Patient Medical History Form

Patient's Last 4 digits of SSN:		Date of Birth	
Last Name		First Name	
Parent/Guardian's Name		Cell Number	
Email Address			
Emergency Contact Name		Cell Number	
Referring Physician		Phone Number	
Previous Medical History			
Previous Surgical History			
Medications			
Is this a re-occuring injury/problem? (Yes/No)			
Time and mechanism of current injury/problem			
Location of current injury/problem			
Describe your current symptoms			
Current pain intensity (0 - 10), 0 = no pain			
Have you received imaging tests? Which one? (X-ray, MRI, etc)			

Have been diagnosed with any of the following?

Condition	Yes/No	Specify
Cancer		
Heart Problems		
Hypertension		
Rheumatic disease		
Osteoporosis		
Asthma		
Neurological Disorder		

Are you currently pregnant? If yes, how many weeks?	
Patient's signature	
Parental/Guardian signature	

Return Email

andwele.jolly@gmail.com
http://www.kineticpt-stl.com/
Jolly Advisory Group, LLC

Policies and Patient Authorization

Billing

Jolly Advisory Group, LLC is an out-of-network provider; therefore charges are your responsibility on the date that service is rendered. Jolly Advisory Group, LLC will assist you by providing an itemized receipt, which you can send, as is, to your insurance company for reimbursement. It is your responsibility to follow-up with your insurance company after the submission of claims to ensure that the claims are processed correctly.

Cancellation Policy

Please notify Jolly Advisory Group of a cancelled appointment 24 hours in advance of the scheduled appointment or a $25 cancellation fee may be applied.

Prescriptions

In the state of Missouri, a physician's prescription is required prior to the initiation of physical therapy treatment of a new injury. However, if you have a reoccurring injury, which has been evaluated by a physician within one year, a prescription is not required. Your physician will be contacted after your evaluation regarding the nature of your condition. Please note that the preventative health screening does not require a physician's prescription.

Consent of Care

You hereby give your consent to Andwele Jolly, PT, DPT, OCS of Jolly Advisory Group, LLC to provide physical therapy care and services and to exercise professional judgment regarding care and services that may be necessary. You understand that you are expected to ask any questions you may have regarding your treatment.

Authorization

I have read all of the above information and agree to the terms. I understand that I am financially responsible for the all charges incurred from physical therapy services rendered. I authorize the release of my medical information to my physician if he or she requests it.

Patient's Name

Patient's Signature & Date

Parent/Guardian Name

Parent/Guardian Signature & Date

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NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by me in any form whether electronically, on paper, or orally, are kept properly confidential. This Act give you, the patient, a fundamental right to be informed of the privacy practices of your health plan and to be informed of your privacy rights with respect to your personal health information. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I may use and disclose your protected health information for the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples include physical therapy examinations and disclosing information with other providers for treatment purposes.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health care operations include the business aspects of running the practice, such as conduction quality assessments and improvement activities, auditing functions, cost-management analysis, and customer review. An example is a quality assessment review.

I may contact you to provide appointment reminders via phone or e-mail or information about treatment alternatives or other health-related benefits and services to you. I am permitted to share information with family and friends that are directly involved in your care or payment for health care. I will use and disclose your protected health information when required to do so according to HIPAA. I may disclose your information to law enforcement officials for circumstances required by law and to public officials responding to a public health emergency where the circumstances of the emergency implicates law enforcement activities, national security and intelligence activities, or administrative and judicial proceedings. I may disclose your information to workers' compensation and other programs.

All other use or disclosure of your protected health information will be made with your written authorization and you may revoke authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization. You have the rights with respect to your protected health information, which you can exercise by presenting a written request to the address listed. An authorization includes the following elements, a description of the PHI that is to be used and disclosed, the person authorized to make the use of disclosure, the person to whom I can make the disclosure, and an expiration date.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, and close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a requested restriction, I must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from me upon request

I am required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

This notice is effective as of October 1, 2007 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that I maintain. You may request a written copy of a revised Notice of Privacy Practices from me.

Acknowledgement of Receipt of Notice of Privacy Practices

I reviewed this Notice of Privacy Practices

Print Name & Date

Return Email
andwele.jolly@gmail.com
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Jolly Advisory Group

Physician Order

Patient's Last Name		First Name	
Parent/Guardian's Name		Cell Number	
Physical Therapy Evaluate & Treat For			
ICD9/ICD10 Code:			

Number of Visits		**Please Check**
	0 - 5 Visits	
	0 - 10 Visits	
	0 - 15 Visits	
	0 - 20 Visits	

Special Orders/ Instructions:	
Print Physician's Name	
Physician's Signature	
Date	
Physician Phone Number	
Physician Fax Number	

Return Email & Phone
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