PREMIER
P
PHYSICAL THERAPY, PLLC

Patient Information:

Date: ______________________________ ☐ PT ☐ OT ☐ ST

___________________________________ ____________________________ ___________ _____________
Last Name First Name ☐ M ☐ F Middle Maiden Name

____ _____________________ _____ _____________
Home Address City State Zip Code

______/______/_______ ______-____-________ ____________________ ____________________
DOB SS# Home/Cell Phone E-Mail Address

Employer STATUS: ☐ FT ☐ PT ☐ Retired ☐ Minor ☐ Self Employed ☐ Unemployed

Employer Name: ____

Address: ____

Employer Phone #____________________________ Occupation____

Next of Kin

Name__________________________________ Phone #____________________________ Relation_______

Address____

Person to Notify

Name__________________________________ Phone #____________________________ Relation_______

Address____

Healthcare Provider

Primary Care Physician_____________________________ Office #__________________ FAX #________________

Referring Physician________________________________ Office #__________________ FAX #________________

Insurance
Primary Insurance Provider: _____________________________________ Phone#______________________

Member ID#____________________________ Group #____________________________

Secondary Insurance Provider: ____________________________________ Phone #______________________

Member ID#____________________________ Group #____________________________

PREMIER

PHYSICAL THERAPY, PLLC

Patient Clinical History /Summary Form

Symptoms began on: (date)___________________

Briefly describe your symptoms:

____

How did your Symptoms Start?

____

Average Pain Intensity:

Last 24 hrs.: No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩worst pain

Past week: No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩worst pain

What makes it worse: ____

What makes it better: ____

How often do you experience your symptoms?

①Constantly (76-100%of the time) ②Frequently (51-75%) ③ Occasionally (26-50% of the time
④Intermittently (0-25%)

How much have your symptoms interfered with your usual daily activities?

①Not at all② A little bit ③Moderately ④Quite a bit ⑤Extremely

In General, would you say your overall health right now is….

①Excellent ②Very Good ③Good ④Fair ⑤Poor

Please list any other prior injuries/surgeries. Include dates if possible.

____

Have you had any treatment for this problem?

____

Circle all tests performed for your **PRESENT** problem (include dates if possible)

CT scan __________ MRI__________X-ray _________Bone Scan

__________EMG/NCV___________

List current medications (prescribed /over the counter)

____

____

**List any
Allergies**____

Have you **EVER** been diagnosed as having, or do you have any of the following conditions? **CHECK** all of those
that apply:

- ❑ AIDS ❑ DIZZINESS ❑ JOINT REPLACEMENT ❑ PROSTATE PROBLEMS
- ❑ ANEMIA ❑ EATING DISORDER ❑ KIDNEY DISEASE ❑ RHEUMATOID ARTHRITIS
- ❑ ANXIETY ❑ EPILEPSY ❑ LUPUS ❑ SEIZURE DISORDER
- ❑ ARTHRITIS ❑ HEADACHES ❑ METAL IMPLANTS ❑ THYROID PROBLEM
- ❑ ASTHMA ❑ HEARING PROBLEMS ❑ MULTIPLE SCLEROSIS ❑ TUBERCULOSIS
- ❑ CANCER ❑ HEART ABNORMALITY ❑ NERVOUS DISORDER ❑ URINARY INCONTINENCE
- ❑ CIRCULATORY PROBLEMS ❑ HEART ATTACK ❑ OESTEOPOROSIS/OSTEOPENIA ❑ VERTIGO
- ❑ COPD ❑ HEART DISEASE ❑ PACEMAKER ❑ VISION PROBLEMS
- ❑ CVA/Stroke ❑ HEPATITIS ❑ PARKINSON'S ❑ WEIGHT GAIN/LOSS > 10LBS
- ❑ DEPRESSION ❑ HIGH/LOW BLOOD PRESSURE ❑ PREGNANT ❑
- ❑ DIABETES ❑ HIV + ❑ POST-POLIO
- ❑ **Other** ___________________________________

What are your expectations of therapy?

____

Patient informed Consent Obtained: Discussed with patient/family diagnosis, goals, plan of care, possible risks, anticipated outcomes(s), and other alternatives to therapy.

____

Patient or Guardian Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practice and Patient information

As required by the Privacy Regulations, I hereby acknowledge that I have been presented a copy of this practice's "HIPPA Notice of Privacy Practices" and Patient Information and Responsibilities.

As required by the Privacy Regulator, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

Requests: (leave blank if no objections or notations)

- ❑ I wish to File a "Request for Restriction" of my Protected Health Information.
- ❑ I wish to File a "Request for Alternative Communications" of my Protected Health Information
- ❑ I wish to object to the following in the "Notice of Privacy Practices"

____ _________________________________

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Name (print)____

Patient's Signature____________________________________Date_______________________

Therapist's Signature__________________________________Date_______________________

Patient Information and HIPAA Notice of Privacy Practices

Thank you for preferring Premier Physical Therapy for your rehabilitation treatment.
We appreciate your confidence in our services.

Our mission is to provide high quality and comprehensive professional care to educate and empower the patients towards achieving overall physical health, fitness and quality of life.

Non-Discriminatory:
At Premier Physical Therapy we treat our patient regardless of religious belief, legal status, political opinion, age, race, color, cultural background, national origin, gender, sex orientation, physical or mental disability or handicap.

Insurance:

It is your responsibility to ensure we have the latest Health Insurance information on file. If a new card is issued during your treatment, you must bring in to the office asap. You should be aware of terms and conditions of your policy. ie limits, deductible changes etc. Copay and Coinsurance are due at the time of your visit. Any overpayments will be refunded in less than 30 days from final Explanation of Benefits.

Any services not covered by insurance will be due to Premier Physical Therapy 30 days from Statement date. Including lapse of coverage or policy changes.

CareCredit Payment plans are available.

Cancellation within 24 Hours of appointment time or No Show will incur a 25.00 fee.

Please see the office copy of The HIPAA Notice of Privacy Practices.
A personal copy can be made for you upon request.

HIPAA Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Effective date of this Notice: October 2, 2013

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.

If you have any questions about this Notice, please contact CEO/privacy officer: Eva Bertrand

What is "Protected Health Information" or "PHI"?
"Protected Health Information" (PHI) is information that identifies who you are and relates to your past, present, or future personal health condition; the provision of past, present, or future health care to you, or the past, present, or future payments
For the provision of health care to you. PHI does not include information about you that is publicly available, or that is in a summary form that does not identify who you are. If you are an employee of our office, PHI does not include your health information in your personnel file

Purpose of this Notice
At Premier Physical Therapy, we gather and maintain PHI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information private and locked. This Notice describes our privacy practice and how we protect the confidentiality of your PHI. We are required to maintain the privacy of your PHI by implementing reasonable and appropriate safeguard. We are also compelled to explain to you this Notice about our legal obligations to maintain the privacy of your PHI. We must follow our Notice that is currently in effect.

How we protect your PHI
We limit admission to your PHI only to those employees who need access in order to provide services to our patients. We have established and maintain appropriate physical, electronic and procedural safeguard to defend your PHI against unauthorized use or disclosure.

Types of Use and Disclosure of PHI
We May Make Without Your Authorization for Treatment. Payment, Health Care Operations
We will use your protected information for the purposes of treatment, payment and health care operations.

Treatment: includes the disclosure of health information to the providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment: Includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations: Includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Appointment Reminders, Treatment Plans, and Health Related Benefits and Services

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Special Situations

We are also allowed by law to use and disclose your PHI without your authorization in the following situations. We may share some of your PHI with a family member or friend involved in your care if you do not object. We may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example, by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

YOUR PRIVACY RIGHTS

Right to Access your PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Right to amend your PHI

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Right to Receive an Accounting of Disclosures or Your PHI

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include the disclosures made for treatment plans, payment purposes, or other health care operations, or for which we have obtained authorization.

Right to receive a copy of this Notice

You have the right to receive a paper copy of this Notice upon request

Right to Request Restrictions

You have the right to request restrictions on how do we use and disclose your PHI. However, we are not required to agree with your request. If we do agree, we must abide by your request.

Right to confidential communication

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Right to Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

<u>OUR DUTY TO PROTECT YOUR PRIVACY</u>

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

If you would like more information about our privacy practices or to file a complaint, you may contact:

Eva Bertrand 817-462-8111