PROActive
REDEFINING PHYSICAL THERAPY

Name:_____ Date of birth:____/____/____
(last) (first) (M.I.)

SS number:_____ Marital Status: M D S Other Gender: M F

Address:_____ City:_____ State:_____ Zip:_____

Phone: (home) _____ (cell)_____ E-Mail address:_____

Spouse's full name:_____

Emergency contact:_____ Emergency contact number:_____

Referring MD:_____ Referring MD phone #:_____

Employer:_____ Phone (work):_____

Did a family member or friend recommend us to you? Y N If yes, who was the treating PT? _____

If no, how did you choose us for your physical therapy? Radio Print Ad MD Location Website

Yellow pages Insurance Other:_____

Is your injury/condition a result of a motor vehicle accident? Yes No

Is your injury/condition a result of a work related incident? Yes No

Medicare Only

Have you had any physical/speech therapy so far this year? Yes No

Do you have a home health care agency coming to your house? Yes No

If YES, who is the agency and what is the phone number: _____

Do you have secondary insurance? Yes No

Workers' Compensation/No Fault Only

Have you had any physical/speech therapy so far this year? Yes No

Ins Co:_____ Address:_____ City:_____ State/Zip_____

WCB#: _____ Claim #: _____ Phone #:_____

Date of Injury/accident:_____ Employer:_____ Employer contact:_____

Employer ph #:_____ Attorney:_____ Attorney ph #:_____

I, _____ hereby authorize and instruct my insurance carrier to pay Primary Physical Therapy, PLLC D/B/A PRO*Active* Physical Therapy, directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. I understand that if I default on my account it may be sent to collections, which will result in an additional fee of 23% of account balance. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

_____ _____
Insured or Authorized Person's Signature Date

Name: _____ Date: _____

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Newest Research, Fewest Visits, Best Results

Past Medical History: Place an "x" in front of any of the medical conditions that apply to you

__Hemophilia/Anemia __Ulcer/GI disorder __Tuberculosis __Double vision
__Kidney/Liver problems __Skin disease __ Lung Disorder __Diabetes
__High blood pressure __Nerve Disorder __Alzheimer's __Metal implants
__Osteoporosis __Parkinson's __Multiple Sclerosis __Stroke
__Circulatory problems (i.e. PVD, clots, etc) __Back Disorder __Allergies to Medications
__Currently any sleeping difficulties __Pacemaker/Heart Conditions
__Past pregnancy: Yes or No? Vaginal or Cesarian delivery (circle one)? If Currently Pregnant, # months ___

Circle your answer:

Do you currently take Blood thinners?: Yes or No Allergic to Latex?: Yes or No

Arthritis: Yes or No? What kind? _____ History of Cancer, Yes or No? What kind? _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes or No
During the past month, have you often been bothered by little interest or pleasure in doing things? Yes or No
If you answered yes to either of these questions, would you like help? Yes__, No__, or Yes, but not today __

Current Symptoms

Where are you currently having symptoms? _____
_____
What date (approximately) did your present pain start? _____
How (gradually, sudden onset, injury date)? _____
My symptoms are currently: **Getting better / About the same / Getting worse**
Have you received any treatments for this problem? Yes or No. If so, what did you have done and did it help?
_____
Any other medical conditions/disorders (whether related or not): _____
What is your personal goal for therapy? _____
Do you have any barriers to learning, if so list? _____

Have you RECENTLY noted any of the following (place an x in front of all that apply)

__Fever/chills/sweats __Poor balance (Falls) __Unexplained weight loss __Numbness or Tingling
__Changes in appetite __Difficulty swallowing __Depression __Shortness of breath
__Dizziness __Headaches __Nausea /Vomiting __Increased pain at night
__Fatigue __Menstrual/Bowel irregularities

Changes in bowel or bladder function: Loss of control, pain with either, or any other issues? Yes or No

List any medications you are currently using and **for what purpose** (or provide the front office with a list of medications to photo copy), as well as any taken in the past week: _____
List any major surgeries and date: _____
List any brace/orthotic/ergonomic device you currently utilize: _____
List and date any tests relating to your present symptoms **(X-ray, MRI, CT scan, EMG test, bone scan, etc):**
_____

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatments that are offered._____(Sign)

On the scales below, please circle the numbers that best represent the severity of your pain.

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

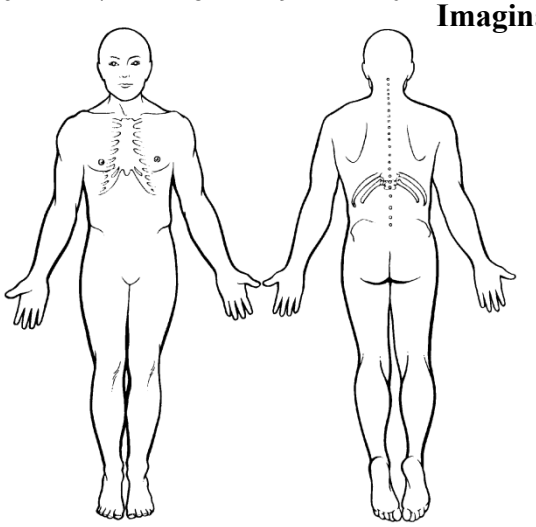
Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Body Chart:
Please mark the areas where you feel pain on the chart to the right



For the therapist

+ / - Saddle Anesth.
+ / - Bwl/Blddr Changes
+ / - Numb/Ting.
+ / - Any Other Red Flag Indicators

What makes your symptoms better?_____

_____

Please circle the activities which make your pain better:

lying down standing walking sitting bending

What makes your symptoms worse?_____

_____

Please circle the activities which make your pain worse:

lying down standing walking sitting bending

Please indicate the best and worst times of day for your symptoms by circling all that apply

Best – morning, nighttime, improves as the day goes on

Worst – morning, nighttime, worsens as the day goes on

Functional Limitations: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem.

1)_____

2)_____

3)_____

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Primary Physical Therapy, PLLC, DBA, PRO-Active Physical Therapy or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Practices Notice of Privacy

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

PRO-Active Physical Therapy may or may not agree to restrict the use or disclosure of your protected health information.

If PR0-Active Physical Therapy agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

PRO-Active Physical Therapy reserves the right to modify the privacy practices outlined in the notice. You can request a current privacy policy by calling 315-451-6541.

Signature

I have reviewed this consent form and give my permission to PRO-Active Physical Therapy to use and disclosure my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____Date

_____
Signature of Patient Representative/ Relationship to patient

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REDEFINING PHYSICAL THERAPY

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties above to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____
Patient Name

_____
Patient Signature

_____
Date

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REDEFINING PHYSICAL THERAPY

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of PRO-Active Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Fund raising. We will not use your name and address to support our fund-raising efforts. If you do want to participate in fund-raising please inform the Office Coordinator.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

PRO-Active Physical Therapy Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Coordinator at the clinic where you are a patient. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints /Contact Person

If you would like additional information or you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Barbara Christiana/ Privacy Officer
PRO-Active Physical Therapy
5496 E Taft Rd Ste 2.
North Syracuse, NY 13212

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.
You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This Notice is effective on or after April, 2003.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Primary Physical Therapy, PLLC,DBA,PRO-Active Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

Signature Of Provider:_____

I have received a copy of the Notice of Privacy Practices for PRO-Active Physical Therapy.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____

Signature of Patient Representative:_____
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information occurs.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Division of Primary Physical Therapy, PLLC

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315-458-2552

358 Madison St., PO Box 396
Waterville, NY 13480
315-841-3222

1259 Fisher Ave
Cortland, NY 13450
607-756-7991