Teamwork Therapy & Sports Performance
10855 Irma Drive, Northglenn, CO
Phone: 303-525-0573 Fax: 303-594-0355
Email: teamworkcolorado@gmail.com

Name: _____

Address: _____

Phone: Home_____ Cell: _____Email: _____

Preferred way to contact: Home/Cell Gender: _____

Date of Birth: _____Employer: _____

Occupation: _____ Emergency Contact: _____

Referred By: _____

Risk Factors & Medical History

Please state reason for today's visit and any diagnosis that that has been given from a physician:_____

_____

_____

_____

Please provide approximate date of injury if known:

_____

_____

Please list any restrictions given from physician:

_____

_____

_____

_____

_____

Please list any restrictions from your work:

_____

_____

_____

Is there any litigation/insurance settlement pending regarding this injury? _____yes _____ no

Do you have a family history of any of the following? If yes, please circle all that are applicable.

Please check any of the below that apply to you either presently or in the past:

High/Low Blood Pressure	Low Blood Sugar	Asthma
Osteoporosis/Osteopenia	Psychiatric Problems	Lung Disease
Diabetes	Nausea/Vomiting	Bleeding Disorders
Cancer	Shortness of Breath	Night Sweats
Smoking	Sharp, Heavy Pressure in Chest	Rheumatoid Arthritis
Stroke	Pacemaker	Osteoarthritis
Memory Loss	High Cholesterol	Epilepsy/Seizures
Pregnant/Possibly Pregnant	Hernia	Vertigo/Dizziness
Circulatory Problems	Skin Disease/Allergies	Allergies (please specify below)

Allergies if applicable:

_____

_____

Other conditions and/or symptoms

_____

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized and applicable dates:

Please list all medications you are taking and reason:

Please list any adverse reactions to drugs:

What activities in your normal day are you unable to perform due to your current injury:

What are your therapy goals?

Signature: DATE:

Patient Name:

_____

CONSENT TO TREAT:

I agree and give my consent for TEAMWORK Therapy & Sports Performance Inc. to furnish Medical Soft Tissue Therapy/Fascial Stretch Therapy and treatment considered necessary and proper in treating my physical condition.

_____ [initial here]

CANCELLATION/NO SHOW POLICY:

Unless cancelled at least 24 hours in advance, our policy is to charge $35.00 for missed appointments per each half hour scheduled. We may have patients waiting for appointments on a cancellation list and your courtesy of a phone call allows us to schedule them. A total of three cancellations and/or no shows may result in discharge from our practice and/or notification of your insurance company of non-compliance. Individuals who are more than 15 minutes late will be charged a cancellation fee and be required to re-schedule their appointment for another day.

I have read and understand Teamwork Therapy & Sports Performance's Cancellation/No Show Policy:

_____ [initial here]

RELEASE OF INFORMATION:

I do/do not (please circle one) authorize_____(physicians name) to release any of my medical records, reports, x-rays, or diagnostic images to Teamwork Therapy & Sports Performance Inc. for the purpose of obtaining information relevant to my treatment.

_____ [initial here]

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, hereby acknowledge that I have received the Notice of Privacy Practices from TEAMWORK Therapy & Sports Performance Inc. and understand it completely.

_____ [Initial here]

Signature
Date

FOR OFFICE USE ONLY: In lieu of patient signature, I _____, a staff member of Teamwork Therapy & Sports Performance Inc. state that_____ has been given our current Notice of Privacy Practices.

Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared his explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operation.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **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 our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the part has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may

disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody

of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and discloses will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to you PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are 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 PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

HIPPA Privacy Officer
Justin Willis, President, BEXSc, NMT, CFST II, CPFT

TEAMWORK Therapy & Sports Performance Inc.
(303) 525-0573
For more information about HIPAA or to file a complaint:
Office of Civil Rights, U.S. DHHS
1961 Stout Street – Room 1426
Denver, CO 80294
(303) 844-3439