PACIFIC SPRINGS
Physical Therapy, PC

# *Patient Information Form*

| PERSONAL INFORMATION | |
|---|---|
| TODAY'S DATE | SEX ☐ M ☐ F |
| NAME | DATE OF BIRTH |
| SOCIAL SECURITY NUMBER | AGE |
| ADDRESS | MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER: |
| CITY STATE ZIP | REFERRING DOCTOR |
| HOME PHONE NUMBER ( ) | PRIMARY DOCTOR |
| WORK PHONE NUMBER ( ) | DATE OF INJURY OR ONSET OF SYMPTOMS |
| CELL PHONE NUMBER ( ) | AREA BEING TREATED/DX |
| OCCUPATION | EMPLOYER |

| INSURANCE INFORMATION | |
|---|---|
| IS THIS VISIT A RESULT OF AN ACCIDENT? ☐ YES ☐ NO | |
| **IF YES,** SPECIFY WHAT KIND OF ACCIDENT | |
| DATE | ATTORNEY NAME |
| IS THIS VISIT A RESULT OF A WORK INJURY? ☐ YES ☐ NO | |
| **IF YES,** DATE TIME | PLACE |
| EMPLOYER | |
| MEDICARE? ☐ YES ☐ NO | MEDICAID? ☐ YES ☐ NO |
| **PRIMARY INSURANCE INFORMATION** | |
| NAME OF INSURANCE COMPANY | |
| **SECONDARY INSURANCE INFORMATION** | |
| NAME OF INSURANCE COMPANY | |
| **WORKER'S COMPENSATION/MVA** | |
| NAME OF INSURANCE COMPANY | |
| CONTACT PERSON & PHONE NUMBER | ( ) |
| PROVIDER | |

| EMERGENCY INFORMATION | |
|---|---|
| **IN CASE OF EMERGENCY, PLEASE CONTACT:** | |
| NAME | RELATIONSHIP |
| ADDRESS | HOME PHONE NUMBER ( ) |
| CITY | WORK PHONE NUMBER ( ) |
| STATE | ZIP CODE |

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# *Patient Medical History*

Name____________________________________________ Date______________________

Please explain the nature of the problem you are seeing us for today.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Was this problem a result of injury? ☐ Yes ☐ No
If yes, what was your functional status prior to your injury?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Have you had or do you have any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | ☐ Yes | ☐ No | Dizziness | ☐ Yes | ☐ No |
| Hernia | ☐ Yes | ☐ No | Cancer | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No | Metal Implants | ☐ Yes | ☐ No |
| Seizures | ☐ Yes | ☐ No | Chronic Headaches | ☐ Yes | ☐ No |
| Heart Disease | ☐ Yes | ☐ No | Previous Physical Therapy | ☐ Yes | ☐ No |
| Previous Surgery | ☐ Yes | ☐ No | Currently Pregnant | ☐ Yes | ☐ No |
| Pacemaker | ☐ Yes | ☐ No | | | |

If you answered yes to any of the above questions please explain and give the date of occurrence.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Do you have a latex allergy? ☐ Yes ☐ No

What medications are you currently taking? ________________________________________

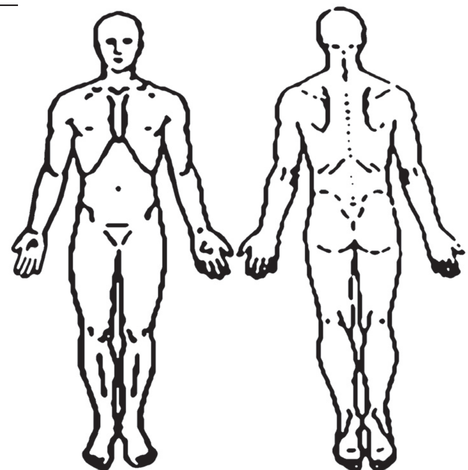
Have you had any injections? ☐ Yes ☐ No
If yes, where?________________________________________

Have you had any X-Rays, MRI, etc.? ☐ Yes ☐ No
If yes, for what area?__________________________________

Please circle on the scale below your level of pain today.
**0** = No pain **10** = Pain that would make you go to the emergency room

**1 2 3 4 5 6 7 8 9 10**

Please indicate on the drawing the location(s) of your pain:



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# *Patient Functional Questionnaire*

***Please choose the answer in each section that best describes your condition.***

*Today's Date:* ________________________

**WALKING**
- ☐ Symptoms do not prevent me walking any distance.
- ☐ Symptoms prevent me walking more than 1 mile.
- ☐ Symptoms prevent me walking more than 1⁄2 mile.
- ☐ Symptoms prevent me walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet.

**WORK**
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do nay work at all (only light duty).
- ☐ I cannot do any work at all.

**SLEEPING**
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleeplessness).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleeplessness).
- ☐ My sleep is severely disturbed (5-7 hrs. sleeplessness).

**RECREATION/SPORTS**
- ☐ I am able to engage in all my recreational/sports activities without increased symptoms.
- ☐ I am able to engage in all my recreational/sports activities with some increased symptoms.
- ☐ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
- ☐ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
- ☐ I can hardly do any recreational/sports activities because of increased symptoms.
- ☐ I cannot do any recreational/sports activities at all.

**REACHING**
- ☐ I can reach to a high shelf to place an empty cup without increased symptoms.
- ☐ I can reach to a high shelf to place an empty cup with some increased symptoms.
- ☐ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
- ☐ I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
- ☐ I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
- ☐ I cannot reach my hand above waist level without increased symptoms.

**STAIRS**
- ☐ I can walk stairs comfortably without a rail..
- ☐ I can walk stairs comfortably, but with a crutch, cane, or rail.
- ☐ I can walk more than 1 flight of stairs, but with increased symptoms.
- ☐ I can walk less than 1 flight of stairs.
- ☐ I can manage only a single step or curb.
- ☐ I am unable to manage even a step or curb.

**HEADACHES**
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come less than 3 per week.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come 4 or more per week.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all of the time.

**LIFTING**
- ☐ I can lift heavy weights without extra symptoms.
- ☐ I can lift heavy weights but it gives extra symptoms.
- ☐ My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned. (e.g. on a table)
- ☐ My symptoms prevent me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

**SITTING**
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ My symptoms prevent me from sitting more than 1 hour.
- ☐ My symptoms prevent me from sitting more than 1⁄2 hour.
- ☐ My symptoms prevent me from sitting more than 10 minutes.
- ☐ My symptoms prevent me from sitting at all.

**STANDING**
- ☐ I can stand as long as I want without increased symptoms.
- ☐ I can stand as long as I want, but it gives me extra symptoms.
- ☐ Symptoms prevent me from standing for more than 1 hour.
- ☐ Symptoms prevent me form standing for more than 30 minutes.
- ☐ Symptoms prevent me from standing for more than 10 minutes.
- ☐ Symptoms prevent me from standing at all.

*Thank you for providing this valuable information.*

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# *Consent for Treatment*

I voluntarily consent to care which may include routine treatment by a physical therapist, his/her designees, as necessary in his/her judgment. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as the result of service, procedures, treatments or examinations at Pacific Springs Physical Therapy, PC.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**
I understand that as part of my health care, Pacific Springs Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

**PAYMENT**
I request that payment of authorized Medicare/insurance benefits be made either to me, or on my behalf to Pacific Springs Physical Therapy, PC for any services furnished by this provider employed by the same. I authorize any holder of medical information about me to release to my Medicare/insurance carrier, and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand that as a service, Pacific Springs Physical Therapy will submit all claims to Medicare/my insurance company and that on occasion these institutions will decide not to pay unless I receive services. Therefore, I may be billed for items or services and may have to pay the bill while Medicare/my insurance company denies payment. I agree to be personally and fully responsible for payment. That is, I personally will pay, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision. Payment can be made at any time to our office. You may pay your co-pay at the time of service. If your insurance requires a primary care referral, it is your responsibility to obtain this. If you do not obtain a referral and your insurance company requires this you will be responsible for payment.

**CANCELLATION AND NO SHOW POLICY**
I understand that by signing the consent for treatment, I have received, read and understand Pacific Springs Physical Therapy's cancellation and no show policy.

Signature________________________________________ Date ______________________

*If you are 18 years of age or younger, a parent or guardian must sign this form on your behalf.*

**MEDICARE PATIENTS**
As a Medicare patient I have received and understand my responsibilities in regards to seeing my referring physician and obtaining new orders.

Signature________________________________________ Date ______________________

*Thank you for assisting us with your care.*

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# *Notice of Privacy Policies*

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

## INTRODUCTION

At Pacific Springs Physical Therapy, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

### Understanding Your Health Record/Information

Each time you visit Pacific Springs Physical Therapy, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

### Your Health Information Rights

Although your health record is the physical property of Pacific Springs Physical Therapy the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

## OUR RESPONSIBILITIES

Pacific Springs Physical Therapy is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also ßdiscontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

**For More Information or to Report a Problem**
If have questions and would like additional information, you may contact the practice's Privacy Officer, Kristi Heine, at (402) 933-3036.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

**Examples of Disclosures for Treatment, Payment and Health Operations**
1. *We will use your health information for treatment.*

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

2. *We will use your health information for payment.*

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

3. *We will use your health information for regular health operations.*

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

4. *Business associates:* There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

5. *Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

6. *Communication with family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

7. *Marketing:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

8. *Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

9. *Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

*Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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# *Cancellation and No Show Policy*

Consistent attendance of all therapy sessions is very important and cancellations/no shows are highly discouraged. Please arrive for your appointment on time. If you are more than **15 minutes late** for your appointment, you may be asked to wait until your therapist is available, or more likely, to reschedule your appointment and have a cancellation recorded for that day.

All cancellations and 'no show' appointments will be recorded in your chart.

One 'no show' appointment and you will be removed from any future scheduled appointments (unless justifiable circumstances have been communicated). You will need to call the morning of the day you wish to come in for physical therapy and see what is available.

In the event that you must cancel an appointment, you will need to call at **least 2 hours in advance.** This notice is necessary in order to allow the availability of the time slot for other patients needing an appointment.

The accumulation of **three cancellation/no show appointments** will result in discharge from the therapy program. You will be required to obtain a new order from the referring physician before any further appointments can be scheduled.

We appreciate your cooperation in helping us help you and others.

I understand that my physician will be notified when I have missed the specified number of treatment sessions.