Libby Hinsley, PT -- Yoga Rx of Asheville, Inc.

New Patient Information

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____Email: _____ Primary MD: _____

Do you have Medicare as primary or secondary insurance coverage? Yes □ No □

Who may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone: _____

Sex assigned at birth: _____ Preferred gender pronouns: _____

Occupation: _____ Full-time□ Part-time□ Disability□ Sick Leave□

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

□ Cancer (type)_____
□ Rheumatoid arthritis
□ Diabetes
□ Heart disease
□ Stroke
□ Multiple sclerosis
□ High blood pressure
□ Depression
□ Kidney/liver problems
□ Asthma
□ Anemia
□ Stomach ulcers
□ Pacemaker inserted
□ Lung problems
□ Epilepsy
□ Osteoporosis
□ Thyroid problems
□ Parkinson's disease
□ Chemical dependency (i.e., alcoholism)
□ Heart Attack
□ HIV/AIDS
□ Other_____ □ Other_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

Please list all current medications and supplements:

Are you currently taking a blood thinner or anticoagulant medication? **Yes** □ No □
ALLERGIES: _____
Are you latex sensitive? Yes □ No □

During the past month have you been feeling down, depressed or hopeless? **YES □ NO □**
During the past month have you lost interest or pleasure in doing things? **YES □ NO □**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES □ NO □**

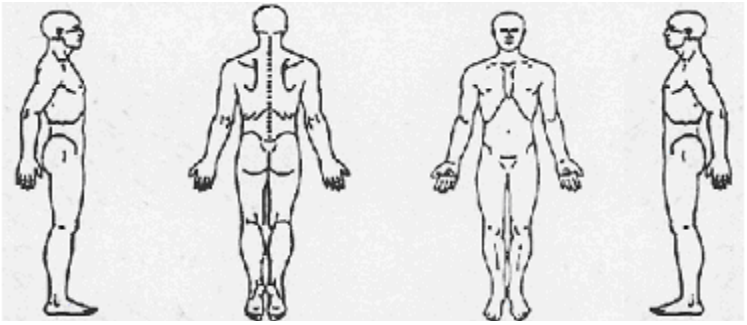
Please describe your primary reason for seeking Physical Therapy at this time:

When did your condition begin?_____Specific Date if possible:___/___/___
Did you have surgery for this condition? □No □Yes Date____/____/____
Have you had any diagnostic tests for this condition? □ X-Ray □MRI □CT Scan □Other: _____

Please describe the nature of your pain/discomfort (check all that apply):

□ Sharp Pain
□ Dull Ache
□ Throbbing
□ Numbness
□ Shooting
□ Burning
□ Tingling
□ Constant (76%-100% of the time)
□ Frequent (51%-75% of the time)
□ Occasional (26%-50% of the time)
□ Intermittent (25% or less of the time)

MARK ON THE PICTURES BELOW WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Indicate the intensity of your ***pain at rest*** : (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Indicate the intensity of your ***pain with movement*** : (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began, your symptoms have: □ Decreased □ Not changed □ Increased
Your symptoms are worse in: □ Morning □ Afternoon □ Night □ During the day □ Same all day

Have you been treated in the past for the same problem? □ Yes □ No If yes, who did you see?
□MD □Physical Therapist □Occupational Therapist □Chiropractor □ Massage Therapist □Other

Briefly describe your dietary habits:_____

Briefly describe your physical fitness habits:_____

Current level of psychological/emotional stress (circle one): **Low** **Medium** **High**

Please list your current favorite past times or hobbies: _____

POLICIES: Please sign and/or initial where indicated:

- **PAYMENT OF FEES**

Full payment by check, cash, or credit card is expected at the time of treatment. I do not file claims with any insurance companies. I understand that Yoga Rx of Asheville, Inc. requires fees to be paid at the time of service _____(initial). I understand that Yoga Rx of Asheville, Inc. does not participate with any insurance provider, and therefore will not bill my insurance carrier for services rendered ____ (initial).

- **CANCELLATION AND NO-SHOW POLICY**

If you need to change your appointment, I require at least **48 hours notice** or there will be a **$60.00 fee**. Repeated late cancelations and no-shows will result in discharge from the practice. I understand I will be charged a $60 fee for a late cancelation (<48 hours) ____(initial).

- **HIPAA DISCLOSURE STATEMENT:**

I acknowledge that I have been informed of the Provider Notice of Patient Information Practices which can be found at the end of this document ____(initial).

- **PHONE CALL AUTHORIZATION:**

I authorize Yoga Rx of Asheville, Inc. to leave messages on my answering machine regarding relevant information. Yes □ No □ ____(Initial). I authorize Yoga Rx of Asheville, Inc. to email me and/or text message my cell phone for appointment reminders. Yes □ No □ ____(Initial)

- **CONSENT FOR TREATMENT:**

I authorize and request Yoga Rx of Asheville, Inc. to administer all necessary treatments and care required for my (or my dependent's) rehabilitation. This consent is effective from the date it is executed until the date the client terminates it in writing. ____ (initial).

- **COVID-19 SAFETY PROTOCOLS:**

Patients will text me upon their arrival to the building and I will come out to let you in. Please cancel your appointment if you have any symptoms of illness. Face masks must be worn at all times in the building. I understand these safety protocols. ____ (initial)

I understand and agree to the all of the terms stated above.

Patient (or Guardian) Print Name: _____

Patient (or Guardian) Signature: _____ Date: _____

Witness Signature (to be signed by office): _____
Witness Print Name (to be completed by office): _____

Libby Hinsley, PT – Yoga Rx of Asheville, Inc. NOTICE OF PRIVACY PRACTICES

LEGAL DUTY: Yoga Rx of Asheville, Inc. is required by law to protect the privacy of your personal health information, provide this notice about my information practices, and follow the information practices below.

USES AND DISCLOSURES OF HEALTH INFORMATION: Yoga Rx of Asheville, Inc. may:

- Use or disclose your personal health information for providing physical therapy services for treatment, and for obtaining payment for services.
- Use of disclose your personal health information without prior authorization for purposes of public health, auditing, emergencies, and when required by law.
- Any other use of this information needs your written authorization.

TRANSMISSION OF MEDICAL INFORMATION:

As the need for speedy exchange of information may be important for the purposes of continuity of care and exchange of essential and timely information regarding your current care and treatment, Yoga Rx of Asheville, Inc. may use the most efficient method available while preserving the confidentiality of your personal health information.

PATIENT'S RIGHTS:

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request a correction of any inaccurate or incomplete information in your records. You also have the right to request a list of the instances that your personal health information has been disclosed for reasons other than treatment, payment or administrative purposes.

If you have given written authorization to provide your personal health information for any reason other than the above, you may revoke this in writing at any time.

You have the right to restrict how your personal health information is used and disclosed for treatment, payment and administrative operations if you notify Yoga Rx of Asheville, Inc. in writing. Yoga Rx of Asheville, Inc. is not required to agree to the requests for restrictions.

Note: Yoga Rx of Asheville, Inc. may change its policies at any time without notice. When changes are made, a new Notice of Information Practices will be posted in the office and will be provided to you on your next visit. You may also request an updated copy at any time.