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 Performance Physical

Therapy, PLLC for ____me or ____ specify patient name ________________________________.

____	_______	____________________________
Signature of Patient or Personal Representative	Date	Relationship to Patient

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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 Performance Physical Therapy to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize Performance 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: ☐ S.S.#: ________________

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:______________________________ Diagnosis:______________________________

Injury Occurred At: Home ☐ Work ☐ School ☐ MVA/Auto ☐

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

Insurance Adjuster's Name:______________________________ Phone: ______________________________

Claim #: ______________________________

Attorney Name:______________________________ Phone: ______________________________

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

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Performance PHYSICAL THERAPY

460 East Brannon Rd. | Nicholasville, KY | 40356
Tel: 859.887.0599 | **Fax:** 859.887.0979

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)

|____|____|____|____|____|____|____|____|____|____|
0 1 2 3 4 5 6 7 8 9 10

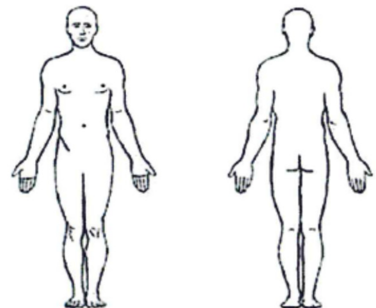
CURRENT Pain Level: (Circle)

|____|____|____|____|____|____|____|____|____|____|
0 1 2 3 4 5 6 7 8 9 10

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

|____|____|____|____|____|____|____|____|____|____|
0 1 2 3 4 5 6 7 8 9 10

Please mark the location of pain with an "X"



If you do have pain, please describe your symptoms to the best of your ability (i.e. numbness, tingling, pins & needles, etc)

____

____

Hand Dominance: ☐ Right ☐ Left

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?

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

<u>Consent To Treat</u>

The patient authorizes the Physical Therapist to examine and treat the condition as he/she deems appropriate through the use of physical therapy measures, and the patient gives authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Physical Therapist. The patient will not hold the Physical Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatments procedures.

The patient shall not be subjected to any procedure without his/her voluntary competent and understanding consent or the consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised of Performance Physical Therapy proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

After reading the above (or having it read to me), I,___________________________________ hereby consent to receive physical therapy at Performance Physical Therapy, commencing on _______________ and terminating when determined by myself, my physician or my Physical Therapist.

I have read (or have had read to me) the above information and understand the content.

_____________________________________ _______________________________

Patient (or Guardian) Signature Date

_____________________________________ _______________________________

Witness Signature Date