INTAKE FORM NEW PATIENT INFORMATION

(Please fill out forms completely) *If Patient is under 18 years of age, legal guardian must sign all paperwork.

Date: _____

Patient Name: Last: _____ First: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____ DOB: _____

Sex: Male / Female Marital Status: Single Married Widowed Divorced

Emergency Contact: Last: _____ First: _____

Relationship: _____ Phone: _____

Employment Status: Student Working Retired Homemaker Unemployed

Employer: _____ Type of Work: _____

Problem/Chief Complaint:

_____

Date of Injury: _____ Mechanism of Injury: _____

Referring Physician: Last: _____ First:_____

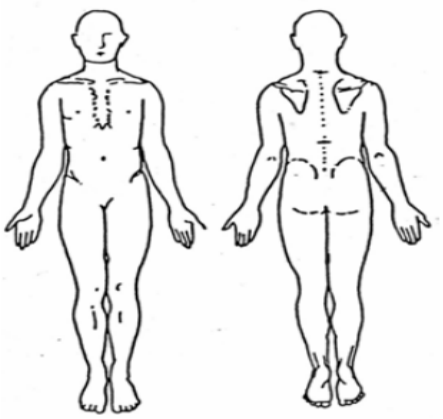
Date of Physician Visit:_____

Referral to Zeren PT: Family Friend Doctor Internet Other

Referring Person: Last: _____ First:_____

FUNCTION & SYMPTOM QUESTIONNAIRE

Please indicate where you are experiencing pain on the diagram.



Are Your Symptoms:

Worsening Improving Remaining the Same

Quality of Pain:

Achy Sharp Dull Throbbing Radiating Unrelenting

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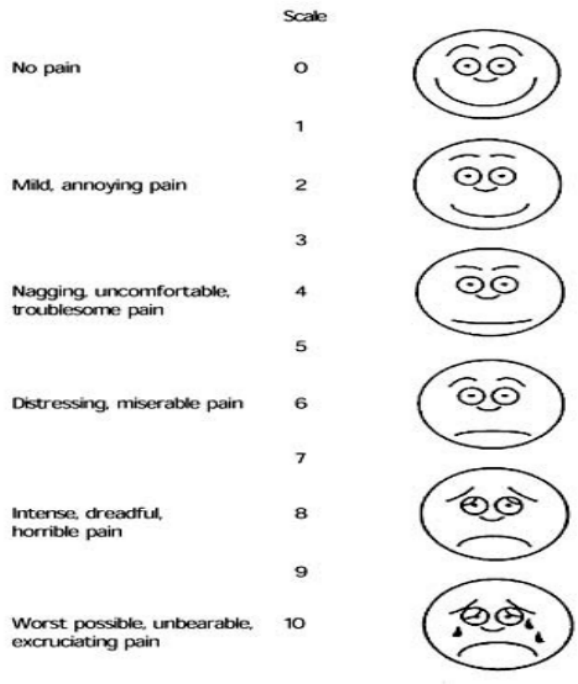
PICTORAL PAIN ASSESSMENT

In the diagram on the right please circle the one which best describes your pain or mood. Use numbers and/or faces.



MEDICAL HISTORY

Remarkable Past Medical & Surgical History:
(Please list dates)

_____
_____
_____
_____
_____
_____

Current Medications: (Please list type and dosage)

_____
_____
_____
_____
_____
_____

How many days a week do you perform physical activity:

none 1 2 3 4 5 6 7

Do You Currently Have or Have Past Medical History of Any of the Following?

Asthma	Congestive Heart Failure	Osteoporosis	Gout
Bronchitis	Hernia Knee	Injury/Surgery	Emphysema
Blood Clot/Emboli	Headaches	Varicose Veins	Allergies
Leg/Ankle Surgery	Shortness of Breath	Latex Sensitivities	Broken Bones
Lung Problems	Pain with Sneezing	Chest Pain	Thyroid Disease
Pregnant	Visual Difficulties	Goiter	Depression
Hearing Difficulties	Pin or metal implants	Tobacco Coronary	Artery Disease
Anemia	Shoulder Injury/Surgery	Hypoglycemia	Pace Maker
Fibromyalgia	Angina	Infectious Disease	Chronic Pain
Dizziness of Fainting	Neck Injury/Surgery	Eating Disorders	Heart Attack
High Blood Pressure	Diabetes Head Injuries	Liver Problems	Metal Implants
Kidney Problems	Bowel/Bladder Problems	Neurological Deficits	Heart Surgery
Joint Replacement	Arthritis Weight Loss/Fatigue	Back Injury/Surgery	Cancer
Seizures/Epilepsy	Elbow/Hand Injury/Surgery	Stroke	Weakness
Other:_____		Other:_____	

Please provide us with any other information that you think will help us improve your care as well as your rehabilitation goals and expectations:

_____
_____

First Name: _____ Last Name: _____

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OUT OF NETWORK PROVIDER ACKNOWLEDGEMENT

Zeren PT LLC is an out of network provider and therefore does not participate with insurance companies. It is the responsibility of patients interested in seeking care from Zeren PT LLC to ascertain their outpatient physical therapy benefits prior to receiving treatment. Zeren PT LLC will provide every patient with an itemized receipt that can be submitted to your insurance company for reimbursement provided that you have out of network benefits, have met the deductible that corresponds with your plan, and have not exceeded your benefits for the calendar year set forth by your insurance provider. To help you determine your benefits we have provided an insurance worksheet under the "Physical Therapy" tab of our website (www.zerenpt.com).

PAYMENT AND SERVICES RENDERD

Patients receiving physical therapy at Zeren PT are expected to pay at the conclusion of each individual treatment session. Cash, check, and charge are all accepted.

NO SHOW/CANCERLATION POLICY

Physical therapy appointment scheduled represent time specifically set aside for you as a patient. All cancellations MUST be made 24 hours prior to the start of your scheduled appointment time to avoid incurring a late fee. Patients who cancel or no show on three separate occasions will automatically discharged from my care and will not be able to return to Zeren PT LLC for care in the future.

All cancellations (less than 24hrs notice) and no show appointments will be charged $100 to the credit card kept of file.

CONSENT TO TREAT

I agree to give my consent for Zeren PT LLC to furnish rehabilitation services considered necessary and proper in my treatment for my physical condition. I also agree to the cancellation policy outlined above.

Name of Patient (Please Print): _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

COMMUNICATION POLICY

CONTACTING ZEREN PT

When you need to contact Zeren PT for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

- You may leave messages on the voicemail (347-721-6789), which is confidential.
- By email (chris@zerenpt.com)
- If you wish to communicate with Zeren PT by normal email or normal text message, please inquire about the potential confidentiality risks of doing so.
- If you wish to communicate with us by normal email or normal text message, please read and complete the Consent For Non-Secure Communications form included with these office policies.

If you need to send a file such as a PDF or other digital document, please send it to chris@zerenpt.com.

Please refrain from making contact with us using social media messaging systems such as Facebook Messenger or Twitter. These methods have very poor security and we are not prepared to watch them closely for important messages from patients. It is important that we be able to communicate so please speak with us about any concerns you have regarding our preferred communication methods.

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RESPONSE TIME

We may not be able to respond to your messages and calls immediately. For voicemails and emails, you can expect a response within one business day. We may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when we are unable to receive or respond to messages, such as when out of cellular range or out of town.

EMERGANCY CONTACT

If you are ever experiencing an emergency please call 911. If you need to contact us about an emergency, the best method is:

- By phone (347-721-6789)
- If you cannot reach us by phone, please leave a voicemail and then follow up with an email to the address listed above.

DISCLOSURE REGARDING THIRD-PARTY ACCESS TO COMMUNICATION

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ (Patient Name) AUTHORIZE: Zeren PT LLC

TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA:

- Scheduling of meetings or other appointments
- Billing and payment related information
- Email communication

TERMINATION

- ☐ This authorization will terminate _____ days after the date listed below. OR
- ☐ This authorization will terminate when the following event occurs: _____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

First Name: _____ Last Name: _____

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ELECTRONIC RECORDS DISCLOSURE

Zeren PT keeps and stores records for each client in a record-keeping system produced and maintained by Google. This system is "cloud-based," meaning the records are stored on servers which are connected to the Internet. Here are the ways in which the security of these records is maintained:

- We have entered into a HIPAA Business Associate Agreement with Google. Because of this agreement, Google is obligated by federal law to protect these records from unauthorized use or disclosure.
- The computers on which these records are stored are kept in secure data centers, where various physical security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- Google employs various technical security measures to maintain the protection of these records from unauthorized use or disclosure.
- We have our own security measures for protecting the devices that we use to access records:
    - On computers, we employ firewalls, antivirus software, and passwords to protect the computer from unauthorized access and thus to protect the records from unauthorized access.
    - With mobile devices, we use passwords to protect unauthorized users from accessing them.

Here are things to keep in mind about our record-keeping system:

- While our record-keeping company and Zeren PT both use security measures to protect these records, their security cannot be guaranteed.
- Some workforce members at Google, such as engineers or administrators, may have the ability to access these records for the purpose of maintaining the system itself. As a HIPAA Business Associate, Google is obligated by law to train their staff on the proper maintenance of confidential records and to prevent misuse or unauthorized disclosure of these records. This protection cannot be guaranteed, however.
- Our record-keeping company keeps a log of my transactions with the system for various purposes, including maintaining the integrity of the records and allowing for security audits.

EMAIL AND TEXTING QUESTIONAIRE
REGARDING EMAIL

1. Technical experts often describe email as being like a postcard, in that it can be viewed by all hands it passes through. Are you familiar with the risks of emails being viewed by various engineers, administrators, and bad actors as it passes through the Internet?
2. Think about where you read and write emails, and what devices you do that on. Think about who can see you reading and writing emails in these places, and who can access the devices you use to read and write emails. Would there be any negative consequences to any of those people reading or glancing at emails exchanged with your therapist? Are there certain kinds of email contents that you would feel safe letting these people see and other kinds of contents you would not feel safe letting them see? Let your therapist know the answers to these questions if you wish to use email with him or her.
3. Think about which email address(es) you might use with your therapist. Who has access to each address? If you use a work email address, know that your employer may legally view all the emails your send receive with that address. Be aware that engineers and administrators at your email service provider may be able to view your emails.
4. How quickly do you normally receive replies from others via email? Do you expect replies more quickly than your therapist's stated response time? Can you see any negative consequences occurring if your therapist does not or cannot reply to an email as quickly as others in your life typically do?

Your therapist's email service is through this company: Google

PAYMENT

Zeren PT takes payments in cash, check and credit card. If you would like to pay with a credit card please see below.

To make credit card payments easy, we ask that you provide us the the information below. Once we have processed your first payment we will shred this document and save your information on a secure HIPPA compliant payment system (Sage Terminal). By signing below you are acknowledging you have read this and have give Zeren PT permission to use this information for the sole purpose of billing you for services rendered. Thank you for trusting your coaching and physical therapy needs to us.

Name: _____

Email: _____

Address: _____

_____

Phone: _____

Credit Card #: _____

Expiration: _____ CV: _____

Signature: _____