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Patient Demographics

Patient Information

Name _____Preferred Name_____

Social Security #_____Date of Birth_____

Phone_____Gender: Male/Female/Non-Binary (circle)

Address_____

How did you hear about Perception Physical Therapy?_____

Email (for appointment reminders):_____

Patient Employment Information

Employment Status (circle) Full/Part-Time/Retired/Unemployed/Disabled/Student

Occupation_____Employer_____

Address_____Phone_____

Patient Emergency Contact

Name_____Relationship to Patient_____Phone_____

Responsible Party (if under 18yo)

Name_____Relationship to Patient_____Date of Birth_____

Phone_____Address_____

Consent to Treat

I authorize Perception Physical Therapy to examine me, administer treatment as necessary, and perform procedures that are considered therapeutically or diagnostically necessary.

Patient/Guardian Signature_____Print Name_____Date _____

Release of Information

I authorize the release of information to the following individuals. I understand that only the individuals listed below will be able to obtain information regarding myself (including date and time of appointments):

(1)_____
(2)_____
(3)_____
(4)_____

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Patient Medical History

Name_____Date_____

Reason for Visit_____Date of Injury_____

Is this related to a Workers Compensation claim? Yes/No

Is this related to an Auto Accident claim? Yes/No

List all surgeries with date:	List all imaging/testing with date:	List all medications with dosage:

Are you currently experiencing any of the following (please check all that apply):

Health in General
- ❑ Lack of energy
- ❑ Unexplained weight gain or weight loss
- ❑ Loss of appetite
- ❑ Fever
- ❑ Night sweats
- ❑ Pain in jaws when eating
- ❑ Scalp tenderness
- ❑ Prior diagnosis of cancer

Ears, Nose, Mouth & Throat
- ❑ Sinus problems
- ❑ Runny nose
- ❑ Post-nasal drip
- ❑ Ringing in ears
- ❑ Mouth sores
- ❑ Loose teeth
- ❑ Ear pain
- ❑ Nosebleeds
- ❑ Sore throat
- ❑ Facial pain or numbness

Cardiovascular
- ❑ Irregular heartbeat
- ❑ Racing heart
- ❑ Chest pains
- ❑ Swelling of feet or legs
- ❑ Pain in legs with walking

Respiratory
- ❑ Shortness of breath
- ❑ Night sweats
- ❑ Prolonged cough
- ❑ Wheezing
- ❑ Sputum production
- ❑ Prior tuberculosis
- ❑ Pleurisy
- ❑ Oxygen at home
- ❑ Coughing up blood
- ❑ Abnormal chest x-ray

Gastro-Intestinal
- ❑ Heartburn
- ❑ Constipation
- ❑ Intolerance to certain foods
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Difficulty swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Blood in stools
- ❑ Unexplained change in bowel habits
- ❑ Incontinence

Genito-Urinary
- ❑ Painful urination
- ❑ Frequent urination
- ❑ Urgency
- ❑ Prostate problems
- ❑ Bladder problems
- ❑ Impotence

Musculoskeletal
- ❑ Joint pain
- ❑ Aching muscles
- ❑ Shoulder pain
- ❑ Swelling of joints
- ❑ Joint deformities
- ❑ Back pain

Integumentary
- ❑ Persistent rash
- ❑ Itching
- ❑ New skin lesion
- ❑ Change in existing skin lesion
- ❑ Hair loss or increase
- ❑ Breast changes

Neurologic
- ❑ Frequent headaches
- ❑ Double vision
- ❑ Weakness
- ❑ Change in sensation
- ❑ Problems with walking or balance
- ❑ Dizziness
- ❑ Tremor
- ❑ Loss of consciousness
- ❑ Uncontrolled motions
- ❑ Episodes of visual loss

Psychiatric
- ❑ Insomnia
- ❑ Irritability
- ❑ Depression
- ❑ Anxiety
- ❑ Recurrent bad thoughts
- ❑ Mood swings
- ❑ Hallucinations
- ❑ Compulsions

Endocrinologic
- ❑ Intolerance to heat or cold
- ❑ Menstrual irregularities
- ❑ Frequent hunger/ urination/thirst
- ❑ Changes in sex drive

Hematologic
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Anemia
- ❑ Abnormal blood tests
- ❑ Leukemia
- ❑ Unexplained swollen areas.

Allergic/Immunologic
- ❑ Seasonal allergies
- ❑ Hay fever symptoms
- ❑ Itching
- ❑ Frequent infections
- ❑ Exposure to HIV

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Notice of Privacy Practices

This Notice describes how Perception Physical Therapy LLC may use and disclose your healthcare information and how you can obtain access to this information. Please review it carefully.

Perception Physical Therapy LLC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Perception Physical Therapy LLC or received by Perception Physical Therapy LLC from other healthcare providers. We are required to provide you notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this notice. Perception Physical Therapy LLC will abide by the terms of this notice, or the notice currently in effect at the time of the use or disclosure of your protected health information.

Perception Physical Therapy LLC reserves the right to change the terms of this notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses of Disclosures of Your Protected Health Information Not Requiring Consent:

Perception Physical Therapy LLC may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment, and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment May Include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers.
- Consultations between healthcare providers concerning a patient.
- Referrals to other providers for treatment, including nursing homes, foster care homes, or home health services.

For example, Perception Physical Therapy LLC may determine that you require the services of a specialist. In referring you to another doctor, Perception Physical Therapy LLC may share or transfer your healthcare information to that doctor.

Payment Activities May Include:

- Activities undertaken by Perception Physical Therapy LLC to obtain reimbursement for services provided to you.
- Determining your eligibility for benefits or health insurance coverage.
- Managing claims and contacting your insurance company regarding payment.
- Collecting activities to obtain payment for services provided to you.
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges.
- Obtaining pre-certification and re-authorization of services to be provided to you.

For example, Perception Physical Therapy LLC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Perception Physical Therapy LLC may contact you, by phone, text, mail, or email to provide appointment reminders. You may notify us if you do not wish to receive appointment reminders.

Perception Physical Therapy LLC may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Perception Physical Therapy LLC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

As permitted or required by law.

- In certain circumstances, we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement officials for the purpose of reporting an apparent crime on our premises.

For public health activities.

- We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authorities authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

For health oversight activities.

- We may disclose health records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring, and evaluation and facility or individual licensure of certification. HIV test results may not be released to federal or state government agencies without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

Judicial and administrative proceedings.

- Patient healthcare records, including treatment records and HIV results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records, except for HIV results.

For activities related to death.

- We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigation for a death. HIV test results may be disclosed under certain circumstances.

For research.

- Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

To avoid a serious threat to health or safety.

- We may report a patient's name and other relevant data to the Department of Transportation, if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For worker's compensation.

- We may disclose your health information to the extent such records are reasonably related to any injury for which worker's compensation is claimed.

For business associates.

- We may disclose your health information to other entities that provide a service to Perception Physical Therapy LLC that requires the release of your health information, but only if we have received satisfactory assurance that the other entity will also protect your health information.

Perception Physical Therapy LLC will not make any other use of disclosure of your protected health information without your written authorization. Perception Physical Therapy LLC will not use your health information to contact you for marketing purposes or sell your health information without your written consent. You may revoke such authorization at any time, except to the extent that Perception Physical Therapy LLC has taken action in reliance thereon. Any revocation must be in writing.

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Insurance Notification

Services provided by Perception Physical Therapy LLC are payable at the time of service. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance, and although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payments made on your behalf.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know the limitations associated with your insurance policy. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company. It is also your responsibility to notify us if your insurance changes or terminates. You will be responsible for any unpaid services. If you have additional questions, you will need to speak to someone prior to your appointment or contact your insurance company directly for all specific plan benefit information.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Perception Physical Therapy LLC's Notice of Privacy Practices. This notice describes how Perception Physical Therapy LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information. I am aware and agree that Perception Physical Therapy LLC may use or disclose my health information for research purposes, under certain limited circumstances, and that, in the event my medical records are requested by a third party, I, or my appointed legal guardian, must sign a medical release form in order to distribute that information.

By signing below, I am acknowledging that I have read, understand, and agree to the **Release of Information, Insurance Notification, and the Notice of Privacy Practices**.

Patient/Guardian Signature_____Print Name_____Date _____

Patient Cancellation and No-Show Policy

This policy has been established in order to provide the highest level of physical therapy service to all our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation we may be able to accommodate other patients with your appointment slot.

- Patients must call at least 24 hours prior to their scheduled appointment time, when they knowingly are unable to make their appointment. Cancellations with less than 24 hours of appointment time will be considered a "late cancellation".
- A "no-show" is when a patient does not show up for their scheduled appointment time without prior notice.
- After two (2) "no-shows" and/or "late cancellations" occur the patient (not insurance) will be charged $150 for each missed appointment moving forward.

Our practice firmly believes that a good physical therapist/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show policy should be directed to the office manager at Perception Physical Therapy LLC 907-312-1233.

We understand that emergencies happen. In the event of an emergency (sickness, work related, death in the family, etc) exceptions may be made when adequate documentation is provided.

Please sign that you have read, understand, and agree to this cancellation and no-show policy.

Patient/Guardian Signature_____Print Name_____Date _____

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Your Rights Regarding Your Protected Health Information (HIPPA)

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Perception Physical Therapy LLC to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restrictions, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to restrict disclosure of your health information to a health plan if you choose to pay out-of-pocket in full for the services at the time they are provided.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Perception Physical Therapy LLC may deny access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Perception Physical Therapy LLC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Perception Physical Therapy LLC not send information to a particular address or location or contact you at specific locations, such as your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to be notified if your unsecured health information is breached.

You have the right to request that Perception Physical Therapy LLC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing and under certain circumstances, the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Perception Physical Therapy LLC for the six years prior to the date of the request. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request to receive a paper copy of the notice, if you have previously received or agreed to receive the notice electronically.

Any person or patient may file a complaint with Perception Physical Therapy LLC and/or the Secretary of Health and Human Services if they believe their rights have been violated. To file a complaint with Perception Physical Therapy LLC, please contact the Privacy Office at the following: **Privacy Officer: c/o Perception Physical Therapy LLC, 205 East Benson Blvd, Suite 439, Anchorage, AK 99503, 907-312-1233 (p).**

It is the policy of Perception Physical Therapy LLC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspect or actual non-compliance or violation of the privacy standards.

Patient/Guardian Signature_____Print Name_____Date _____