DizzyFree PT

Lauren Dillon MSPT, GCS, CCVT, AIB-CON
P: 267-332-5131 F: 267-585-6066

www.DizzyFreePT.com
Lauren@DizzyFreePT.com

Patient Information

Name:	**Date of Birth**::
Home Address (Street, City, State, Zip):	**Email Address**:
Daytime phone:	**MOBILE phone**:
Emergency contact **Name**: **Relationship**:	**Emergency contact** **Phone Number**:
Physician Information **Name**: **Address**:	**Physician Information** **Phone number**: **Fax Number**:
I have Medicare Insurance: ☐ Yes ☐ No ☐ Advantage plan If Yes': **"I understand these are Wellness visits and DizzyFree PT is not treating a specific injury."** ☐ Yes ☐ No	**Date of Injury**:

Payment is collected at time of service. DizzyFree PT accepts **cash or checks**.
DizzyFree PT can also accept cards but **will have to charge** 2.75% per transaction as an added fee.
For cards, we use **Ivy Pay** which works with credit, debit, HSA and FSA cards. It's HIPAA-secure, keeps our therapy confidential and makes payment easy for all parties. All I need is your **mobile** number and you will receive a text with a secure link to add card information.

SIGNATURE_____TODAYS DATE____/_____/_____

HOW DID YOU FIND OUT ABOUT DizzyFree PT?_____

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The following information is very important to us in taking care of your health. Please take the time to completely and accurately fill out all of this information. Please also make sure you update this information as charges occur.

Name:
Age:
Are you under the care of Physician, therapist or physiatrist? ☐ Yes ☐ NO
Please list dates of hospitalizations or surgeries
Height/ weight:
Medications (include dose)

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please circle if you have ever had or presently have any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease/ heart attack
5. Chest discomfort
6. Heart murmur/ valve disease
7. Shortness of breath
8. Swollen ankles
9. Palpitations
10. Lightheadedness / Dizziness
11. Arthritis
12. Asthma
13. Persistent swollen glands
14. Hearing problems
15. Bone fractures
16. Mental Health Issues
17. History of fall. How many episodes did you have in past 12 month____?
18. Bronchitis
19. Pneumonia
20. Persistent cough
21. Tuberculosis
22. Hay fever
23. Sinusitis
24. Abdominal discomfort
25. Indigestion/heartburn
26. Nausea
27. Vomiting
28. Diarrhea
29. Blood in stool
30. Vision problems
31. Other:

Signature_____ Todays Date_____

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Patient Authorization and Guarantee Form

Release of Information

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendations as well as any other data pertinent to my treatment, by **DIzzyFree PT** to the physician who referred me for therapy. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of **DizzyFree PT.**

Guarantee of Account

In consideration of services rendered to me by **DizzyFree PT**, I hereby guarantee payment for any and all services rendered to me whether or not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation at time of services.
I acknowledge that I do not have Medicare insurance. If I do have Medicare then I understand that DizzyFree PT is seeing me as a Wellness client, and these services cannot be submitted for reimbursement as they do not treat a specific illness or problem.

Cancellation /No show policy

I authorize DizzyFree PT to issue a $25 Cancellation Fee charge if cancellation occurs less than 24 hours from scheduled visit. I authorize DizzyFree PT to issue a $50 No Show fee if client is not home at time of scheduled appointment.

Communication consent

By signing below, I consent to the use of email and / or text communication between myself and Dizzy Free PT, specifically Lauren Dillon. I recognize that there are risks to its use, and despite Lauren's best efforts, she cannot absolutely guarantee confidentiality.

I, _____, by signing this document, acknowledge my consent to the above.

Signature: _____. Todays Date: _____

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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. Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information. We must safeguard your Protected Health Information and give you this Notice about our privacy practices that explains how, when and why we may use or disclose your Protected Health Information. Except in the situations set out in the Notice, we must use or disclose only the minimum necessary Protected Health Information to carry out the use or disclosure. We must follow the practices described in this Notice, but we can change our privacy practices and the terms of this Notice at any time. If we revise the Notice, you will be informed. You also may ask for a copy of the Notice by calling us at 267-332-5131 and asking us to mail you a copy or by asking for a copy at your next appointment. **Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent** We may use and disclose your Protected Health Information as follows without your permission: **For treatment purposes.** We may disclose your health information to doctors, nurses and others who provide your health care. For example, your information may be shared with people performing lab work or x-rays. **To obtain payment.** We may disclose your health information in order to collect payment for your health care. **For health care operations.** We may use or disclose your health information in order to perform business functions like employee evaluations and improving the service we provide. We may disclose your information to students training with us. We may use your information to contact you to remind you of your appointment. **When required by law.** We may be required to disclose your Protected Health Information to law enforcement officers, courts or government agencies. For example, we may have to report abuse, neglect or certain physical injuries. **For public health activities.** We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety. **For health oversight activities.** We may be required to disclose your health information to government agencies so that they can monitor or license health care providers such as doctors and nurses. **For activities related to death.** We may be required to disclose your health information to coroners, medical examiners and funeral directors so that they can carry out duties related to your death, such as determining the cause of death or preparing your body for burial. We also may disclose your information to those involved with locating, storing or transplanting donor organs or tissue. **For studies.** In order to serve our patient community, we may use or disclose your health information for research studies, but only after that use is approved by UWM's Institutional Review Board or a special privacy board. In most cases, your information will be used for studies only with your permission. **To avert a threat to health or safety.** In order to avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat. **For specific government functions.** In certain situations, we may disclose health information of military officers and veterans, to

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correctional facilities, to government benefit programs, and for national security reasons. **For workers' compensation purposes.** We may disclose your health information to government authorities under workers' compensation laws. **For fundraising purposes**. We may use certain information (such as demographic information, dates of services, department of service, treating physicians, and outcomes) to send fundraising communications to you. However, you may opt out of receiving any such communications by contacting our Privacy Officer (listed below) and your decision to opt-out will have no impact on your treatment. **Uses and Disclosures of Your Protected Health Information That Offer You an Opportunity to Object** In the following situations, we may disclose some of your Protected Health Information if we first inform you about the disclosure and you do not object: **In patient directories. To your family, friends or others involved in your care.** We may share with these people information related to their involvement in your care or information to notify them as to your location or general condition. We may release your health information to organizations handling disaster relief efforts. **Uses and Disclosures of Your Protected Health Information That Require Your Consent** The following uses and disclosures of your Protected Health Information will be made only with your written permission, which you may withdraw at any time: **For research purposes.** In order to serve our patient community, we may want to use your health information in research studies. For example, researchers may want to see whether your treatment cured your illness. In such an instance, we will ask you to complete a form allowing us to use or disclose your information for research purposes. Completion of this form is completely voluntary and will have no effect on your treatment. **For marketing purposes.** Without your permission, we will not send you mail or call you on the telephone in order to urge you to use a particular product or service, unless such a mailing or call is part of your treatment. Additionally, without your permission we will not sell or otherwise disclose your Protected Health Information to any person or company seeking to market its products or services to you. **For any other purposes not described in this Notice.** Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice. Your Rights Regarding Your Protected Health Information You have the following rights related to your Protected Health Information: **To inspect and request a copy of your Protected Health Information.** You may look at and obtain a copy of your Protected Health Information in most cases. **To request that we correct your Protected Health Information.** If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by us, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request and denial and your written response added to your file. If we approve your request, we will change the file, report that change to you, and tell others that need to know about the change in your file. **To request a restriction on the use or disclosure of your Protected Health Information.** You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send Protected Health Information to a health plan for purposes of payment or health care operations if you have paid in full for the related product or

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service. If we agree to all or part of your request, we will put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law. **To request confidential communication methods.** You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so. **To find out what disclosures have been made.** You may get a list describing when, to whom, why, and what of your Protected Health Information has been disclosed during the past six years. We must respond to your request within sixty days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures made to you or for purposes of treatment, payment, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities. **To receive notice if your records have been breached.** You will be notified if there has been an acquisition, access, use or disclosure of your Protected Health Information in a manner not allowed under the law and which we are required by law to report to you., We will review any suspected breach to determine the appropriate response under the circumstances. **To obtain a paper copy of this Notice.** Upon your request, we will give you a paper copy of this Notice. If you have any questions about these rights, please contact us.

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. This signature is an acknowledgement that you have received this notice of our Privacy Practices.

Please only return this last page.

Print name:_____

Todays Date:_____

Signature:_____

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COVID-19 Patient Screening Questionnaire

Name (Last, First)
Date:

PLEASE ANSWER TO THE BEST OF YOUR ABILITY	YES	NO
Have you received a COVID-19 vaccine?		
Do you have an unexplained fever, or have you felt feverish recently?		
Do you have a unexplained cough?		
Are you having unexplained shortness of breath or any difficulty breathing?		
Do you have unexplained chills or repeated shaking with chills?		
Do you have any unexplained muscle pain or body aches?		
Do you have any recent onset of unexplained headache or sore throat?		
Have you been experiencing unexplained nausea and/or vomiting?		
Do you have any recent unexplained loss of taste or smell?		
Have you been experiencing unexplained fatigue recently?		
Have you experienced any recent unexplained GI upset or diarrhea?		
Have you been advised to self-quarantine because of exposure to someone with COVID-19?		
Have you traveled in the past 14 days to any regions affected by COVID-19?		
Have you recently been tested for COVID-19? (within last month)		
If you answered yes to previous question, what was the result?		
Have you been diagnosed with COVID-19?		
If you answered yes to previous question, when?		
Could you have answered yes to any of these questions regarding other members of your household?		
If you answered yes to previous question, please explain		

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Name: _____ **Date:** _____

How Does Dizziness Affect You?

Please mark the box **Yes**, **No**, or **Sometimes** to each question as it relates to your dizziness.

		Yes	Sometimes	No
P **1**	Does looking up increase your problem?	○	○	○
E **2**	Because of your problem, do you feel frustrated?	○	○	○
F **3**	Because of your problem, do you restrict your travel for business or recreation?	○	○	○
P **4**	Does walking down the aisle of a supermarket increase your problems?	○	○	○
F **5**	Because of your problem, do you have difficulty getting into or out of bed?	○	○	○
F **6**	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	○	○	○
F **7**	Because of your problem, do you have difficulty reading?	○	○	○
P **8**	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	○	○	○
E **9**	Because of your problem, are you afraid to leave your home without having someone accompany you?	○	○	○
E **10**	Because of your problem have you been embarrassed in front of others?	○	○	○
P **11**	Do quick movements of your head increase your problem?	○	○	○
F **12**	Because of your problem, do you avoid heights?	○	○	○
P **13**	Does turning over in bed increase your problem?	○	○	○
F **14**	Because of your problem, is it difficult for you to do strenuous homework or yard work?	○	○	○
E **15**	Because of your problem, are you afraid people may think you are intoxicated?	○	○	○
F **16**	Because of your problem, is it difficult for you to go for a walk by yourself?	○	○	○
P **17**	Does walking down a sidewalk increase your problem?	○	○	○
E **18**	Because of your problem, is it difficult for you to concentrate	○	○	○
F **19**	Because of your problem, is it difficult for you to walk around your house in the dark?	○	○	○
E **20**	Because of your problem, are you afraid to stay home alone?	○	○	○
E **21**	Because of your problem, do you feel handicapped?	○	○	○
E **22**	Has the problem placed stress on your relationships with members of your family or friends?	○	○	○
E **23**	Because of your problem, are you depressed?	○	○	○
F **24**	Does your problem interfere with your job or household responsibilities?	○	○	○
P **25**	Does bending over increase your problem?	○	○	○

Clinician Instructions: Add up the number of selections in each column and write this on the underline provided for each section. Calculate the product and write the answer below. For example, if there were 3 selections in the **Yes** column, it would be **3** x 4 = **12**. Add up all three column totals to calculate the total DHI Score.

Yes	Sometimes	No	DHI Score
____ x 4	____ x 2	____ x 0	
☐	☐	☐	

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Is there anything you'd like me to know about you?