IN OFFICE INTAKE

PERSONAL INFORMATION

First Name	Last Name	MI	Preferred Name

Date of Birth	Gender	Policy Holder SSN	Email	Cell Phone

Home Mailing Address	Unit	City	State	Zip

EMERGENCY CONTACT

First Name	Last Name	Phone Number	Relationship to Patient

REFERRAL AND INJURY INFORMATION

How did you hear about us?	**Workers Compensation?** Employer Name Employer Contact # Employer Address Case Mgr Case Mgr Contact # Case Mgr Email	**Auto Accident?** Law Firm Name Attorney Name Attorney Contact #	**Post Operative Therapy?** Date of Surgery Surgeon When did your surgeon recommend you to start PT?

INSURANCE INFORMATION

Are you a Medicare Patient?	Are you receiving home health now or have you received it in the past 60 day?	Have you been Discharged from home health?
	Please provide the name of the home health agency.	Please enter the date of your last Home Health Visit:

YOUNGS PHYSICAL THERAPY & SPORTS PERFORMANCE

MEDICAL INFORMATION

Height	Weight	Approximate date of Injury/Symptom Onset	Have you fallen in the past year?	Tell us about other forms of treatment you've had for this issue in the past	Affected Regions

Are you experiencing or have you experienced any pain associated with this injury?	What kind of pain are you experiencing?	Please indicate the intensity of pain levels over the past 24 hours 0 (No Pain)-10 (Worst pain):		
		Best pain level (0-10)	*Worst* pain level (0-10)	*Current* pain level (0-10)

Please mark the conditions that you have been or are presently being treated for. This information helps your therapist develop a treatment plan that will be best for you.

Acquired Respiratory Distress Syndrome	Emphysema	Nausea/Vomiting
Allergies	Epilepsy or Seizure Disorder	Osteoporosis
Angina	Fracture	Pacemaker
Anxiety or Panic Disorders	Headaches	Parkinson's Disease
Arthritis	Hearing Impairment	Peripheral Vascular Disease
Asthma	Heart Attack	Pregnancy
Back Injury	Hepatitis A, B, or C	Ringing in your ears
Bleeding Disorders	Hernia	Sexual Dysfunction
Bowel/Bladder Abnormalities	High Blood Pressure	Skin Abnormalities
Cancer	HIV/AIDS	Smoking
Chronic Obstructive Pulmonary Disease	Hypoglycemia	Special Diet Guidelines
Degenerative Disc Disease	Immunosuppressant Condition or	Stroke/TIA
Depression	Medication	Tuberculosis
Diabetes	Kidney Problems	Upper Gastrointestinal Disease
Dizzy or Fainting Spells	Liver/Gallbladder Problems	Visual Impairment
	Metal Implants	
	Multiple Sclerosis	

Are you currently taking any medications?	Please list current medications as well as Dosage, Frequency, and Method of Delivery			
	Medication	Dosage	Frequency	Route of Administration

YOUNGS PHYSICAL THERAPY & SPORTS PERFORMANCE

Youngs Physical Therapy &
Sports Performance

1301 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-565-8812
Fax: 252-565-8814
Email: office@youngsphysicaltherapy.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

YOUNGS PHYSICAL THERAPY & SPORTS PERFORMANCE

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• 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 privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Youngs Physical Therapy & Sports Performance does NOT:

** Manage or create a hospital directory*
** Provide mental health care*
• Sell your information
** Prepare or maintain psychotherapy notes at this practice*

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Instruction F: Insert Effective Date of Notice here.

This Notice of Privacy Practices applies to the following organizations.

Youngs Physical Therapy & Sports Rehab, Inc.

DBA Youngs Physical Therapy & Sports Performance

I acknowledge receipt of the Youngs Physical Therapy & Sports Performance privacy policy. I understand that I can request an additional copy of the policy at any time.

Privacy contact: Spencer Kerstein, Operations, contact 252-565-8812 or via email Office@youngsphysicaltherapy.com

Insurance Information Disclosure

I have provided my insurance information accurately and to the best of my knowledge. I understand and accept the insurance information I provided will be verified by Youngs Physical Therapy & Sports Performance. The verification of benefits is **not a guarantee of payment**. All benefits are subject to eligibility, medical necessity and the terms, conditions, limitations and exclusions of the patient's health benefit plan at the time the services are rendered.

Acknowledgement of Clinic Policies

Correct Information: Patient is responsible to provide correct demographic and insurance information, as well as notify Youngs PT&SP immediately of any demographic or insurance changes. Failure of which may result in denial of coverage, the fees for which the patient or guarantor will be responsible.

Insurance Coverage Disclaimer: Every attempt is made to obtain accurate physical therapy benefit information. At times, insurance companies give incorrect information. This error will not be determined until claims are processed after services are rendered. Patients are ***encouraged*** to verify their own benefits. It is ultimately the patient's responsibility to know and understand their benefits, and to notify our office of any change in insurance. Once the claim is finalized, if insurance processes patient responsibility higher, the patient will be responsible for these charges.

Payment: All payments are due at each visit. In office charges are estimates. Exact charges are not determined until services process through insurance companies. Balances due may take up to 45 days to be determined. This timeframe is dependent on how long your insurance company takes to process claims.

Credit Card on File: Each patient is required to have a credit card on file. You will receive a checkout form summarizing the services you received at the end of each appointment. At the checkout desk you can choose to pay with your preferred method of payment (cash, check, credit card, or health savings account). If you choose to streamline your checkout, your card on file will be charged for the services received that day and a receipt will be sent electronically following the completion of the transaction. If for any reason your insurance company processes your claims differently, you will receive an electronic invoice and will have 72 hours to contact our office to pay with another payment method before your card on file is charged.

Refunds: If a patient overpays for services, a refund will be issued once the patient has been discharged and all outstanding claims have processed through the insurance company, or the credit may be applied to services within the office.

Arriving Late: Late arrivals may be rescheduled so that other patients may be seen on time.

Same Day Cancellations and Rescheduling: A $25.00 fee may be assessed for **same day** cancellations or rescheduled appointments. This fee will not be covered by insurance.

No Shows: If you fail to show for an appointment, you will be charged a $85 no show fee. After the third no show, all future appointments will be cancelled. This fee will not be covered by insurance.

Social Media: At YPT&SP we highlight our patient's strengths and accomplishments by promoting their successes through pictures and/or videos on social media.

Appointment Reminders: Our system will send appointment reminders via text and/or email. It is the patient's responsibility to attend all scheduled appointments even if the system fails to send the reminder.

Text Message Communication: We utilize text messaging to streamline communication with patients regarding appointment availability and account balances.

Fees can change without additional notification

Consent to Evaluation and Treatment Statement

Please read and review the patient consent to evaluation and treatment at Youngs Physical Therapy & Sports Performance.

Consent to Evaluation and Treatment: I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage.

I hereby give authorization for payment of insurance benefits to be made directly to Youngs Physical Therapy & Sports Performance for services rendered. In the event that my insurance company forwards payment directly to me, instead of Youngs Physical Therapy & Sports Performance, I will immediately deliver said payment to Youngs Physical Therapy & Sports Performance.

I understand and agree that I am responsible for payment of all charges assessed for professional services rendered and will pay any sum due when requested. I understand and agree that if necessary, to commence legal actions for the collection of any outstanding charges on my account, I will be responsible for any costs and/or court fees, in the addition to the outstanding balance.

Assignment of Benefits/Proceeds: I hereby instruct and direct ALL payers responsible for making payments towards the treatment of my injuries to pay Youngs Physical Therapy & Sports Rehab, Inc. DBA Youngs Physical Therapy & Sports Performance, or the professional or medical benefits/proceeds allowable, and otherwise payable to me as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits/proceeds under ANY applicable policies/agreements. I further intend for this Assignment to create a secured interest under the applicable Uniform Commercial Code.

Authorization to Release Information: I authorize the release of any medical or other information necessary to verify benefits/obtain payment or complete treatment.

Consent to Evaluation & Treatment: I do hereby consent to the evaluation and treatment by Youngs Physical Therapy & Sports Performance. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

By signing I acknowledge and agree to adhere to the above listed policies.

_____ _____

Signature of Patient or Parent/Guardian if the Patient is under 18 years of age: Date:

Updated: 01/2023