Welcome To

CONCIERGE

PHYSICAL THERAPY

A PRACTICE THAT WILL BRING HIGH QUALITY, PERSONALIZED,
ORTHOPEDIC PHYSICAL THERAPY SERVICES TO YOUR HOME

CONSENT TO TREAT

I, _____ understand that I will be participating in private, one-on-one physical therapy, incorporating hands-on treatment, manual treatment techniques so that I can improve my strength, endurance, flexibility, balance, and overall health and wellness.

I understand that my physical therapist is licensed in the State of Maryland, and is educated and highly-trained in the areas above.By signing below, I am giving my consent to treatment ("informed consent"). And, I also consent for treatment to occur in my home, gym, workplace, hotel room, or other location previously agreed upon.I have been instructed by my physical therapist to alert my therapist of any special needs, injuries, preferences, or considerations prior to starting the first visit evaluation and treatment, as these could affect my safety and security during the treatment process.

I understand that by signing below, I release this physical therapist of all liabilities for my health and safety during my participation in this treatment process. I only provide this release with the understanding that my instructor is fully trained and upholds an active license to perform physical therapy in the State of Maryland.

Print Name: _____ Date of Birth: _____

Address: _____City, State: _____ ZIP: _____

Phone Number: _____ Email:_____

Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Name of Parent/Guardian:_____

FEDERAL HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

AH Concierge Physical Therapy

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.

"We: refers to AH Concierge Physical Therapy. "You" or "yours" refers to any individual receiving treatment by AH Concierge Physical Therapy employees."
Federal law - means the Health Insurance Portability and Accountability Act and related privacy rules -- requires AH Concierge Physical Therapy to keep your health information private. We are not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires us to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that we may make. It also informs you of your rights and our duties with regard to this health information.

We must follow the terms of this Notice. We do reserve the right to change the terms of this Notice and make the new Notice provisions apply to all the health information we keep. This includes health information we had prior to any change in this Notice. We must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. To receive such Notices by email, you should tell the contact listed at the end of this Notice.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal law permits us to use and disclose protected health information for purposes of treatment, payment and health care operations as those terms are defined under federal law. We will comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information.
There are also times when federal law permits or requires us to use or disclose your information without your written permission.
Additionally, where appropriate, we may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

Permitted Disclosures:
We may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission
• When we disclose your information to you.
• To third party non-AH Concierge Physical Therapy associates that perform services for us or on our behalf.
• Where disclosure is required by law.
• To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
• To a health oversight agency for such activities.
• For judicial and administrative proceedings.
• To a law enforcement official for a law enforcement purpose.
• To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
• To organ donor organizations in order to aid in such donations.
• For certain research purposes authorized by and subject to federal law.
• To avert a serious threat to health or safety.
• To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
• To comply with workers' compensation and other similar programs.

Required Disclosures:
We must disclose your information when required by the Secretary of the Department of Health and Human Services to make sure we comply with federal law. We are also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that we keep. See "Federal Law Provides You with the Right to Inspect and Copy Protected Health Information" below.

I**NDIVIDUAL RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS:**

You have the right to request that restrictions be placed on certain uses and disclosures of your information.
We are not required to agree. If we do agree, we may not use or disclose any of your information except where you need emergency treatment. We may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION:

If you choose to have your information sent to you by a means of your choice or to an address of your choice, we will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION:

You have the right to inspect and copy your information, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE:

You have the right, even if you have agreed to receive notice by email, to get a paper copy of this Notice. All requests should be in writing and sent to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT:

If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

THE CONTACT TO WHOM YOU SHOULD ADDRESS YOUR COMPLAINT IS:

AH Concierge Physical Therapy
Allison Hoff, PT, DPT, OCS, COMT
410-934-4028
ah@ahconciergept.com

Effective October 8, 2020

Acknowledgements, Financial Responsibility, Cancellations

“We”: refers to AH Concierge Physical Therapy or affiliates. "I" refers to any individual receiving treatment by AH Concierge Physical Therapy or affiliates.

Release of Information:
We are authorized to release pertinent medical information to your referring physician.We are authorized to release medical information to your insurance company regarding coverage for services performed with the patient.

HIPAA Acknowledgement:
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices as required by HIPAA.

Notice of Advice:
Notice of Advice: In accordance with the Direct Access Law, I attest that: I understand that my treatment may not be covered by my health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that my treatment may be a covered expense if rendered with a referral. I understand that I am responsible for contacting my health care plan or insurer to determine whether my health care plan or insurer covers my treatment without a referral from a physician, dentist, podiatrist, or nurse practitioner. Treatment will begin on _____.

My treatment is not related to a no-fault injury or a workers’ compensation covered injury, that there is no pending liability case related to my condition, and I am not insured through Medicare. I understand that I am fully responsible for any and all costs associated with the direct access treatment session(s) that are due and owing AH Concierge Physical Therapy and not otherwise covered by my health care plan or insurer.

I attest that I have read and understand this Notice of Advice regarding Maryland State’s Direct Access Law and I consent to receive physical therapy treatment from AH Concierge Physical Therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner. Contact information for referral if needed:

Name:_____Fax:_____

Guarantee of Payment/Financial Responsibility/Insurance:
Payment is due at the time of service. I agree to pay AH Concierge Physical Therapy in full at the beginning of each treatment session, unless otherwise agreed upon by both parties in writing. I understand that any outstanding balance is my/our responsibility. I agree to pay the balance within 14 days of receipt of invoice (unless a payment plan has been discussed and agreed upon beforehand).

Cancellations:
I understand that if I am unable to attend a scheduled appointment, I am required to cancel the appointment by email or call AH Concierge Physical Therapy 12 hours prior to the said appointment; otherwise a fee of 100% of the agreed appointment fee will be incurred for late cancellations. This full-rate fee is required because another patient, who needs treatment, could have been scheduled and treated in this time slot.

Insurance Coverage:
Services without a referral might not be covered by the patient's health plan or insurer, but may be covered with a referral. Call your insurance company and let us know what you need to make sure that you are able to be reimbursed.

Consent:
By signing my name below, I verify that I have read and agree to the information contained in this packet and that the information I have provided is true and accurate.

Patient's name:_____ **Date:** _____

Patient's signature: _____

Responsible Party name: _____**Relationship:** _____

Responsible Party Signature: _____**Date:**_____

Physical Therapists Name: _____**Date:**_____

Physical Therapist Signature:_____

Patient Intake Form

Name: _____ DOB: _____
Height:_____ Weight: _____ Occupation: _____

Family Medical History:
Please indicate if your family has any of the following by circling yes or no and indicating on the line which blood related relative has the condition.

Thyroid Disease: Yes / No _____ Heart Disease: Yes / No _____
Stroke: Yes / No _____ Diabetes: Yes / No _____
Cancer: Yes / No _____ Heart Disease: Yes / No _____
Hypertension: Yes / No _____ Other: _____

Personal Medical History:
Please indicate any surgical history to date: _____
_____

Have you RECENTLY noticed any of the following - circle all that apply

Fatigue	Nausea/vomiting	Difficulty with balance
Numbness or tingling	Dizziness	Difficulty swallowing
Constipation	Shortness of breath	Cough
Fever/chills/sweats	Weight loss/gain	Falls
Muscle weakness	Heartburn/indigestion	Bowel/bladder dysfunction
Diarrhea	Fainting	Headaches

Have you EVER been diagnosed with any of the following conditions - circle all that apply

Cancer	High blood pressure	Ulcers
Depression/Anxiety	Asthma	Anemia
Seizures/Epilepsy	Multiple Sclerosis	Kidney problem/infection
Thyroid problems	Circulation problems	Liver problem
Heart problems	Rheumatoid arthritis	Bone or joint infection
Lung problems	Developmental problems	Sexually transmitted disease
Chest pain/angina	Blood clots	Hepatitis
Tuberculosis	Other arthritis conditions	Chemical dependency
Osteoporosis/Osteopenia	Eye problem/infection	Pelvic inflammatory disease
Bladder/UTI	Stroke	Pneumonia

Current Medications: _____

_____

Current Symptoms:

Chief Concern: _____

How and when did this start: _____

How long does it last? _____

Have you received any treatment for this problem? _____

Have you had any imaging ? If so, what kind and when _____

Have you ever had this problem before?_____

Please circle the number that best represents the severity of your pain below.

Average for the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Best for the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Worst for the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Aggravating factors (what makes your symptoms worse):

_____

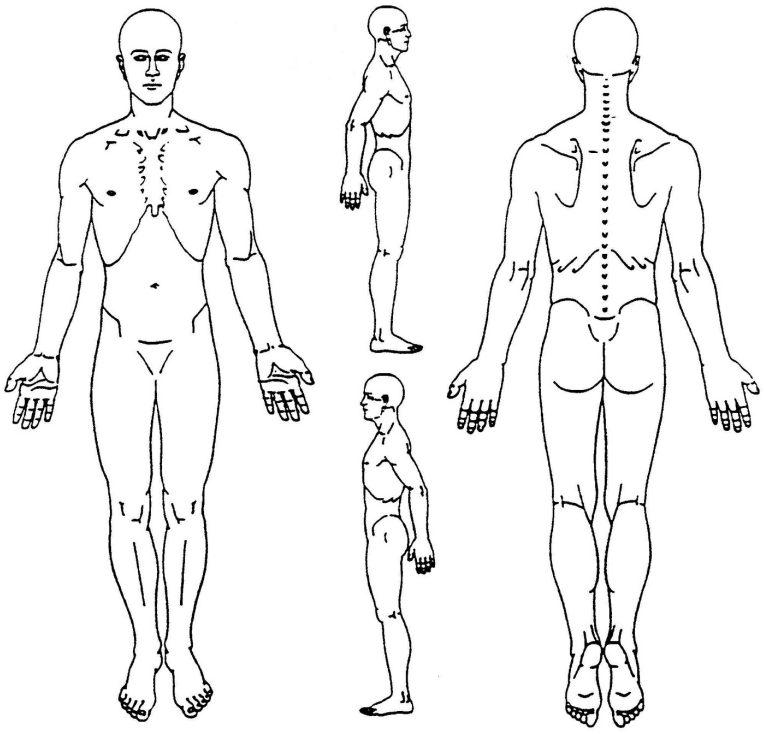
Easing factors (what makes you symptoms better):

_____

Please circle 1-3 that apply to your symptoms:

sharp	pressure	electric shocks
aching	squeezing	dull
burning	cramping	intense
throbbing	burning	gnawing
numb	shooting	gripping
freezing	stabbing	heavy
tingling	stinging	tender

Symptom Diagram:



Please indicate on this body diagram where your symptoms are located.

Patient Specific Functional Scale:List 3-5 activities that are the most limiting for you to do at the moment:

1. _____
2. _____
3. _____
4. _____
5. _____

List 3-5 questions that you would like answered about your condition.

1. _____
2. _____
3. _____
4. _____
5. _____

Referral Information:

How did you hear about us?_____

If by a friend or family member, please give their phone number and address below that we may send a thank you note:

Phone

_____

Address

_____

_____

_____

If you were referred by a Physician: _____

When do they want you to return to their office? _____

Consent:

By signing my name below, I verify that the information I have provided is true and accurate.

Patient name: _____ Date: _____

Patient signature: _____

Responsible Party name: _____ Relationship: _____

Responsible Party Signature: _____Date:_____

Physical Therapist Name: _____ Date:_____

Physical Therapist Signature:_____