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:_____

Performance PHYSICAL THERAPY

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 ☐

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

Subjective History / Report
Past Medical History

Patient Name: _____ Date of Eval: _____

Date of Birth: _____ Male: ☐ Female: ☐ Date of Onset: _____

Diagnosis: _____ Surgical Procedure: _____

Referring Physician: _____ Date of Surgery: _____

Reason: ☐ Trauma ☐ PVD ☐ DM ☐ Infection ☐ Cancer ☐ Other: _____

Subjective History:

What was the date of your injury / onset of symptoms? _____

Have you had any of the following? ☐ X-Ray ☐ CT Scan ☐ MRI ☐ Other: _____

Last physician appointment? _____ Next physician appointment? _____

Current Complaints:

What is your chief complaint? _____

_____

What are your goals for therapy? _____

_____

Do you have pain? ☐ Yes ☐ No Where? _____

On a scale of 0-10 with 0 being no pain and 10 being so bad you must go to the Emergency Room, what would your rating be? _____

Do you have phantom pain or sensation (feeling pain in extremity that's no longer there)? What is the rating?

_____

_____

What makes your pain better? _____

What makes your pain worse? _____

Occupation / Work Status

What is your occupation? _____

Are you currently working? Yes ☐ No ☐

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 ☐

What interests/hobbies would you like to return to? _____

Previous Medical History / General Health / Prior Hospitalizations:

☐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
☐Surgeries	☐Fever	☐Kidney Problems	☐Pregnancy (Currently)
	☐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): _____

_____

_____

Prosthetic Information:

Prosthetist Name: _____ Company/Location: _____
How long have you had Prosthesis? _____
Previous therapy with Prosthesis? _____

Any other relevant physical conditions or injuries: _____

_____

Prior Level of Function:

Living Status/Condition: _____
Level of Activity: _____
Use of Walking Aid/Time Since Able to Walk: _____

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: _____

Performance
PHYSICAL THERAPY

Consent To Treat

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