Chapel Hill Scoliosis and Postural Restoration Center

77 South Elliott Road, Chapel Hill, NC 27514 phone 919.932.7266 fax 919.932.7250

PATIENT INFORMATION

First Name _____MI _____Last _____Preferred Name_____

Date of Birth _____ /_____ /_____ Age _____ Gender _____ Pronouns _____

Street Address _____

City _____ State _____ Zip _____

Primary Phone _____ Home/Cell/Work Alternate _____ Home/Cell/Work

Patient/Guarantor SS# _____ Marital Status ☐ Single ☐ Married ☐ Other

Email Address _____

Profession _____ If student, grade in school _____

Emergency Contact Name _____ Phone _____

Relationship to patient _____

Primary Care Provider _____

Referring Provider (if different) _____

Next appointment with Primary Care or Referring Provider (if applicable) _____

Medical Diagnosis or Primary Concern _____

_____

Approximate Date of Onset _____ Date of Surgery _____

Is the pain or injury listed above related to a motor vehicle accident or an accident at work? ☐ YES ☐ NO

If YES, choose ☐ MOTOR VEHICLE ACCIDENT ☐ WORKPLACE ACCIDENT Date of Accident ____/____/_____

How did you hear about Chapel Hill Scoliosis and Postural Restoration Center?
☐ Friend/Family ☐ Referral ☐ Walk/Drive by ☐ Internet search for _____
☐ Other _____

Would you like to receive courtesy appointment reminders? ☐ DECLINE ☐ E-MAIL ☐ PHONE CALL ONLY: HOME OR CELL

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of Chapel Hill Scoliosis and Postural Restoration Center, to administer evaluation and treatment necessary and advisable for my condition, including teletherapy. If patient is a minor, a parent or legal guardian must sign. **Consent for treatment must be signed before we begin treatment.**

_____ _____
Signature of Patient (or Legal Guardian) Date

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CONSENT FOR E-MAIL COMMUNICATION

I, the undersigned, give permission to the practitioner/s of Chapel Hill Scoliosis and Postural Restoration Center, to communicate with me via email. I understand that Chapel Hill Scoliosis and Postural Restoration Center cannot guarantee the security of Protected Health Information (PHI) via email. Please indicate if you do not want to receive updates about special clinic events.

☐ Yes, I give consent to use email for Office Communications (appointment reminders, email to/from your PT)

☐ I do not give consent to use email for any purpose. ☐ I do not wish to receive updates about special clinic events.

_____ _____

Signature of Patient (or Legal Guardian) Date

SCHEDULING AND CANCELLATION POLICY

- When cancelling a scheduled appointment, we require patients notify our office by phone **48 BUSINESS HOURS** prior to the scheduled appointment time. If you cancel an appointment within **48 BUSINESS HOURS** prior to the scheduled appointment time there is an automatic CANCELLATION FEE applied to the patient account.
- The charge for a LATE CANCELLATION OR NO-SHOW FEE is **$40.00 per hour** of scheduled appointment time.
- There is no charge for cancelling an appointment due to illness prior to the scheduled appointment time.

_____ _____

Signature of Patient (or Legal Guardian) Date

CONSENT FOR USE AND DISCLOSURE OF NOTICE OF PROTECTED HEALTH INFORMATION

I have read and fully understand Chapel Hill Scoliosis and Postural Restoration Center's (CHSAPRC) Notice of Information Practices. I understand that Chapel Hill Scoliosis and Postural Restoration Center may use or disclose my PHI for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that CHSAPRC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in CHSAPRC's Notice of Patient Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Signature of Patient (or Legal Guardian) Date

PERMISSION TO PHOTOGRAPH AND/OR VIDEO FOR CUSTOMIZATION OF PATIENT CARE

At Chapel Hill Scoliosis and Postural Restoration Center, we make the effort to customize our patients' treatment program for their specific postures and movement patterns. The use of photo and video assessment during treatment greatly helps us evaluate these components.

Photographs and/or videos taken will **NOT** be used for any purpose other than patient treatment unless authorized by the signee via a separate photo release.

I , _____ , **Patient Name or Legal Guardian**, grant Chapel Hill Scoliosis and Postural Restoration Center, LLC, its representatives and employees the right to take photographs and/or video recordings of me/patient for the purpose of customization of patient care and use as indicated by me above.

_____ _____

Signature of Patient (or Legal Guardian) Date

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PAYMENT AGREEMENT

Thank you for choosing Chapel Hill Scoliosis and Postural Restoration Center, LLC ("SPRC'') as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- SPRC is a separate (subsidiary) corporate entity from KJC, Corp. (d.b.a. "Advance Physical Therapy") even though we operate out of KJC's space. SPRC is not in-network with any commercial health plans, Medicare or Medicaid, whereas Advance Physical Therapy is in-network with BCBS, Tricare and Medicare. If you have BCBS, Tricare or Medicare and want to be seen by an in-network therapist, we can refer you to Advance Physical Therapy or another therapist of your choice.
- Since we are not in-network with any health plan, by choosing us, you agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- Out-of-Network Policy. (Commercial Health Plans - Does not apply to Medicare) If you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- Medicare Policy (for Medicare Part B). If you are a Medicare beneficiary, you understand that SPRC's licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and Medicare does not cover many of our specialized treatment and prevention services. Since SPRC's therapists are not enrolled providers, we cannot submit claims to Medicare and Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from Advance Physical Therapy or another Medicare enrolled provider. Therefore, by choosing SPRC's services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from SPRC with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we can transfer you to Advance Physical Therapy or another Medicare enrolled provider and terminate your services with SPRC. You also understand that since SPRC and its therapist are not enrolled Medicare providers, our services are not subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - Medicare supplemental Insurance plans. If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.

- Medicare Replacement and Medicare Advantage Plans ("MAP"). We are not in-network with any Medicare Advantage Plans. If your MAP offers out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your MAP for reimbursement for the services your health plan covers. However, you should be prepared that your MAP may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your MAP to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your MAP denies, in whole or in part, your claims for our services.
- Medicare as a Secondary Payer. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.

- Service Packages. If you purchase a discount package of services, the package discount is applied to the last visit(s) in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying our regular cash payment fee to the visits you used so that the discount is applied to the unused visits.
  - Use of Health Savings Accounts (HSA). If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
  - Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA). An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.
- Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- Appeals Policy. You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Chapel Hill Scoliosis and Postural Restoration Center, LLC and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Chapel Hill Scoliosis and Postural Restoration Center, LLC and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

_____ _____

Signature of Patient (or Legal Guardian) Date

A photocopy of this agreement is to be considered valid, the same as if it was the original.

Patient Name _____ Date _____

MEDICAL HISTORY INTAKE FORM

Have <u>you or an immediate family member</u> ever been told you have any of the following:
(please circle and indicate relation) i.e. "self", "mother", "brother", etc.

Allergies	*Angina or chest pain*	*Anxiety/Panic attacks*
Arthritis	*Asthma or other breathing problems*	*Cancer*
Cirrhosis/Liver Disease	*Chemical Dependency (Drugs/Alcohol)*	*Depression*
Diabetes	*Eating Disorder (Anorexia, Bulimia)*	*Headaches*
Heart Attack	*Hemophilia or slow healing*	*High Blood Pressure*
High Cholesterol	*Kidney Disease/Stones*	*Multiple Sclerosis*
Osteoporosis	*Scoliosis*	*Stroke*
Tuberculosis	*Other (please describe)* _____	

HAVE <u>YOU</u> EVER HAD (please check any that apply)

___ *Anemia*	___ *GERD/Ulcers*	___ *Joint Replacement*	___ *Rheumatic Fever*
___ *Epilepsy/Seizures*	___ *Gout*	___ *Parkinson's*	___ *Skin Problems*
___ *Fibromyalgia*	___ *Hypoglycemia*	___ *Peripheral Vascular*	___ *Urinary Problems*
___ *Hepatitis/Jaundice*	___ *Hypo/Hyper Thyroid*	___ *Polio/Post-Polio*	___ *Sleep Apnea*

<u>FOR WOMEN</u> (please circle)	Are you pregnant? **Y / N**	**<u>FOR MEN</u>** (please circle)
Endometriosis	# of pregnancies? _____	Prostate Problems
Pelvic Inflammatory Disease	# of live births? _____	Genital Pain / Problems

ALLERGIES ☐ NO KNOWN ALLERGIES ☐ LATEX ALLERGY

☐ MEDICATION ALLERGIES _____

GENERAL HEALTH

1. I would rate my health as: ***Excellent Good Fair Poor***
2. Have you been sick in the last 3 weeks? **YES / NO** if YES, describe _____
3. Have you noticed any lumps or thick skin/muscle anywhere on your body? _____
4. Do you have any sores that have not healed or any change in size, shape, or color of a wart or mole?
   YES / NO (circle one) if YES, describe _____
5. How many alcoholic drinks do you consume per week? _____
6. How much caffeine do you consume daily (soda, coffee, tea, chocolate)? _____
7. Do you smoke or chew tobacco? ☐ **NO** ☐ **YES**, How much per day? _____ # of years? _____
8. I <u>used</u> to smoke/chew tobacco but quit. How much per day? _____ # of years? _____
9. I would like to quit smoking/chewing tobacco? ☐ **YES** ☐ **NO**

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Patient Name _____ Date _____

10. Are you on any special diet? _____
11. Do you currently exercise? ☐ **NO** ☐ **YES**, how often? _____
    Types of exercise _____
12. How many falls have you had in the past year? _____
13. Describe problems with your balance or fear of falling? _____
    _____

14. Do you have, or have you recently had any of these problems (please check any that apply)

_____ *Blood in urine, stool, vomit, or mucous*
_____ *Dizziness, fainting, or blackouts*
_____ *Fever, chills, day or night sweats*
_____ *Nausea, vomiting, loss of appetite*
_____ *Changes in bowel and/or bladder function*
_____ *Throbbing sensation in belly or elsewhere*
_____ *Skin rash or changes*
_____ *Cough*
_____ *Urinary issues/Stress incontinence*
_____ *Heart palpitations*
_____ *Numbness or tingling*
_____ *Swelling or lumps anywhere*
_____ *Problems seeing and/or hearing*
_____ *Unusual fatigue or drowsiness*
_____ *Difficulty swallowing or speaking*
_____ *Memory loss*
_____ *Confusion*
_____ *Sudden weakness*
_____ *Trouble sleeping*
_____ *Jaw pain, noise, teeth grinding*

MEDICAL / SURGICAL HISTORY

1. Have you ever been treated with chemotherapy, or radiation therapy? _____
2. Have you had any X-rays, sonograms, CT scans, MRI, bone scans or other imaging tests recently?
   ☐ **NO** ☐ **YES**, what? _____ When? _____
   Results _____
3. Have you had any lab work done recently? ☐ **NO** ☐ **YES**, Results _____
4. Please describe any other recent clinical tests _____
5. Please list other providers or treatments for this condition _____
6. Please list any significant operations that you have had and the dates _____
   _____
7. Do you have a pacemaker, transplanted organ, breast implant, or other implants? _____
   _____

LIVING ENVIRONMENT

1. Please describe your physical work requirements/exposure to chemicals _____
   _____
2. Please describe any difficulty with these _____
3. Who lives with you? _____
4. Do you feel safe in your home? ☐ **YES** ☐ **NO**, _____

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ALLERGIES & CURRENT MEDICATIONS

ALLERGIES (choose one)

☐ NO KNOWN ALLERGIES ☐ MEDICATION ALLERGIES _____

☐ LATEX ALLERGY _____

CURRENT HEIGHT _____ ft. _____ in. **CURRENT WEIGHT** _____ lbs.

☐ I am not currently taking any prescription medications, supplements, or over-the-counter medications.

1. Medication _____
   Frequency _____
   Dosage _____ Route _____
2. Medication _____
   Frequency _____
   Dosage _____ Route _____
3. Medication _____
   Frequency _____
   Dosage _____ Route _____
4. Medication _____
   Frequency _____
   Dosage _____ Route _____
5. Medication _____
   Frequency _____
   Dosage _____ Route _____
6. Medication _____
   Frequency _____
   Dosage _____ Route _____
7. Medication _____
   Frequency _____
   Dosage _____ Route _____
8. Medication _____
   Frequency _____
   Dosage _____ Route _____
9. Medication _____
   Frequency _____
   Dosage _____ Route _____
10. Medication _____
    Frequency _____
    Dosage _____ Route _____
11. Medication _____
    Frequency _____
    Dosage _____ Route _____
12. Medication _____
    Frequency _____
    Dosage _____ Route _____

☐ Patient brought medication list

☐ Medication list received from referring provider