BLUE ROSE
PHYSICAL THERAPY

PATIENT INFORMATION

Patient's Name_____ DOB _____ Gender: M / F
last first MI

Address_____ City/State/Zip _____

Social Security Number (SSN) _____ Email _____

Home Phone_____ Cell Phone_____ Best Contact Method: ☐ Call ☐ Text ☐ Email

Employer _____ Occupation_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If married, spouse's name_____ DOB _____

Emergency Contact _____ Phone# _____ Relation _____

HEALTH INSURANCE INFORMATION

Primary Insurance Carrier _____ Group #_____ Policy#_____

Policy Holder _____ Relation to Patient _____ DOB _____ SSN_____

Secondary Insurance Carrier _____ Group #_____ Policy#_____

Policy Holder _____ Relation to Patient _____ DOB _____ SSN_____

Are you **currently** receiving Home Health Services? ☐Yes ☐No

WORKER'S COMPENSATION

(Skip Section if not applicable)

Carrier _____ Mailing Address _____ Phone#_____

Date of Injury_____ Claim # _____ Case Manager _____

MOTOR VEHICLE ACCIDENT

(Skip Section if not applicable)

Auto Insurance or Med Pay _____ State the Accident Occurred _____

Date of Injury_____ Adjuster _____ Phone # _____ Claim # _____

Attorney (if involved) _____ Mailing Address _____

Phone # _____ Fax # _____ Has your insurance been advised? ☐Yes ☐No

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FINANCIAL POLICY

I acknowledge that my physical therapy benefits via current health insurance have been explained to my satisfaction and it is ultimately my responsibility for any co-pay(s), deductible(s), co-insurance amount, or any other balance that is not paid for by my insurance, including medical supplies. I acknowledge that I should and will contact Blue Rose Physical Therapy if I do not understand my physical therapy benefits, have questions about any balances or due payments, or if I am unable to provide such payments before receiving treatments**. I understand the quotes provided in relation to insurance coverage for provided services are estimates only and should not be taken as the exact balance that will be owed. I acknowledge I am responsible for any balance not covered by insurance and I have the right and responsibility to contact my current health insurance for full explanation of benefits and any other inquiries in regard to my individual policy.**

Patient/Parent or Legal Guardian: _____ Date: _____

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Blue Rose Physical Therapy. The physical therapist will explain the nature and purposes of these procedures, evaluation, and plan of care. The physical therapist will inform me of expected benefits and potential complications, discomforts, and risks that may arise. The physical therapist will provide education of alternatives to the proposed treatment and the risk and consequences of no treatment.

Patient/Parent or Legal Guardian: _____ Date: _____

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Patient Medical Screening

Name: _____ Date: _____ DOB: _____

Referring Physician: _____ Primary Physician: _____
(PCP)

How did you hear about us? □ Family/friend □ Social Media □ Internet/Google □ Other _____

Occupation: _____ Are you currently working? □ Yes □ No _____

Present Problem: _____

Date of injury: _____ Have you experienced these symptoms before? □ Yes □ No

What relieves your current pain? _____ What worsens your pain? _____

Check all that apply to your current condition:

□ Fever/Chills	□ Numbness/Tingling	□ Headaches	□ Falls
□ Unexplained Weight Loss	□ Shortness of Breath	□ Vomiting/Nausea	□ Pain with Meals
□ Dizziness	□ Chest Pain	□ Difficulty Swallowing	□ Speech Difficulty
□ Increased Night Pain	□ Changes in Bowel/Bladder	□ Vision Changes	□ Fainting

Check all that apply to your Previous Medical History:

□ Cancer	□ Arthritis	□ High Blood Pressure	□ Depression
□ Diabetes	□ Heart Disease	□ Stroke	□ Mental illness
□ Pacemaker	□ Liver Disease	□ Blood Clot(s)	□ Osteoarthritis
□ Kidney Disease	□ Lung Disease	□ Fibromyalgia	□ Rheumatoid Arthritis

Smoker? □ Yes □ No If so, How many years? _____ Pregnant? □ Yes □ No If so, How many weeks?_____

Allergies: _____

Past Surgical History: _____

_____

Current Medications: _____

_____

_____

The Patient Health Questionnaire- 2

The PHQ-2 inquiries about the frequency of depressed mood and anhedonia over the past two weeks. The purpose of the PHQ-2 is to screen for depression in a "first-step" approach.

Please circle the following numbers that best represents your mood over the past two weeks:

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

I attest the information above is correct to the best of my knowledge:

Patient/Parent or Legal Guardian: _____ Date: _____

HIPPA NOTICE OF PRIVACY RIGHTS AND PRACTICES

THIS "NOTICE" DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY (EFFECTIVE DATE 7/2021). You have the right to restrict how your protected patient health information (PHI) is used and disclosed for treatment, payment, other healthcare operations, and for other purposes that are permitted or required by law. We are required by the Health Insurance Portability and Accountability Act (HIPAA) to maintain privacy of your health insurance and provide you a copy of our Notice of Privacy Rights and Practices. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Blue Rose Physical Therapy is required by law to abide by the conditions of this Notice currently in effect.

Below describes the ways and purposes we may use and disclose health information about you:

Treatment, Payment and Health Care Operations

For Treatment and to Run our Organization: We will keep records of each visit and make uses and disclosures of your PHI as necessary for your treatment. Physicians, nurses, and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include tests, results, medications, medical history, etc. Your medical information may also be used to remind you about upcoming appointments**.** We may use your health information to run our practice, improve your care, and contact you when necessary.

For Payment and Billing: We will make uses and disclosures of your protected health information as necessary for payment and reimbursement purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

For Healthcare Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Academia/Research: In certain circumstances, we may use and disclose your protected health information for academia and research purposes. In all cases where we do not need to obtain specific authorization, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board (IRB) which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement, Workers' Compensation, Other Government Requests: We may release health information if asked to do so by law enforcement officials. For example, reporting certain injuries as required by law or in response to a court order, subpoena, workers' compensation request, or similar process. Blue Rose Physical Therapy shall, following the discovery of a breach of unsecured protected health information, notify each affected individual.

Public Health and Safety: We can share health information about you for certain situations, such as: preventing disease, product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.

Compliance with Laws: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal law.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility and be updated online. The notice will contain on the first page, the effective date. In addition, each time you register as a new patient for treatment or health care services, we will offer you a copy of the current notice in effect. This notice is also available at www.bluerosephysicaltherapy.com.

You may also file a complaint with the Office of Civil Rights US Department of Health and Human Services by sending a letter to 200 Independence Ave. S.W., Washington, D.C 20201, call 1-877-696-6775 or visit www.hhs.gov/ocr/privacy/hipaa/complaints

Filing a complaint will not affect the treatment or services you receive. Please contact us to exercise any of the above items using the information at the end of this Notice. You may have to complete a form and submit your request in writing. For example, to request an amendment of your record you must fill out a form.

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA. For more information or questions about this Notice, please contact the Front Office at BRoffice@bluerosephysicaltherapy.com.

PATIENT'S RIGHTS AND RESPONSIBILITIES

You, as the client, have the right to:

1. Receive courteous, respect, dignity, and timely responsive treatment to meet your needs.
2. Access to impartial care- all clients receive quality and exceptional care regardless of gender, sexual orientation, age, color, race, national origin, or disability as protected by the law.
3. You have the right to receive care in a health and safe environment.
4. Refuse care at any point as permitted by law and to be informed of the medical consequences of refusing such care.
5. Have your cultural, spiritual, psychosocial and personal values, beliefs, preferences and convections respected.
6. Copy or inspect to your medical records upon written request, or amend any protected health information you previously provided.
7. Expect all of your information confidential, unless otherwise released by you with written consent.
8. Know the clinic rules and regulations that apply to your conduct as a client of Blue Rose Physical Therapy.
9. You have the right to be advised and educated of the researched related with your care. You have the right to refuse to participate in any research projects.
10. Have visitors present during your care if approved by attending therapist. However, the Physical Therapist does have the right to not allow such visitors if deem a health concern to client and others, as well as if such visitation with negatively interfere with treatment session.
11. You may request restriction on uses and disclosures of your Protected Health Information in order to carry out treatment, payment, and other related healthcare operations, but Blue Rose Physical Therapy is not required to agree to any restrictions requested.
12. Revoke authorization of personal health information, provided that the revocation is in writing, except to the extent that Blue Rose Physical Therapy has taken action in reliance thereon or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
13. Get a list of those with whom we've shared your information.
14. Get a copy of this privacy notice.
15. Choose someone to act for you.
16. File a complaint if you believe your privacy rights have been violated.

You, as the client, have the responsibilities to:

1. Attend therapy sessions on time, participate in activates, promote a positive attitude, and remain consistent with home exercise program as provided by your therapist(s) while active with Blue Rose Physical Therapy.
2. Provide the most complete and accurate medical and health information to the best of your ability.
3. Contact your health insurance provider for full explanation of benefits and any other inquiries in regard to your individual policy.
4. Pay any balance that is not covered by your insurance policy for such services including, co-pays, co-insurance, and/or deductibles, as well as non-covered services.
5. Provide the clinic a 24-hour advance if requesting a reschedule or cancellation (may be subject to fees- see Cancellation/No Show Policy).
6. Be considerate of the other clients' rights while attending Blue Rose Physical Therapy.

I confirm that I have read the HIPAA Notice of Privacy Rights and Practices and Patient's Rights and Responsibilities.

Patient/Parent or Legal Guardian: _____ Date: _____

PHOTO AND VIDEO RELEASE FORM

I consent and authorize Blue Rose Physical Therapy to use or reproduce my image or likeness in any photographs, videos, or other digital media for printed or web-based publications. The publications in reference may be, but not limited to social media, videos, emails, website and/or affiliates, newsletters, general publications, educational presentations, blogs, and marketing brochures. I authorize Blue Rose Physical Therapy to copy, edit, and otherwise alter my image or likeness of any format in any way they deem fit and forfeit my rights to inspect or approve of such changes. I also waive my rights to any royalties or other compensations arising from or related to the use of the image(s).

- ☐ I am 18 years of age or older
- ☐ I authorize the use of my First and Last name
- ☐ I authorize the use of my First name only
- ☐ I do not authorize any use of my name

Client Signature (if over 18): _____ Date: _____

Parent or Guardian Signature (if under 18) _____

Name (Printed): _____

BLUE ROSE
PHYSICAL THERAPY

ATTENDANCE POLICY

Here at Blue Rose Physical Therapy, we strive for excellence to best Serve You! The best way to ensure we best Serve You is to arrive consistently to your scheduled therapy appointments. Your attendance and full participation with your treatment regimen given by your expert therapist(s) is vital to your recovery. We will make every effort to best accommodate and meet your needs on the schedule because we know your time is valuable and we ask that you do the same for us. Please review our cancellation and no show policy guidelines below:

1. Please provide a **24-hour notice** if you would like to reschedule or cancel an appointment. If you do not provide the **24-hour notice**, you may incur a **$20.00 cancellation fee**.
2. All cancellations and no shows will be documented in your medical record and be provided to your referring physician in an appropriate manner.
3. If you fail to arrive to your scheduled appoints **(NO SHOW)** without notifying the front office or therapists, you may be charged the **$20.00 cancellation fee** each missed visit. If you have 3 no shows or an excessive cancellation rate, the remaining visits will be cancelled due to non-compliance to your clinical program.
4. If you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule that appointment as to not negatively impact the schedule and care of our other valued clients.
5. All fees are to be paid in full and are the responsibility of the client, not the responsibility of the insurance or third party payor.

The Attendance Policy is in place and written in such a way to provide the utmost level of care and to ensure ALL of our clients have the greatest opportunity to achieve their goals and wanted/deserved outcomes.

Everyone here at Blue Rose Physical Therapy wants the best for ALL of our clients and we truly appreciate your future cooperation with this policy. We are excited to assist you in accomplishing your goals and get you back to your passions in life as safely and quickly as possible.

Patient/Parent or Legal Guardian: _____ Date: _____