INTAKE INFORMATION

DATE_____ **NAME:**_____
(AS IT APPEARS ON INSURANCE CARD)

ADDRESS: STREET_____ **APT#**

CITY_____ **STATE**_____ **ZIP**_____

HOME PHONE_____ **CELL PHONE**_____

WORK PHONE_____ **EMAIL**_____

SS#_____ **DOB**_____

HEIGHT_____ **WEIGHT**_____ **MARITAL STATUS** _____

OCCUPATION/EMPLOYER _____

INSURANCE CARRIER_____ **INSURANCE ID#**_____

INSURED PARTY_____ **DOB**_____ **SS#**_____

REFERRING PHYSICIAN _____

GENERAL PRACTITIONER_____

RESULT OF AUTO ACCIDENT? ___YES ___ NO JOB INJURY? __YES __ NO

DATE INJURY/SYMPTOMS APPEARED _____

HAVE YOU HAD EPISODES LIKE THIS BEFORE? ____YES ____NO

HAVE YOU HAD P.T. ANYWHERE ELSE THIS YEAR? ____ YES ____ NO

IF SO, WHERE?_____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT: NAME_____**PHONE:**_____

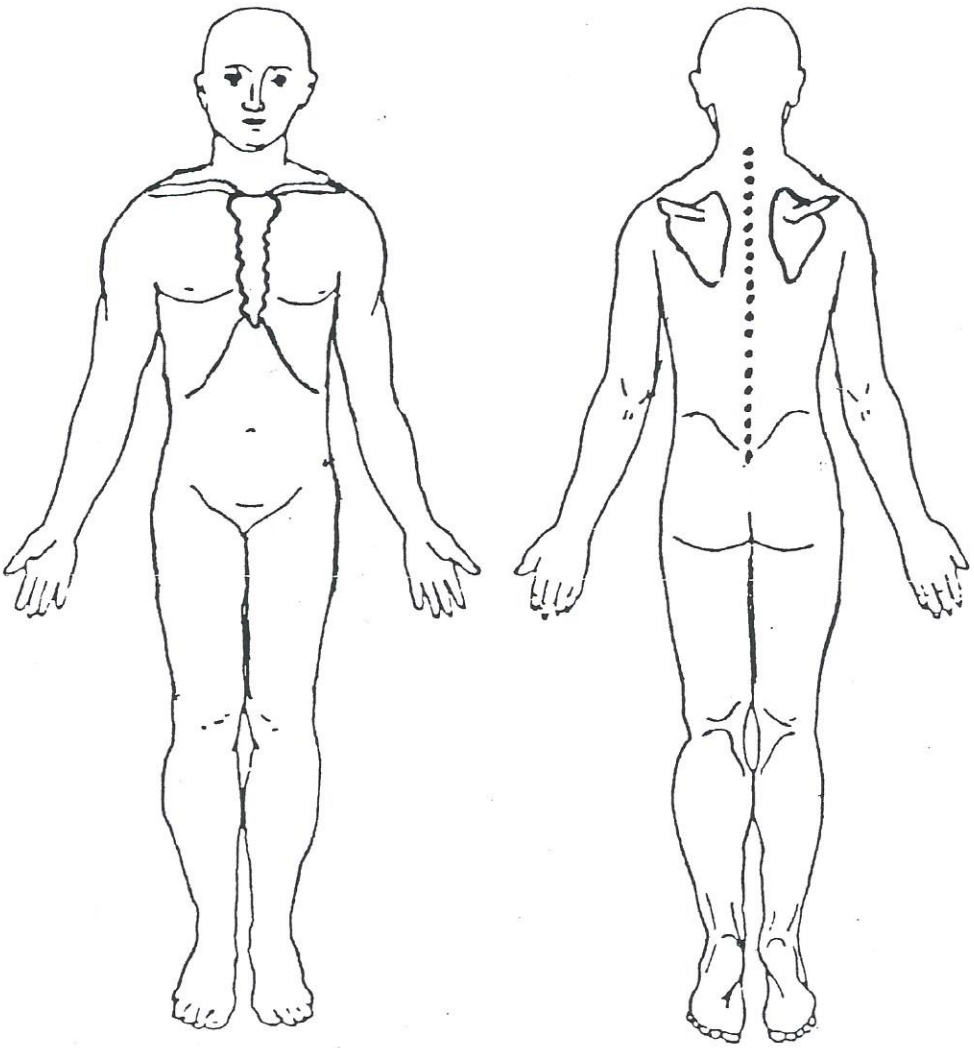
I Intake Information

NAME: _____

DATE: _____

A Pain Drawing

Please mark on the drawings below the areas where you feel pain.



B Pain Intensity

Using the scale from 0 to 10, 0 indicating no pain and 10 indicating worst possible pain:

1.) Circle the level of pain you are feeling now.

0 1 2 3 4 5 6 7 8 9 10

2.) Circle your greatest level of pain.

0 1 2 3 4 5 6 7 8 9 10

Name:_____

Date:_____

Present Medication Intake

Name	Dosage	Frequency	For How Long	Route Of Administration

Nutritional Supplement Intake

Name	Dosage	Frequency	For How Long	Route Of Administration

List Any Allergies

_____

_____

_____

_____

Revised 10/13/16

G. Self-Stress Rating Scale

Multiple research studies indicate a relationship between stress related events and treatment outcomes in individuals with musculoskeletal pain. [1-7] Identifying stressful events in the following Self-Stress Rating Scale will help in the management of your pain condition.

Please check the events that you have experienced in the past year.

Family/Social

____ Death of spouse/partner
____ Death of a loved one/friend (other than spouse/partner)
____ Divorce or separation from partner/spouse
____ Marriage/engagement
____ Conflict with spouse/partner
____ Conflict with family members (other than spouse/partner)
____ New addition to family
____ Change in family members health
____ Change in number of family gatherings
____ Son/daughter leaving or returning home
____ Change in social activities
____ Caretaker – of children
____ Caretaker – of family member

Work/School

____ Begin new job
____ Business re-adjustment
____ Retirement
____ Begin/Finish school
____ Partner begins/stops work or school
____ Trouble with boss/colleagues/employees
____ Change in work responsibilities

Financial

____ Change in financial status
____ Financial concerns/Debt

Personal

____ Change in living situation/conditions
____ Change in lifestyle/habits (diet, exercise, etc.)
____ Change in sleep patterns
____ Sexual difficulties
____ Trouble finding time to do the things you want to do
____ Multi-tasking – taking on too much at once
____ Involved in a lawsuit
____ Drug and/or alcohol dependency

Other Please list other stressors that you are experiencing, not list above:

____ _____
____ _____

Total combined score: ____/ 30 Percentage of total: ____

(1) Spine 2003: 28: 953-959, (2) Spine Journal 2005: 5: 24-35, (3) Spine 1995: 20: 722-728, (4) Spine 1995: 20: 2702-2709, (5) Spine 2000: 25:
2114-2125, (6) Spine 2006: 31: 931-939, (7) Spine 2000: 25: 1259-1265

revised 09/07/10

X = Required

CONTACT INFORMATION AND HOW TO REPORT PRIVACY RIGHTS VIOLATION

If you have questions and/or would like additional information regarding the uses and disclosures of your health information, you may contact our Privacy Officers at:

Address: 1841 Montreal Rd Ste 110 Tucker, GA 30084
Attn: Privacy Officer
Telephone: 770-491-6004
Fax: 770-723-0872
E-mail: info@AtlantaBackClinic.com
Website: www.AtlantaBackClinic.com

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at, 200 Independence Avenue S.W. Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts of omissions and violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The effective date of this privacy notice is X_____, 20___.

BY SIGNING BELOW, I HEREBY ACKNOWLEGE RECEIPT OF THIS PRIVACY NOTICE

X_____ X_____
Printed Name of Patient Date

X_____
Signature of Patient or Patient's Representative

_____
Printed Name of Patient's Representative (If Applicable)

_____
Representative's Relationship to Patient

*****TO BE COMPLETE BY HEALTH CARE PROVIDER*****

After a good faith attempt to obtain an acknowledgment of receipt, the patient or representatives have refused or were unable to sign the Privacy Notice for the following reason(s),_____

_____

_____

_____ _____
Signature of Health Care Provider Date

ATLANTA BACK CLINIC
ORTHOPEDIC PHYSICAL THERAPY SERVICES

OFFICE POLICIES, FEES, AND AGREEMENTS

- Our office schedules appointments during office hours Monday-Friday 8:00 am to 5:00 pm. The schedules are available on the 15th of every month. **It is your responsibility to contact the office to schedule your appointments.**
- Georgia state law allows Physical Therapists to evaluate and treat without referrals for up to 8 sessions. For insurance purposes, however, we strongly recommend and sometimes require a medical referral. All Medicare patients need to have a medical referral. If your insurance company requires a referral or authorization we ask that you obtain these documents before your appointment. If you are unable to obtain these documents you will be responsible for payment in full until the documents are received by our office.
- We ask that all new patients arrive 15 minutes prior to appointment time to complete the new patient paperwork and to allow adequate time for the front office to check you in. We request that you provide a copy of your state issued ID and insurance card(s).
- If for any reason that you have to cancel or reschedule an appointment, we require a 24 hour notification. If notification is not received within the allotted timeframe we will charge a $75 No-Show fee which will be billed directly to the patient. Our office does not allow patients to switch appointments. If you are going to be late to an appointment we ask that you please call to notify our office in a timely manner. After hour appointments will have a fee of $30 billed directly to the patient.
- Calls received after 5:00 pm Monday-Friday, on holidays and weekends will be received by voicemail. Your call will be returned the next business day. Appointment requests and all insurance matters should be called in during scheduled business hours.
- Our office may submit claims to your insurance company for supplies/equipment however, most plans do not reimburse for them so therefore, you are responsible for payment of any supplies/equipment received from the Atlanta Back Clinic.
- Patients are expected to pay all fees (copays, deductibles, coinsurance, and self-pay) due at the time of service. Our office accepts cash, check, Visa, Discover, and Mastercard. We will charge $30 for returned checks. Any account that is turned over to a collection agency will incur a 25% collection fee plus attorney fees if applicable.
- Gym fees are due at the time of use. Gym fees are $5 per session or $40 monthly sessions.

_____ _____

Signature Date

1841 Montreal Rd. Ste. 110 Tucker, GA 30084 Phone: 770-491-6004 Fax: 770-723-0872

Revised 08/2016