PHiLEO health

partners purpose progress

Phileo Health Network – Welcome!

Phileo Health, LLC / Birch Tree PT, LLC / Turning Point Physical Therapy, LLC / Rapha Massage

Thank you for choosing the Phileo Health Network of health care providers for your physical therapy, massage and wellness needs! We appreciate the opportunity to work with you to meet (and hopefully exceed!) your goals. In order to provide the best possible care, we need to collect some information from you and get your consent to proceed with treatment. Please take some time to fill out this packet of forms before your visit:

- This patient intake form, so we know how to reach you.
- The informed consent form. This way, you know what to expect from us, and we know that you know the policies and procedures we follow related to treatment, privacy, information transfer and payment.
- The medical history form (we know it's detailed, but we need to cover all the bases to make sure nothing important is missed, especially if you are coming in without a physician's referral).

Please print and complete this packet, and bring it with you on the first day so we can get right to business instead of spending too much time on paperwork formalities. If you are unable to do this before your first visit, please come at least 15 minutes early to complete the forms at the office.

Thank You SO MUCH!

PATIENT INFORMATION			
First Name:	**Last Name:**		**Date of Birth:**
Street Address:	**City/State:**		**Zip Code:**
Preferred Phone Number:	**Secondary Phone Number:**	**Email Address:**	
Employer:	**Work Phone:**	**Can you be contact at work re: appointment?** **Yes** **No**	
EMERGENCY CONTACT Name:	**Phone Number(s):**	**Relationship**	
How did you hear about us?			

Phileo Health Network -- Patient Consent Form

Phileo Health, LLC / Birch Tree PT, LLC / Turning Point Physical Therapy, LLC / Rapha Massage

Consent to Treat

I consent for the physical therapists and massage therapists associated with the Phileo Health Network of health care providers to provide direct evaluation and treatment to me as advised by my treating clinician. This includes Jessie Podolak, PT, DPT; Amy Flug, PT, DPT, Curt Riley, PT, DPT, and Dawn Cripe, LMT.

_____ (initial)

Independent Providers and Liability

I understand that Phlieo Health, LLC (Jessie Podolak, PT, DPT, TPS), Birch Tree PT, LLC (Amy Flug, PT, DPT, OCS), Turning Point Physical Therapy, LLC (Curt Riley, PT, DPT, OCS), and Rapha Massage (Dawn Cripe, LMT) **are each independent providers** who share treatment space and equipment, and occasionally refer patients to one another for consultation and care. By participating in a treatment session with any of these providers, I consent to be evaluated and treated under their licensed, professional expertise. I acknowledge and consent that any claims that may arise from my treatment are only valid against the individual provider whom I am seeing on the treatment day in which the claim occurs. I hold harmless the independent providers unrelated to my care or claim.

____ (initial)

Attendance

I understand that a 24-hour notice is requested for cancellations. Providers in the Phileo Health Network reserve the right to refuse to treat patients who habitually cancel or fail to show up for scheduled appointments.

_____ (initial)

Privacy

I understand that, under the Health Insurance Portability and Accountability Act of 1996 **(HIPPA),** I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician communications

I have been informed by you of your NOTICE of PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of practices prior to signing this consent form. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Act.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this content in writing at any time, except to the extent that you have taken action relying on this content.

_____ (initial)

Electronic Information

I understand that all therapists associated with the Phileo Health Network use a secure, HIPPA compliant, online documentation system called PtEverywhere, as well as e-mail, fax, and cell phones (voicemail and texting) in their daily operations. I understand that technology puts some of my personal information at risk (for example, a cell phone with my contact information can be misplaced or stolen). Although Phileo Health Network therapists use password-protected devices, information regarding my treatment may be transmitted electronically, carrying with it the inherent risk of being viewed by an unintended audience. Any payment or credit card information will ONLY be transmitted on a confidential, secure banking platform (Card Connect).

_____ (initial)

Direct Pay Policy

Phileo Health, LLC, Birch Tree PT, LLC, and Turning Point Physical Therapy, LLC are direct-pay physical therapy practices, and Rapha Massage is a direct-pay massage therapy practice. This allows us to keep costs much more reasonable than traditional health care clinics. Shifting the responsibility of payment onto the patients directly eliminates the need for office staff to verify insurance coverage, bill third-party payers, and track down delayed payments.

Payment for all services is due at the time of service. Payment can be made via cash, check, ATM/Debit card or credit card. Phileo Health Network therapists do NOT bill insurance for physical therapy services rendered.

Some private insurance companies may cover part or all of the services provided, with Phileo Health Network providers considered “out-of-network” providers. It is the responsibility of the patient to obtain this information from their insurance company and submit appropriate paperwork to their insurance carrier. Phileo Health Network providers will provide a detailed receipt for services rendered, found in the Documents section of patients’ PtEverywhere Accounts. These receipts include diagnosis information as well as a brief description of services rendered:

- PT Evaluation
- Neuromuscular Re-Education
- Therapeutic Dry Needling
- Wellness / Prevention
- Manual Therapy
- Therapeutic Exercise
- Therapeutic Massage
- Performance Enhancement

Note that most traditional health insurance companies ONLY cover services aimed at restoring patients to a reasonable level of function following an injury or disease. Services such as therapeutic massage, wellness/prevention, performance enhancement and maintenance therapy do not typically fit these criteria. Health Savings Accounts and Flexible Savings Accounts may be more amenable to covering such services.

“I have read and understand the Patient Agreement for Cash-Based Policy and agree to pay for services rendered, in full, at the time of service. I understand that it is my responsibility to work with my health insurance, HSA or FSA to try to obtain any reimbursement that I may be eligible for.”

_____ (initial)

I AGREE TO ALL OF THE ABOVE NOTED POLICIES OF PHILEO HEALTH, LLC, BIRCH TREE PT, LLC, TURNING POINT PHYSICAL THERAPY, LLC and RAPHA MASSAGE.

_____ _____
Patient Signature Date

_____ _____
Parent / Guardian Signature (if patient is under 18 years of age) Date

Phileo Health / Birch Tree PT / Turning Point PT / Rapha Massage Medical History Form

Name: _____ DOB: _____ Age: _____
Primary Complaint: _____ Date of onset: _____
Referred by: _____ Primary Physician: _____
Other clinicians you are currently seeing: _____
Date of next MD appointment: _____ Date of last MD appointment: _____

Body Chart:

Please indicate the area(s) of concern:
(larger copy on final page if needed)

Pain: XXXX

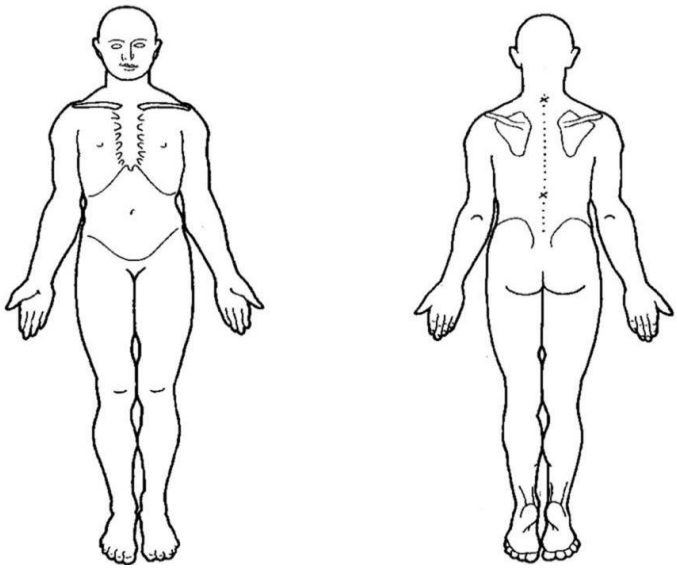
Numbness: OOOO

Tingling: ////////////

Other:
Describe: _____

_____

_____



Do you have or have you had any of the following:

Heart Disease	Yes	No	Arthritis	Yes	No
Blood Clots	Yes	No	Osteoporosis	Yes	No
Angina / Chest Pain	Yes	No	Joint Replacement	Yes	No
High Blood Pressure	Yes	No	Fracture	Yes	No
Heart Attack	Yes	No	Diabetes	Yes	No
Bleeding Disorders	Yes	No	Hypoglycemia	Yes	No
Anemia	Yes	No	GERD / Acid Reflux	Yes	No
Peripheral Vascular Disease	Yes	No	Ulcers / Stomach Problems	Yes	No
Aneurism	Yes	No	Hepatitis / Jaundice	Yes	No
Stroke	Yes	No	Chronic Bronchitis	Yes	No
Epilepsy / Seizures	Yes	No	Emphysema	Yes	No
Multiple Sclerosis	Yes	No	Shortness of Breath	Yes	No
Parkinson Disease	Yes	No	Pneumonia	Yes	No
Guillain-Barre Syndrome	Yes	No	Asthma	Yes	No
Polio / Post-Polio	Yes	No	Tuberculosis	Yes	No
Headaches	Yes	No	Urinary Tract Infection	Yes	No
Depression / Anxiety / Bipolar	Yes	No	Kidney Disease / Dialysis	Yes	No
Eating Disorder	Yes	No	Sexually Transmitted Disease	Yes	No
Chemical Dependency	Yes	No	HIV / AIDS	Yes	No
Fibromyalgia / Myofascial Pain Syndrome	Yes	No	Urinary or Fecal Incontinence	Yes	No
Thyroid Problems	Yes	No	Prostate Problems	Yes	No
Gout	Yes	No	Skin Disorders	Yes	No
Rheumatic Fever / Scarlet Fever	Yes	No	Non-healing Wounds	Yes	No
CANCER	Yes	No	ALLERGIES	Yes	No
Type: _____			List: _____		
Treatment:_____			Other Diagnosis:_____		

Family Medical History:
Have any of your immediate family members (parents, siblings, and children) been told they have:
□ Cancer □ Heart disease □ Diabetes □ Stroke □ Arthritis □ Anxiety/depression
□ Other (please describe): _____

General Health:

How would you rate your health?	□ Excellent	□ Good	□ Fair	□ Poor
How is your sleep? Number of hours:_____	Quality:	□ Good	□ Fair	□ Poor
Do you exercise regularly? If yes, type:_____			□ Yes	□ No
Any illnesses in the past 3 months? (cold, flu, bladder / kidney infection, etc.)			□ Yes	□ No
Females: Is there any possibility you are pregnant?			□ Yes	□ No
Any implants of any kind in your body (ex: joint, breast, pacemaker, transplant)			□ Yes	□ No
Have you fallen in the past year?			□ Yes	□ No
If yes, have you been injured because of the fall?			□ Yes	□ No
Have you been feeling down, depressed or hopeless?			□ Yes	□ No
Have you lost interest or pleasure in doing things?			□ Yes	□ No
Have you had any diagnostic tests (MRI, X-ray, lab) recently? If yes, please list:			□ Yes	□ No

_____

Symptoms:
Do you have, or have you recently had, any of the following?

□ Blood in urine, stool, vomit, or sputum	□ Cough	□ Difficulty swallowing/speaking
□ Dizziness, fainting, blackouts	□ Dribbling of urine	□ Memory loss
□ Fever, chills, sweats (day or night)	□ Inability to tolerate exertion	□ Confusion
□ Nausea, vomiting, loss of appetite	□ Numbness / tingling	□ Sudden weakness
□ Swelling or lumps anywhere	□ Trouble sleeping	□ Bowel or bladder changes
□ Throbbing sensation / pain in belly/elsewhere	□ Problems seeing or hearing	□ Skin rash or other changes
□ Unexplained weight loss or weight gain	□ Unusual fatigue, drowsiness	□ Heart Palpitations / fluttering
□ Heat or cold intolerance	□ Joint pains or muscle cramps	□ None of these

Medications:
Please list any current prescription or over-the-counter medications, supplements, or herbal products:
_____
_____
Are you on Coumadin (Warfarin)? □ Yes □ No

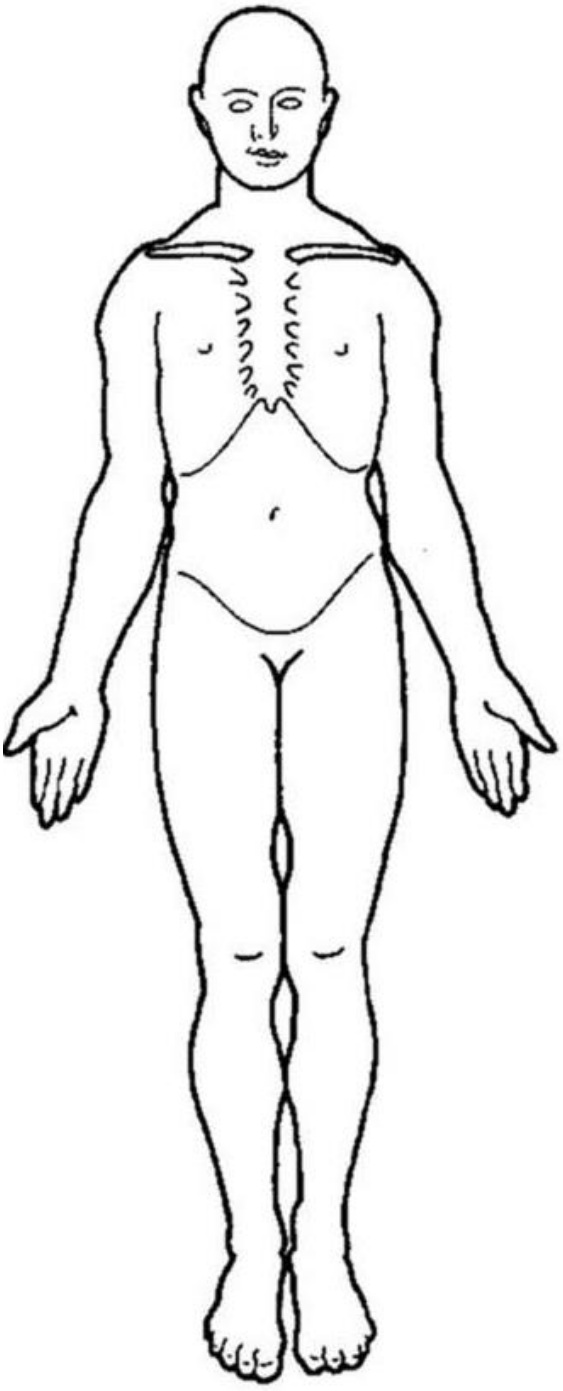
Surgeries: Please list surgeries you have had along w/ approximate dates: _____
_____

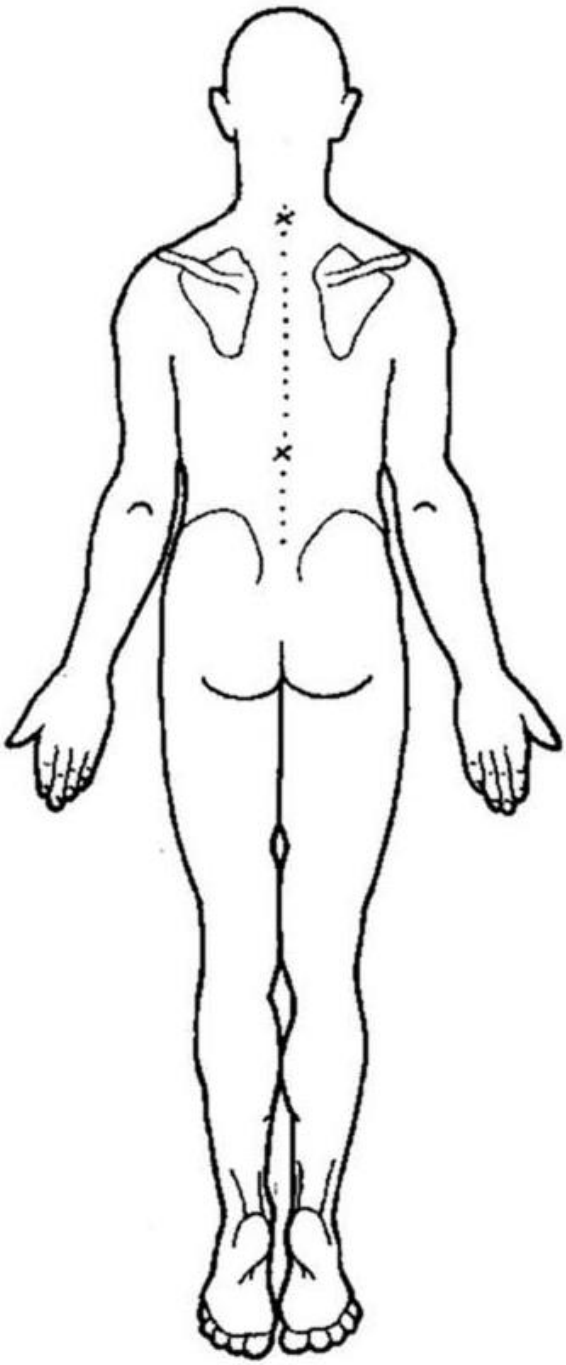
Social History:
Living Situation: □ Alone □ With someone □ Home / apartment □ Other: _____
Marital Status: □ Married □ Single □ Widowed □ Divorced □ Other
Occupation: _____ Company worked for: _____
Tobacco Use: □ Yes □ No □ Previously, but I quit When did you quit?_____
If yes, # of years you've smoked/chewed ____ Amount you smoke/chew per day_____
Alcohol: □ Yes □ No □ Previously, but I quit When did you quit?_____
If yes, how often and how much do you drink? _____
Illicit Drug Use: □ Yes □ No □ Previously, but I quit Please specify: _____
Caffeine Intake: _____ # drinks/servings per day Nutrition Concerns?_____
Artificial sweeteners (NutraSweet, Aspartame, Splenda, etc.): □ Yes □ No ____ # drinks / servings per day

Do you have any religious or cultural concerns that may affect your treatment? □ Yes □ No
If yes, please specify: _____
Do you have any barriers to learning that your therapist should be aware of? □ Yes □ No
If yes, please specify: _____
Do you have any other symptoms, anywhere else in your body, not covered above? □ Yes □ No

Patient Signature: _____ Date:_____

Parent/Guardian Signature (if applicable):_____ Date:_____





Pain: XXXX

Numbness: OOOO

Tingling: ////////////