

Welcome To Anchor Physical Therapy, LLC!

Dear New Patient,

Welcome to Anchor Physical Therapy! Thank you for choosing us to provide your Physical Therapy needs. We are committed to getting the results you need to focus on what's important to you. Below is some information that will help you to understand our clinic, along with some forms to send back to us or bring with you to your first appointment.

Our staff is very well trained, specializing in many different areas. Anchor Physical Therapy is known for our one-on-one treatment, utilizing a hands on approach to care. We believe manual therapy coupled with a specific treatment for your injury, both making us who we are. If you are in pain, come in and get it fixed. If your pain is reduced, do not stop coming to see us! This is the time that we can begin doing corrections of the underlying causes, and implement an exercise plan and educational protocol to avoid re-injury. Please understand your pain might possibly increase and decrease as your course of treatment progresses, before any consistent results are seen. Occasionally you may see a therapist other than the one that normally treats you or evaluated you. We believe a multi treatment approach can benefit you! All of our therapists are experienced professionals and will focus their time and attention to your needs.

Our Goals for You

We know how precious your time is and the need to get moving again. At Anchor Physical Therapy we strive to make this happen. It is our goal to help you meet your goals through physical therapy, as well as educate you on your particular condition to help you prevent a recurrence. Please feel free to voice any concerns you may have about your treatment to your therapist. We look forward to working with you and your physician on achieving your goals with physical therapy.

Sincerely,

The Anchor Physical Therapy Team



Patient Intake Form

Anchor Physical Therapy, LLC

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Patient Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____

Telephone #: _____ May we text you? (Yes / No) - circle one

E-Mail Address: _____

Social Security Number: _____ - _____ - _____

Name of (Primary) Physician: _____ Telephone#: _____

Do you have a script? (Yes / No). If so, please bring to first appointment. If not, it is okay!
Anchor is allowed to treat you for 30 days prior to requiring a script from a doctor.

In case of emergency, who do we contact? _____

Relationship to patient: _____ Telephone #: _____

Whom may we thank for referring you to us? _____

If not a referral, what made you choose Anchor Physical Therapy? _____

Insurance Information:

Primary Insurance Provider:	
Policy#:	Group#

***Important: If Patient is insured through someone else's policy, Please fill out below section:**

Primary Insurance Policy Holder: (Name) _____

Relationship to Patient: _____ DOB: _____

Address: _____

Current Condition

Reason for today's visit (Be Specific): _____ Onset date: _____

How did the injury occur: _____

Rate the pain on a scale of 0 {no pain} to 10 {severe pain} 0 1 2 3 4 5 6 7 8 9 10

What type of pain are you experiencing {circle all that apply}:

Sharp Dull Throbbing Ache Burning Numbness Tingling Stiffness Shooting

Does your pain radiate from one area to another? Yes / No If yes, please explain: _____

Have you had this pain before? _____ If yes, have you had treatment for this pain before?

If yes, what did your previous treatment consist of? {medications, surgery, therapy, etc}

Medical History: Please list any past medical history or current diagnoses that you may have.

_____	_____
_____	_____
_____	_____

Medications: Please list **all** current medications, even if they do not pertain to your injury.

_____	_____
_____	_____
_____	_____

Symptoms: Please list all symptoms, and anything else you would like your PT to know for your initial evaluation

Assignment Of Benefits:

I, _____(please print clearly—if minor, parent or guardian signature) consent to evaluation and treatment by Anchor Physical Therapy, LLC., of my problem as diagnosed by my physician.

I hereby assign all medical benefits, to include major medical health benefits to which I am entitled, including Medicare, private insurance and any other health plan to Anchor Physical Therapy, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. If I receive direct payment from my insurance company for my physical therapy treatment, I will be responsible to bring this payment to Anchor Physical Therapy LLC, to be applied to my account for services rendered. I certify this information is true and correct to the best of my knowledge.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: Anchor Physical Therapy, LLC. is authorized to provide and request from my referring physician, other physicians and/or my attorney, information regarding my diagnosis and medical condition for physical therapy while under their treatment. Information to be disclosed may include nature of the physical impairment, history, contributing factors, subjective symptoms, diagnosis, prognosis and other information pertinent to my treatment. Photostatic copy of this authorization shall serve in its stead.

Date: _____ Signature: _____

Receipt of HIPAA Notice and Privacy Practices

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of your legal duties and privacy practices with respect to health information about you
- Follow the terms of notice that is currently in effect.

WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: for multiple reasons including but not limited to treatment, payment, healthcare operations as required by law, and to avert a serious threat to health or safety.

YOUR RIGHT REGARDING HEALTH INFORMATION ABOUT YOU: you have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care.
- **Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us amend the information.
- **Right to Request Restrictions:** You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment, or healthcare options.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location.
- **Right to a paper copy of this notice:** You have a right to obtain a paper copy of this notice at any time.

The Notice of Privacy Practices you have been given describes the above rights and requirements in detail.

You are free to refer to this notice at any time before you sign this form

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare options.

You also signify that you have received a copy of our Notice of Privacy Policies.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Anchor Physical Therapy, LLC.

Signature

Date

PATIENT: THIS IS YOURS TO KEEP. DO NO RETURN TO OFFICE.

Anchor Physical Therapy, LLC

539 Greenfield Ave, Pittsburgh PA, 15207

Website: www.anchor-physicaltherapy.com

Phone: 412-421-2222

Email: apt@anchor-physicaltherapy.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.**

LAYERED SUMMARY TEXT –

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

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

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

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.

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.

Our Responsibilities

Patient Intake Form

Anchor Physical Therapy, LLC

- 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.

Effective Date: 01/01/2017