PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/_____/_____

Patient Address: _____ City: _____Zip:_____

Cell Phone: _____Email: _____

Occupation: _____

Date of Injury: _____ Date of Surgery: _____

Referring Physician: _____ Primary Physician: _____

Person to Contact in Case of Emergency:

First and Last Name: _____ Phone: _____

If this injury was due to a motor vehicle accident, please fill in the following:

Name of motor vehicle insurance: _____ Phone #: _____

Adjusters Name: _____ Claim #: _____

Name of insured: _____

Do you have an attorney? Yes____ No____

If yes, name: _____ Phone #: _____

Please read and initial the following statements:

_____ I hereby authorize Telos Therapy to provide treatment as prescribed by my physician.

_____ I hereby authorize the release of medical records to Telos Therapy and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

_____ I understand that I am legally responsible for payment of all services rendered by Telos Therapy. If my insurance is being billed, I well be responsible for paying co-payment and deductible amounts. I understand that co-payments are due at the time of service.

_____ I understand that I will be charged $50 for missing a scheduled appointment without giving 24 hours notice.

_____ _____

Signature of Patient Date

PATIENT HISTORY

Describe briefly the history of your present Accident, Injury, Illness or Condition:

Onset Date: _____ Description: _____

_____

List any special concerns, questions or expectations:_____

_____

_____.

Have you had <u>any physical therapy</u> during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? _____ If yes, please indicate where and when:

_____

List **ALL** medications you are currently taking:_____

_____

List recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____

_____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.? Describe

_____

List **ALL** surgeries you have had; please give procedures and dates, if possible: _____

_____

_____

_____

_____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Tobacco use	Yes	No
Diabetes	Yes	No			

_____ _____

Signature of Patient/Guardian Date

Please provide us with a copy of your insurance cards

SUMMARY NOTICE OF PRIVACY PRACTICES

Telos Therapy is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THE FOLLOWING CAREFULLY.

"Protected health information" is information about you, including demographic information, present or future physical or mental health or condition and related health care services. We are required by law, in most instances, to have your written consent before we use or disclose to others your medical information for the purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may sometimes use or release your information without your consent or authorization as may be required or permitted by certain laws.

You have the right to the following:

- Look at and make copies of your protected health information
- Ask us to not release parts of your protected health information
- To be told when we release your protected health information
- Ask us to contact you only in certain ways
- Request us to change parts of your protected health information
- File a complaint if you think your rights have been violated

THIS IS ONLY A SUMMARY

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time. You have the right to obtain a copy of our most recent Notice in effect. Please ask the front desk if you wish to receive a full copy of our Notice of Privacy Practices.

If you have any questions, concerns, or complaints about the Notice or your protected health information, please contact Stefany Sarelas, PT at 312-404-1548.

My signature below indicates:

- I have been provided with the Summary Notice of Privacy Practices and I am aware that I may obtain the most recent copy of the Notice of Privacy Practice in its entirety at the front desk.
- I authorize Telos Therapy, LLC to use and disclose my health and medical information for the purposes of Treatment, Payment, and Healthcare Operations.

_____ _____

Signature of Patient/Guardian Dat