Bull Dawg
ATHLETIC TRAINING AND PHYSICAL THERAPY

Bull Dawg Athletic Training and Physical Therapy
5001-A Langston Boulevard, Suite 102 Arlington, VA 22207
Phone: 571-970-6068 | Email: info@bulldawgtraining.com

Physical Therapy Intake Form

Last Name:____________________ First Name: _______________________ Middle Name: _________________

Date of Birth: __________________ Social Security Number: ________________ Sex: _______ Age: ______

Home Address: ____

City: _______________________________________ State: ___________________ Zip Code: _____________

Home Phone: ________________________ Cell Number: _____________________________

Email: ____

Marital Status: Single ( ) Married ( ) Other ( )

Employment Status: Full Time ( ) Part-Time ( ) Student ( ) N/A ( )

Work Address: ____

City: _______________________________________ State: ___________________ Zip Code: _____________

Emergency Contact, Legal Guardian, Insured Information

Last Name:____________________ First Name: _______________________ Middle Name: _________________

Home Address: ____

City: _______________________________________ State: ___________________ Zip Code: _____________

Home Phone: ________________________ Cell Number: _____________________________

Email: ____

Parent/Guardian Date of Birth:________________________

Referring Physician Information

Last Name:___________________ First Name: ____________________ Office Name: _____________________

Address: ____

City: _______________________________________ State: ___________________ Zip Code: _____________

Phone Number: ________________________ Fax Number: _____________________________

Email: ____

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Health History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form, and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Full Name:________________________ Date of Birth: _______________________ Age: __________

Referring Physician: ____________________________ Family Physician:___________________________

Emergency Contact Name: _______________________________________

Date of Last General Health Check: ___________________________ Occupation: ___________________

What is your injury? _______________________________________

Have you had Surgery for this injury? Yes ( ) No ( )
Surgery Dates (if applicable): ___________________________

Are You Currently Taking Any Prescription or Non-Prescription Medications? Yes ( ) No ( )
Please list all medications you're taking (if applicable):

____

____

____

Have you had any of the following Medical or Rehabilitative Care for this injuries/Episode? If yes, when?

____

	Yes	No		Yes	No
Chiropractor	____	____	CT Scan	____	____
General Practitioner	____	____	EMG/NCV	____	____
Occupational Therapy	____	____	MRI	____	____
Physical Therapy	____	____	Myelogram	____	____
Massage Therapy	____	____	X-Ray	____	____
Neurologist	____	____	Emergency Room Care	____	____
Orthopedist	____	____	Podiatrist	____	____

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Do you now have, or have you ever had, any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis. Or Emphysema	___	___	Severe or frequent Headaches	___	___
Shortness of Breath/ Chest Pain	___	___	Vision or Hearing difficulty	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack/Heart Surgery	___	___	Weight Loss/Energy Loss	___	___
Blood Clot/Emboil	___	___	Hernia	___	___
Stroke/TIA	___	___	Epilepsy/Seizures	___	___
Allergies	___	___	Thyroid Trouble/Goiter	___	___
Pins or Medal Implants	___	___	Incontinence (Urinary/fecal)	___	___
Joint Replacement (ant joint)	___	___	Bowel or Bladder Problems	___	___
Diabetes	___	___	Neck Injury/ Surgery	___	___
Infectious Diseases	___	___	Shoulder Injury/Surgery	___	___
Cancer/Chemotherapy/ Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis/Swollen Joints	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Sleeping Problems/Difficulty	___	___	Leg/Ankle/Foot Injury	___	___
Do you smoke	___	___	Surgery	___	___
Latex Sensitivity/Allergy	___	___	Multiple Sclerosis/Parkinson's	___	___
Pelvic inflammatory disease	___	___	Endometriosis	___	___
Irregular Menstrual Cycle	___	___	Are you pregnant?	___	___
Complicated pregnancies/delivery	___	___			

What daily activities, functions, and skills do you have difficulty performing because of your injury?

____
____
____
____

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Pain (please draw a vertical line where you would rate your pain on a 0 to 10 pain scale):

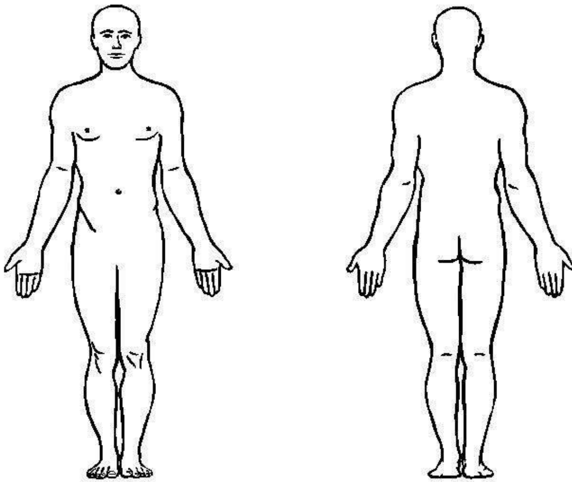
0 1 2 3 4 5 6 7 8 9 10

No pain Max pain

My pain can be described as (please circle all that apply):

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needle

Please indicate where your injury/pain is on the body diagram.



What are your goals for physical therapy?____

Patient/Guardian Signature:____ Date:____________

PT Signature____ Date: _____________

PT Print Name:____ License #__________________________

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Notice of Patient Information Practices

Our policy on Medical Record Privacy
This notice will describe the way our practice will treat medical records we keep regarding your medical care. We are required to keep a record for you care, including your diagnosis, treatment, services you receive, and other information. We are required by law to protect your personal medical record by keeping it private and following certain rules that dictate whether and when we can use or disclose your information. This notice will inform you of these rules. It will also notify you of your rights and our obligations in our use and disclosure of your health information. We are also required to give you notice, and to follow the terms of the notice that is currently in effect. We reserve the right to change this notice, and apply those changes to health information we currently have, as well as information we may receive in the future. If we change this notice, you will receive a new copy of this notice the next time you receive services from our practice. A copy of this notice the next time you receive services from our practice. A copy of this notice will be on display in our office

Understanding Your Health Record
Each time you visit Bull Dawg Athletic Training, LLC Physical Therapy & Wellness, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, may serve as a:

-Basis for planning you care and treatment
-Means of communication among the many health professionals who contribute to your care
-Legal document describing the care you received
-Means by which you or a third party payer (such as your insurance company or HMO) can verify that services billed were actually provided
- A source of data for medical research
- A source of information for public health officials charged with improving the health of Virginia and the nation
-A source of data for planning and marketing a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Your Rights Regarding Your Health Information

You have the right to:

-Request that we restrict the use or disclosure of your health information for treatment, payment, or healthcare operations (as described in this notice)
-Request that we restrict from disclosing information to family or friends
-Request how you would like us to communicate with you
-Inspect and copy certain health information, including most of your medical and billing records. This request must be made in writing to the Privacy Officer. A reasonable fee may be applied for copying, postage, or other expenses related to your request. We may deny your request to inspect and or copy your health information. If we do, another licensed health care professional will review your request and we will comply with the outcome of the review.
-Amend your health record as provided in 45 CFR 164,528
-Obtain an accounting of disclosure of your health information as provided in 45 CFR 164,528
-Obtain a paper copy of this notice upon request

Note: We are not required to agree to your requests. To request restrictions or limitations, you must make a written request to the Privacy Officer. The request must tell us (1) what information you want to limit; (2) whether you want to limit the use of the

Information and or disclosure of the information; (3) to whom the limitation or restrictions will apply.

Our Responsibilities
Bull Dawg Athletic Training, LLC Physical Therapy & Wellness is required to:
- Maintain the privacy of your health information
-Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
-Abide by the terms of this notice
-Notify you if you were unable to agree to a requested restriction
-Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location

For more information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer Tammy Robinson at (571) 970-6068. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below

Office of Civil Rights
U.S Department of Health and Human Services
200 Independence Avenue, S.W
Room 509F, HHH Building
Washington, D.C 20201

How We May Use and Disclose Your Health Information

We may use and disclose your health information for a number of purposes in connection with your medical care and in running our practice. The following lists a number of typical uses and disclosure within our practice. We will use your health information for the following

Treatment

We may use your health information to diagnose your illness or injury, provide you with services, or refer you to another physician. We may disclose your health information to doctors, nurses, technicians, medical students, or other personnel who are involved with your care. We also may disclose your health information to people outside of our medical practice who may be involved in medical care, such as family members, clergy or others.

Payment

We may give your health plan information regarding your diagnosis and treatment in order to be paid for your office visits, procedures, x-rays, or laboratory work. We may also provide information to determine whether your health plan pays for medical care you need, and whether we need to get authorization from the health plan before treating you

Health Care Operations

We may use or disclose your information if we conduct quality assessment and improvement activities to ensure that our patients receive quality medical care. We may also use or disclose your information in training and evaluation of our physicians and other staff, or as part or medical review, audit, or legal activities.

Appointment Reminders
We may use or disclose your information to contact you as a reminder that you have an appointment with our practice.

Individuals Involved in Your Care or Payment for your Care
We may disclose your health information to a family member or friend who is

involved in your medical care or who helps pay for your care. We may also tell your family or friends about your condition, for example, if you are admitted to the hospital or in the event of a disaster relief effort.

Public Health Risk
We may disclose your health information to report disease, injury or disability; birth and deaths; child abuse or neglect; defects, recalls or problems with drugs, medical devices, or other products; to prevent or conditions. We may also notify authorities if we believe you have been the victim of abuse, neglect or domestic violence, if we are required by law to do so, or if you agree to the notification.

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

Law Enforcement
We may disclose your health information when the following circumstances apply:

-If you have incurred certain injuries or wounds that are legally required to be reported;

-In response to a court order, subpoena, warrant, summons, investigative demands, or similar process

- To identify or locate a suspect, fugitive, material witness, or missing person.

- About the victim of a crime if under certain limited circumstances;

-About a suspicious death that we believe may be the result of criminal conduct;

-About criminal conduct on our premises;

-In emergency circumstances to report a crime, its location, or information about the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors

As necessary to carry out their duties

Specialized Government Functions

We may disclose your health information to release information to military command authorities, upon you separation or discharge from military service to authorized officials. We may also disclose your health information to the appropriate government officials when it is necessary to conduct intelligence or other national security activities authorized by federal law. In addition, we may

release your health information if it related to the protection of the President of the United States or foreign heads of state. Finally, we may disclose certain information related to members of the armed services and foreign military services to the appropriate personnel.

Inmates

If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official in order to provide you with medical services, protect you or others, or to ensure safety of the correctional facility.

Workers' Compensation for Work Related Illness or Injuries

We may disclose your health information in relation to workers' compensation or similar programs established by law that provides benefits for work related illness or injuries.

Other Uses of your Health Information

We may disclose your health information when required by federal, state, or local law, for treatment alternatives or health related benefits/ services, organ and tissue donations, or to avert a serious threat to health or safety.

Contact Information
Tammy Robinson
5001-A Langston Blvd Suite 102
Arlington VA, 22207
Email: Tammy@bulldawgtraining.com
Phone: (571)-970-6068
Fax: (571)-970-0671

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I received the Notice of Privacy Practices of Bull Dawg Athletic Training, LLC, Physical Therapy & Wellness

_________________________________Date___________

Patient's Signature

____

Patient's Printed Name

Office Use Only:

_________________________________Date___________

Witness

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Consent for Treatment

I, the undersigned, do hereby agree and give my consent for Bull Dawg Athletic Training, LLC & Physical Therapy to furnish medical care and treatment ________________________________, considered necessary and proper in diagnosing or treating my physical condition

Patient/Parent/Guardian Signature _______________________________________Date___________________

Payment Policy Form

______**MEDICARE**---We will bill Medicare for you. In most cases Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

______**SELF PAY**--- Please pay the balance in full at the time of service or upon the receipt of monthly statement or notice. IN the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Bull Dawg Athletic Training and Physical Therapy is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of our account with a collection agency or attorney for collection. Credit cards are accepted for payment on account.

CANCELLATION POLICY: To maintain appointment times available for all of the patients, there is a charge of **$90.00** (Medicare insurance will not pay for missed appointments), BILLED TO THE PATIENT, for each instance a patient does not show for a scheduled appointment or does not **give a least 24-hour cancellation notice.**

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to Bull Dawg Athletic Training, LLC Physical Therapy & Wellness in the event they file on my behalf, I understand that I am financially responsible for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate or 1.5% per month (12% annually) for unpaid balances over 30 days old. I hereby authorize said assignee to release shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Bull Dawg Athletic Training, LLC Physical Therapy & Wellness as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting for such treatment excepting acts of negligence.

____

AUTHORIZED SIGNATURE **DATE**

__ Checking this line indicates that the formal office **HIPPA policy and procedures** have been explained to the above-noted patient and that a copy of the policy was provided to the patient.

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RELEASE OF MEDICAL INFORMATION

I authorize Bull Dawg Athletic Training and Physical Therapy to release information from my medical record whether it be written, video, photographic, audio, or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my (Doctor) ___________________________________, and (Insurance Company, Lawyers and, Family members)____ for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS-related diagnosis, drug and alcohol, and psychiatric diagnosis.

The undersigned certifies the s/he has read, understood, and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

____

Authorizing Signature   Date

____

Authorizing Name Printed