

ORTHOPEDIC
& SPORTS
PHYSICAL THERAPY


11330 Maple Brook Dr | Louisville, KY | 40241
Tel: 502.426.2221 | Fax: 502.426.2210

1868 Plaudit Place, Suite B | Lexington, KY | 40509
Tel: 859.264.0512 | Fax: 859.264.0595

Orthopedic & Sports Physical Therapy would like to take this opportunity to welcome you to our clinic. It is our goal to provide you with the highest level of care possible at convenient appointment times to meet your busy schedule. Our service will be at the core of how we treat patients and their families. We understand the importance of your condition and your need to return to your previous function. We will work toward those goals with a high intensity. We are open Monday through Friday 7:00 AM – 6:00 PM to meet your scheduling needs. Your compliance with the plan of care discussed with your therapist is very important to the recover process. If you have to miss a scheduled appointment please contact our office so that we can re-schedule to meet your therapy needs. We want each person that enters our clinic to feel at home. If you have any questions or concerns, please feel free to discuss these items with either Bradley or Jim. Again, thank you for allowing Orthopedic & Sports Physical Therapy to provide your PT services and we hope that you are completely satisfied with your care.

Thanks,


Bradley Wheeldon


Jim Rothbauer



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.

1) Used and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment, and health care operations.

Treatment includes the disclosure of health information to other 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 your facility or for business planning activities.

Other Special Uses

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.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: 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.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do not agree, we must abide by your request.

Confidential Communications

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

Access to 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.

Amendments

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.

Accounting of Disclosures

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 those made for treatment, payment, or health care operations or for which we have obtained authorization.

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 without response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

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 of 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.



Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (printed name of patient or personal representative)

acknowledge that I have received a copy of the Notice of Privacy Practices of Orthopedic & Sports Physical

Therapy, PLLC for ____ me or ____ specify patient name _____.

Signature of Patient or Personal Representative Date Relationship to Patient

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request appointment, medical and or billing and account information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient’s consent. If you wish to have any of your information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Orthopedic & Sports Physical Therapy to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize Orthopedic & Sports Physical Therapy to release any of the information stated above to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Name: _____

Patient Signature: _____ Date: _____

INTAKE INFORMATION FORM

Patient Name: _____
Last First M.I.

Address: _____
Street or P.O. Box City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Male: Female: Preferred Language: _____

Ethnicity: Non-Hispanic or Latino Hispanic or Latino Decline to Answer Race: _____

Patient Status: Single Married Widowed Divorced

Spouse's Name: _____ Work/Cell: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Referring Doctor: _____ Date Last Seen: _____

Primary Care Doctor: _____ Date Last Seen: _____

Other Referral: _____

How Did You Hear About Us?

- Newspaper Google Yellow Pages Magazine Social Media
 Our Website Other Website Family/Friend MD Referral Other _____

ADDITIONAL INFORMATION

Patient Employer: _____ Retired: _____

Address: _____ Phone: _____

Are you a student? Yes No Full Time Part Time

Person Financially Responsible: _____ Phone: _____

Address: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy #: _____

Group #: _____

Is Patient the Subscriber? Yes No

Subscriber Name: _____

Subscriber Employer: _____

S.S.#: _____

Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Is Patient the Subscriber? Yes No

Subscriber Name: _____

Subscriber Employer: _____

S.S.#: _____

Date of Birth: _____

Relationship to Patient: _____

INJURY OR ONSET OF PAIN INFORMATION

Date of Onset/Injury: _____

Injury Occurred At: Home Work

If Work Injury/Auto Accident, has incident been reported? Yes No

Insurance Adjuster's Name: _____

Claim #: _____

Attorney Name: _____

Diagnosis: _____

School MVA/Auto

Phone: _____

Phone: _____

Have you had physical & occupational therapy/chiropractic care this year? Yes No

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Subjective History / Report

Past Medical History

Demographics:

Patient Name: _____ Date of Eval: _____
 Date of Birth: _____ Male: Female: Date of Onset: _____
 Diagnosis: _____ Surgical Procedure: _____
 Referring Physician: _____ Date of Surgery: _____

Subjective History:

What was the date of your injury / onset of symptoms? _____
 How did you injure yourself? _____

Have you had any of the following? X-Ray CT Scan MRI EMC/NCV
 ___ Other special Testing including: _____

Last physician appointment? _____ Next physician appointment? _____

Have you had any prior occurrence of this condition or treatment for this condition? Yes No

Please explain: _____

Current Complaints:

What is your chief complaint? _____

What makes your pain better? _____

What makes your pain worse? _____

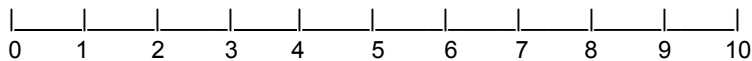
Prior Level of Function:

What were you able to do prior to this injury that you are not able to do presently? _____

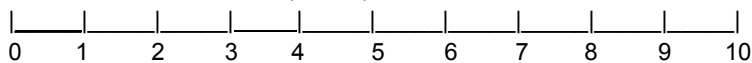
Pain Rating:

If you have pain, what is your pain level? (0 = No Pain, 10 = Extreme Pain)

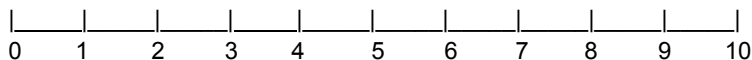
Pain Level at **WORST**: (Circle)



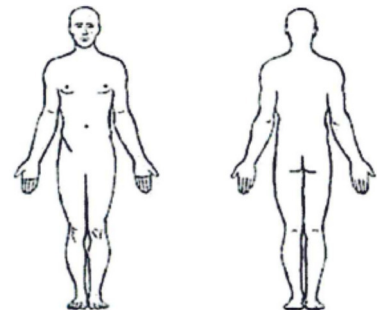
CURRENT Pain Level: (Circle)



Pain Level at **BEST**: (Circle)



Please mark the location of pain with an "X"



Subjective Report/PMHX Form

Patient Name: _____

Date: _____

Information requested regarding current condition:

Occupation / Work Status: What is your occupation? _____

Are you currently working? Yes No

Are you now, or ever have been disabled (service or work)? Yes No When? _____

Social History / Interests / Living Environment:

Do you live: Alone With Spouse With Family Other: _____

Do you have stairs? Yes No How many? _____ Handrails? _____

Do you have any home fall hazards such as throw rugs, poor lighting, etc. Yes No

How are your interests/hobbies affected by your symptoms? _____

Previous Medical History / General Health / Prior Hospitalizations:

How would you classify your general health: Good Fair Poor

Do you have or have you ever had any of the following?

- | | | | |
|------------------------------------------------|----------------------------------------------|-----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Recent Fractures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma / Breath Diff. | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Ringing In Ears |
| <input type="checkbox"/> Bowel/Bladder Diff. | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Seizures / Epilepsy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Skin Abnormalities |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High/Low BP | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Smoking History |
| <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Physical Abnormalities | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Intolerance to Cold | <input type="checkbox"/> Intolerance to Heat | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Fever | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Pregnancy (Currently) |
| | <input type="checkbox"/> Urine Leakage | <input type="checkbox"/> Vision Changes | |

Is there any other information regarding your medical history that we should know about? _____

Medical Precautions / Contraindications:

Are there any factors that may complicate your ability to participate in therapy? Yes No

If yes, please explain: _____

Have you fallen in the past 12 months? Yes No If so, how many times? _____

If yes, please describe the nature of the fall(s): _____

Do you currently or have you in the past used an assistive walking device to walk with? Yes No

If yes, list the device (i.e. case, walker, wheelchair, etc): _____

Medications: Please list all of the medications (with specific dosages) that you are currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals): _____

Patient's Goals for PT: What are your goals for participating in therapy? _____

Patient Signature: _____

To the best of my knowledge, I have fully informed you of the history of my problem and current status.

Therapist Signature: _____

The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
Column Totals:						

Minimum Level of Detectable Change (90% Confidence): 9 points SCORE: ____ / 80

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.