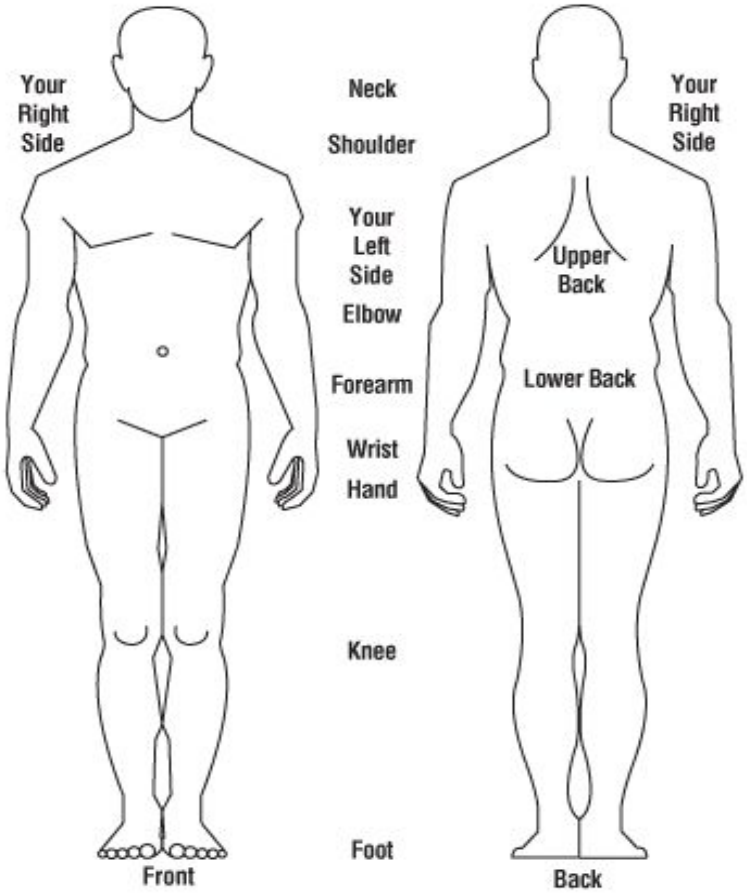
PAIN DRAWING

Instructions:

Mark these drawings according to where you hurt. For example, if the right side of your neck hurts, mark the drawing on the right side of the neck, etc. Please indicate which sensations you feel by referring to the key given below.

Key:

/ / / Stabbing	X X X Burning	000 Pins/Needles	= = = Numbness	+ + + Aching



Pain Level: 0 1 2 3 4 5 6 7 8 9 10
(circle your current pain level)

0	No pain.
1	Mild pain; you are aware of it but it doesn't bother you.
2	Moderate pain that you can tolerate without medication.
3	Moderate pain that requires medication to tolerate.
4-5	More severe pain; you being to feel antisocial.
6	Severe pain.
7-9	Intensely severe pain.
10	Most severe pain; it may make you contemplate suicide.

☐ Right Handed ☐ Left Handed

Norfolk Integrative Manual Therapy
Medical History Questionnaire

1. List all physicians, physical therapists, and chiropractors you have consulted for your present condition (please include dates): _____

_____

_____

_____

2. Scheduled Follow-up Visit with MD? (please circle) YES NO When?_____

3. List or attach all current medications _____

_____

4. For your current condition, have you had any of the following (please provide dates & results):

X-Ray _____ MRI _____
EMG _____ CT scan _____
Discogram _____ Myelogram _____
Bone Scan _____ Other _____
Injection _____ Was it helpful? _____
Surgery_____
Did you improve after surgery? Please explain _____
_____

5. Date of injury or symptom onset _____

6. Is this a:
- ☐ work related injury
- ☐ injury related to a motor vehicle accident
- ☐ sports related injury
- ☐ unrelated to any particular incident
- ☐ other _____

7. Briefly describe how this injury or symptoms occurred? _____

_____

_____

8. Is this a chronic problem? (please circle) YES NO Date of 1st episode_____
Please explain _____

_____

9. Where is your pain/injury located? _____

10. Please rate your pain intensity on a scale from 0-10 (see pain diagram)
Best_____ Worst_____ Average_____ Current_____

11. Describe your pain _____
_____

12. Is your pain:
☐ constant ☐ getting better ☐ getting worse ☐ staying the same

13. Check which activities change the nature of your pain, if applicable:

	INCREASES PAIN	DECREASES PAIN
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Rising to stand	☐	☐
Bending forward	☐	☐
Bending backward	☐	☐
Lying on your back	☐	☐
Lying on your stomach	☐	☐
Driving	☐	☐
Coughing/Sneezing	☐	☐
Sleeping	☐	☐
Reaching	☐	☐

Other _____

14. What activities can't you do because of your pain? _____
_____

15. What are your occupation and your responsibilities? _____
_____

16. Are you currently working? (please circle)
YES NO Restricted/Light Duty Full Duty Hrs/wk_____

17. How much time have you missed from work secondary to injury?_____
18. If you are not working now, do you plan to:
☐ return to same job ☐ modify your work
☐ change jobs ☐ apply for disability
19. (For women) Is there a relationship between your menstrual cycle and your symptoms? (please circle) YES NO

20. Do you smoke cigarettes? (circle) YES NO _____packs per day X_____ years

21. Do you drink alcoholic beverages? (please circle) YES NO _____/week

22. Do you drink caffeinated beverages? (please circle) YES NO _____/week

23. Are you currently:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

24. Have you been diagnosed with or have any of the following conditions?

- ☐ Diabetes
- ☐ Asthma
- ☐ Heart Disease/Heart Attack
- ☐ Rheumatic Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Seizure Disorder
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Prostate Problems
- ☐ Stomach Ulcers
- ☐ Kidney Infection
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Fractures _____
- ☐ Other _____
- ☐ Dizziness
- ☐ Fainting/Balance Problems
- ☐ Emphysema/Bronchitis
- ☐ Loss of Consciousness
- ☐ Difficulty with Bowel Movements
- ☐ Change in ability to urinate
- ☐ Headaches
- ☐ HIV/Aids
- ☐ Difficulty Sleeping
- ☐ Swelling of toes or fingers
- ☐ Fever
- ☐ Kidney Stones
- ☐ Tuberculosis
- ☐ Auto-Immune Disorder

25. Please list or circle any gastrointestinal problems (eg IBS, reflux, chronic constipation/diarrhea, Chron's disease, food allergies)_____

_____

26. Please list or circle any urogenital problems (eg frequent UTIs, bladder/kidney/ureter problems, fibroids, endometriosis, polycystic ovary syndrome)_____

_____

27. Please list ALL SURGERIES: _____

_____

28. Please list ALL physical trauma (accidents, falls, sports injuries, etc): _____

_____

_____

29. Are you currently pregnant? (please circle) YES (if so, congratulations!) NO

Due Date_____

Please explain any complications? _____

How many children have you had? _____

Were your labors/deliveries complicated? C-section? Please explain _____

_____

MOST IMPORTANTLY

What are your goals or what do you hope to achieve from participating in physical therapy at Norfolk Integrative Manual Therapy? (e.g. return to work, increase walking distance, stairs, lifting, return to sports, housecleaning, increase sitting/driving time…)

_____

_____

_____

NEW PATIENT INFORMATION
Integrative Manual Therapy and Wellness

FINANCIAL AGREEMENT
AND INDICATION OF RECEIVING HIPPA PRIVACY NOTICE

NIMT works very hard to maintain one hour physical therapy appointments as we are committed to your recovery; your one hour appointment is reserved time in our schedule. **Because missed appointments are not reimbursed by any insurance company, you are required to give 24 hour notice for cancellations or you will be charged the Full Self-Pay Rate for the missed appointment.** *Cancellations must be called in* to our office directly, or left on our practice voicemail if the office is closed.

I understand that I am responsible for: knowing/confirming my own physical therapy benefits with my insurance company; and meeting the requirements of my insurance plan. Although NIMT can help research your insurance coverage or pre-authorization I understand that some insurance companies require medical or administrative pre-authorization for treatment and that this is my responsibility. I also understand that some insurance companies have reimbursement limits on physical therapy.

I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. NIMT will routinely file insurance as a courtesy to you. However, it is agreed that NIMT will not be held responsible for any administrative errors in processing claims or for denial of claims by your insurer, and shall not be used as an offset against your bill.

Payment for services or your personal (co-pay) portion is expected at the time of service.

If the insurance portion of your bill is not paid within 60 days from the date of service, you will be responsible for the outstanding balance.

Other financial concerns: NIMT understands that financial difficulties occur and we will make every effort to work with you. However, if it becomes necessary to send your account to collections, you agree to pay all costs of collections including attorney's fees (of 33.3% and 18% interest per annum from date services were rendered) on unpaid balances accrued. Additionally, there is a $25 fee for returned checks.

Your signature below indicates you have received and agree with these terms throughout the course of your treatment and will allow NIMT to file insurance claims on your behalf, receive insurance reimbursements, and release information requested by your insurance company. Your signature below also indicates you have received NIMT's **Privacy Notice** to protect the privacy of your health information.

THIS DOCUMENT HAS BEEN READ BEFORE BEING SIGNED.

_____ _____

Signature of Patient/Parent/Guardian
(Person Responsible for Payment)

Date Signed

Print Name _____

PRIVACY NOTICE EFFECTIVE 06/01/03

This notice is written in accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CTR parts 160 and 164 (the "Privacy Regulation"). It describes now medical information about you and your family members may be used and disclosed and how you can get access to this information. Norfolk Integrative Manual Therapy is committed to compliance with the Privacy Regulations and all other laws and regulations pertaining to our patient's right to privacy. Please review it carefully, check the appropriate box to give us permission to file claims with your insurance company and place your signature at the bottom to indicate that you have read this notice.

As a general rule, therapists and physicians will disclose no information obtained from your contacts with them, or the fact that you are their patient, except with you written consent. Upon request for such authorization, you have the right the refuse and/or revoke any disclosure of your personal health information. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law.

NEW PATIENT INFORMATION
Integrative Manual Therapy and Wellness

PRIVACY NOTICE (CONTINUED)

I. It is our policy to provide information to others without your further consent in certain circumstances:

a) VACATIONS/EMERGENCIES (e.g., When your therapist or physician is on vacation or away from the office for extended periods of time, a colleague may cover for his/her practice and take emergency calls. If information is needed in order to assist you during their absence, it will be provided to the on-call therapist or physician.)

b) CONSULTATION (e.g., to insure that quality care is being provided, your therapist may meet with a consultant.) In so doing, no identifying information will be revealed. Your therapist will provide names of consultants upon request.)

c) BILLING (e.g., our billing clerk has access to the information necessary for preparing monthly statements and submitting insurance claims.)

d) EMPLOYEES (e.g., Office colleagues do not have access to other therapists' or physicians' records.)

II. Virginia law requires therapists to release information to others in certain circumstances:

a) Virginia therapists are required by law to report certain information:

(1)Suspicion of abuse or neglect of a child or of an aged or incapacitated adult must be reported to the Department of Social Services.

(2)Information that a therapist of physician is engaging in unethical illegal practice must be reported to their respective licensing board.

b) In Virginia court cases, therapist—patient privilege may not apply in certain cases including the following:

(1) criminal cases
(2) child abuse cases
(3) any court cases in which your physical therapy health is an issue
(4) any case in which the judge "in the exercise of sound discretion, deems it necessary to the proper administration of justice." This means that information communicated to a therapist can be admitted as evidence in a court case against your wishes if a judge so rules. Others sometimes issue a subpoena seeking either treatment records or testimony from your present or former therapist as evidence in a court case.

III. Information will be provided to the Third Party Payers only with your consent

If you wish to obtain third party reimbursement for physical therapy services certain information must be provided. You must decide whether to give consent for Norfolk Integrative Manual Therapy to release the necessary information to an insurance company (or other third party payer) in order to receive reimbursement. Initially, that usually involves providing information about dates of treatment, type of treatment, and diagnosis. If your therapist receives requests for further information these will be discussed with you before the information is provided.

For Managed Care Providers:

If your insurance company contracts with a company to administer (manage) the physical therapy portion of your health care benefits, this is called Managed Care. Many managed care companies require that you obtain a referral from your primary care physician and/or pre-authorization from a case manager in order to receive physical therapy services. In advance, (1) we will discuss possible limits on the benefits available through your plan; (2) we will review a Treatment Plan so that you understand what will be required in order to request reimbursement; and (3) we will discuss the payment plan that will be in effect in the event that our work together continues past the point when third party reimbursement is available.

Most managed care companies initially authorize a limited number of sessions, then require that your therapist furnish a written report pertaining to your progress in physical therapy and goals for your therapy. If additional sessions are authorized, updated Treatment Plans about your progress may be required throughout our work together; your therapist will discuss the content of each Treatment Plan before it is sent to the managed care company.

The information provided to any third party payer becomes a permanent part of your file with them; neither you nor your therapist will have control over the future confidentiality of that information, including whether it is made available to an insurance data bank and/or your employer, or is re-released for other purposes.

NEW PATIENT INFORMATION
Integrative Manual Therapy and Wellness

PRIVACY NOTICE (CONTINUED)

IV. Your Patient Rights
a) RIGHT TO REQUEST RESTRICTIONS (You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your therapist may not be required to agree to a restriction that you request.)
b) RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS (You have the right to request and receive confidential communications of personal health information by alternative means and at alternative locations such as having your bills sent to a different address.)
c) RIGHT TO INSPECT AND COPY (You have the right to inspect or obtain a copy (or both) of your personal health information and physical therapy notes in your therapist's records and billing records that are used to make decisions about you for as long as the personal health information is maintained in the record (in this office six years).
d) RIGHT TO AN ACCOUNTING (You generally have the right to receive an accounting of the disclosures of your personal health information for which you have neither provided consent or authorization as described in Section II of this Notice. On your request, your therapist will discuss with you details of this accounting process.)
e) RIGHT TO A PAPER COPY (You have the right to obtain a paper copy of the notice from your therapist upon request, even if you have agreed to receive the notice electronically.)

Additional Information: In order to check compliance with the HIPPA regulations, the U.S. Department of Health and Human Services can request copes of your medical record from your therapist. Norfolk Integrative Manual Therapy reserves the right to change this Notice and to make a revised and changed notice effective for medical information that NIMT may already have about you as well as any information we receive in the future. We keep a copy of the current Notice containing the effective date in the waiting room of NIMT.

AUTHORIZATION TO RELEASE INFORMATION

I authorize INTEGRATIVE MANUAL THERAPY & WELLNESS and their staff to release any information deemed appropriate concerning my physical condition to my primary care physician noted below, any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and her by release IMTW of any consequence thereof. I agree that a photocopy of this agreement shall serve as the original.

Signature_____ **Date**_____

Witness_____

NOTICE OF ASSIGNMENT

I hereby authorize and direct payment of any medical expense benefits allowable to IMTW as payment toward the total charges for professional services rendered. I agree that a photocopy of this agreement shall serve as the original.

Signature_____ **Date**_____

Witness_____

Assignment and/or release authorization is granted to:

Norfolk INTEGRATIVE MANUAL THERAPY & WELLNESS Initials_____

Primary Care Physician: _____ **Initials**_____

Other: _____ **Initials**_____

_____ **Initials**_____