Flathead Performance Training
Client Intake Form

Name	Birth Date	Social Security #	Marital Status S M W D	Gender M F

Mailing Address	City	State	Zip	Home Phone #
Physical Address	City	State	Zip	Cell Phone #

Occupation	Employer & Work Address	Phone #

Primary Care Physician	Emergency Contact Name	Contact Phone #	Contact Relationship

Mothers Name (If Under 18)	Phone #	Fathers Name (If Under 18)	Phone #

Who can we thank for referring you to our facility or how did you find us (Phone Book, Web Site, Newspaper, etc.)?

Would you like to help us to be environmentally friendly and receive our newsletter via e-mail? YES NO

E-mail address:

Injury Information

Date of injury	Date of Surgery	Type of Surgery	Referring Physician

Was Injury Work Related	Employer Name and Address At Time of Injury

If Work Related – Claim #, Case Manager/Claim Adjustor Name and Phone #

Sport/Activity Information

What sport/activities do you regularly participate in?

What positions do you play?

What School/Team do you play for and what is your coach's name?

Program Goals

What goals do you have for this program and what weaknesses do you feel may keep you from attaining these goals?

Client Signature		Date
Parent/Guardian Name If Client Is Under 18 (Printed)	Signature	Date

Medical History

Have you ever had or do you now have any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Epilepsy	☐	☐	Heart Disease	☐	☐
Ex. Induced asthma	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Low Blood Pressure	☐	☐	Arthritis	☐	☐
Hernia	☐	☐	Bronchitis	☐	☐	Muscle Cramps	☐	☐
Chest Pain	☐	☐	Sickle Cell Anemia	☐	☐			

Have you ever:

	Yes	No		Yes	No
Passed out before or during exercise	☐	☐	Had a neck injury	☐	☐
Been dizzy during or after exercise	☐	☐	Dizziness of fainting spells	☐	☐
Had chest pain during or after exercise	☐	☐	Had trouble breathing	☐	☐
Been told you have a heart murmur	☐	☐	Had trouble sleeping or unusual fatigue	☐	☐
Had racing of your heart of skipped beats	☐	☐	Had trouble with dehydration	☐	☐
Had a seizure	☐	☐	Had heat exhaustion, stroke or cramps	☐	☐
Had a stinger, burner, or pinched nerve	☐	☐	Had numbness/tingling in arms or legs	☐	☐

Do you:

	Yes	No
Take any prescription medication	☐	☐
Take any non-prescription medication	☐	☐
Use any performance enhancing drugs	☐	☐

List all medications that you currently take: ____

____

If *YES* to any of the above, please explain: ____

____

____

____

Read and answer the following questions carefully

	Yes	No	
Have you ever or do you now experience back pain?	☐	☐	____________________
Have you ever had a bone graft or spinal fusion?	☐	☐	____________________
Have you had a fracture in the past 2 years?	☐	☐	____________________
Have you had any operation in the past 2 years?	☐	☐	____________________
Have you ever been told you have a hernia?	☐	☐	____________________
Are you under the care of a physician for any condition not already listed?	☐	☐	____________________

Has anyone in your immediate family ever had any of the following and who?

	Yes	No			Yes	No	
Diabetes	☐	☐	__________	High blood pressure	☐	☐	__________
Arthritis	☐	☐	__________	Sudden death	☐	☐	__________
Cancer	☐	☐	__________	Blood disorders	☐	☐	__________
Neuro. Disorders	☐	☐	__________	Kidney disease	☐	☐	__________
Heart disease	☐	☐	__________	Tuberculosis	☐	☐	__________
Epilepsy	☐	☐	__________	Stroke	☐	☐	__________

Orthopedic History

Read and answer the following questions carefully and be specific:

HAVE YOU EVER SUSTAINED AN INJURY TO YOUR:

	Yes	No	Explanation of injury
Head	☐	☐	______________________
Neck	☐	☐	______________________
Abdomen	☐	☐	______________________
Back	☐	☐	______________________
Chest and Ribs	☐	☐	______________________

	Left		Right		Explanation of injury
	Yes	No	Yes	No	
Shoulder	☐	☐	☐	☐	______________________
Upper arm	☐	☐	☐	☐	______________________
Elbow	☐	☐	☐	☐	______________________
Forearm	☐	☐	☐	☐	______________________
Wrist	☐	☐	☐	☐	______________________
Hand	☐	☐	☐	☐	______________________
Finger Thumb	☐	☐	☐	☐	______________________
Index	☐	☐	☐	☐	______________________
Middle	☐	☐	☐	☐	______________________
Ring	☐	☐	☐	☐	______________________
Little	☐	☐	☐	☐	______________________
Hip	☐	☐	☐	☐	______________________
Groin	☐	☐	☐	☐	______________________
Thigh	☐	☐	☐	☐	______________________
Hamstring	☐	☐	☐	☐	______________________
Knee	☐	☐	☐	☐	______________________
Lower leg	☐	☐	☐	☐	______________________
Ankle	☐	☐	☐	☐	______________________
Foot	☐	☐	☐	☐	______________________

Have you had or do you have now any other medical conditions/problems or injuries not listed on this form? Yes ☐ No ☐
If Yes, explain:

____

____

Do you have any medical or health condition that you are currently receiving medical care for? Yes ☐ No ☐
If Yes, explain:

____

____

I certify that I have answered this questionnaire completely and accurately to the best of my knowledge. I certify that I have not had any prior illnesses of injuries other than those listed on this questionnaire.

______________________	__________	______________________	__________
Client Signature	Date	Parent Signature (if client is under 18)	Date

Consent to Athletic Training Services

1. I hereby consent and authorize the performance of Athletic Training services as is necessary in the judgment of the Certified Athletic Trainer.
2. I understand that Flathead Performance Training Center, LLC is not responsible for my personal belongings that may include; clothing, jewelry, credit cards, money or other items of value, etc.
3. I agree to abide by the rules and procedures of Flathead Performance Training Center, LLC.
4. I agree to promptly pay for all services rendered.
5. I will not hold Flathead Performance Training Center, LLC responsible for any injury sustained while training independently and it is my responsibility to ask for help with any machine or free weight to prevent such injury.

Authorization to Release Medical Information

I authorize Flathead Performance Training Center, LLC to release medical information about me to any insurance company (or other organization responsible for paying my medical bills) as identified in this record. Medical information may be provided to a payer or its agent orally, in writing of by allowing the agents to receive copies of, or view my medical records in the Athletic Training facility. The purpose of releasing this information will be to allow the payer to determine the extent of my health coverage and benefits to pay my medical bills.

This authorization will be effective for two (two) years from the date it is signed. I understand that I may revoke this authorization at any time, except to the extent action has been taken in reliance on it.

Assignment of Insurance Benefits

The undersigned agrees that in consideration of the services rendered, or to be rendered to the patient, he/she individually obligates him/herself to pay the account of Flathead Performance Training Center, LLC resulting from the services in accordance with the regular rates and terms of Flathead Performance Training Center.

The undersigned authorizes Flathead Performance Training Center, LLC to furnish all medical information from the patients file to any insurance carrier that may provide insurance benefits to pay the account.

The undersigned irrevocably assigns Flathead Performance Training Center, LLC, any and all insurance benefits to which the patient may be entitled to for payment of the services provided by the Certified Athletic Trainer and clinic. The undersigned understands that he/she is responsible for any and all charges not paid by the insurance carrier even if the carrier's refusal of failure to pay is wrongful and in breach of the carrier's obligation.

The undersigned further understands and agrees that Flathead Performance Training Center, LLC is not an agent of any insurance carrier, and it is agreed that the Athletic Training facility is not responsible for any failure or refusal of any insurance carrier to pay benefits that may be due under any policy of insurance.

I have read, or had read to me, all of the foregoing and understand its content.

____

Print Name Signature Date

____

Parent/Guardian Name (if under 18) Signature Date

2006 Hospital Way
Whitefish, MT 59937
(406)862-9372

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that you are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the clinicians practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician/healthcare professional to which you have been referred to ensure that the physician/healthcare professional has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, your health information may be provided to an attorney or law firm that is representing you on a claim.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your clinicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to physical therapy students that see patients at our office. In addition, we may call you by name in the waiting room when your Therapist/Athletic Trainer is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors; Organ Donations; Criminal Activity; Military Activity; National Security; Worker's Compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object Unless Required By Law.

You may revoke this authorization, at any time, in writing, except to the extent that your Athletic Trainer or athletic training practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Therapist/Athletic Trainer is not required to agree to a restriction that you may request. If your Therapist/Athletic Trainer believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at any alternative location. You have the right to obtain a paper copy of this notice from us upon request.

You have the right to have your Therapist/Athletic Trainer amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with Mike Carey, our HIPPA Compliance Officer, in person or by phone at 406-862-8250.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____

Signature: ____ **Date:** _________________