

# Institute of Physical Medicine & Sports Therapy Inc

## Patient Information (Please complete all sections)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M ☐ F ☐  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Person financially responsible for account \_\_\_\_\_ DOB \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Insurance Information

Primary Insurance \_\_\_\_\_ Phone \_\_\_\_\_ ID# \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Relation to patient \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Phone \_\_\_\_\_ ID# \_\_\_\_\_  
Is your injury work/auto accident related? ☐ Y ☐ N Date of injury \_\_\_\_\_ Claim # \_\_\_\_\_  
Adjuster Name \_\_\_\_\_ Adjuster Phone # \_\_\_\_\_

## Payment Policy

I hereby consent to such physical therapy procedures as may be rendered by Institute of Physical Medicine & Sports Therapy Inc. I hereby assign all medical benefits to include major medical insurance benefits to which I am entitled to Institute of Physical Medicine & Sports Therapy Inc. and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A photocopy of this assignment if to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

1. All Copayments are due in full at time of service. Those without insurance must pay in full at time of service.
2. **A minimum of \$60.00 will be charged per visit for patients whose deductibles have not been met.**
3. We will gladly bill your insurance company for you according to the services and procedure(s) performed during your visits, however, **please remember that it is your responsibility to know exactly what your insurance plan covers.** Some insurances have limits, either monetary, or numerical, as to how much they will cover. **It is important to understand your individual plan.**
4. All payments become due and payable upon 30 days after final billing to insurance.
5. We will be happy to work with you regarding payment arrangements on your account. Any account left unpaid after 60 days may be referred for collection or legal proceedings.

Office Use only: Treating Therapist \_\_\_\_\_ Diag. codes \_\_\_\_\_

# Patient Medical History Questionnaire

## Personal History

Check each as it applies to you. Have you ever had:

### Condition:

Cardiac Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Severe Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep Interference	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
T.B.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Condition:

Peripheral Neuropathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arm Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indigestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteopenia/Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For any conditions in which a "yes" was indicated please give dates and pertinent details:

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Previous surgeries/injuries: 

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Have you had physical therapy during this calendar year? 

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Any other medical problems? If so, please describe: 

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Family History: Check each as it applies to a blood relative:

High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Height: 

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 lbs.

Do you consume alcohol? ☐ Yes ☐ No If yes, how much? 

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 drinks per week/month

Do you smoke? ☐ Yes ☐ No If yes, how much? 

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 packs per day/week

# Notice of Privacy Practices Institute of Physical Medicine & Sports Therapy

Patient Signature \_\_\_\_\_

Effective Date of this Notice: January 1, 2015

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.**

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

### File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting ????
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

#### **Our Uses and Disclosures** How do we typically use or share your health information?

We typically use or share your health information in the following ways:

##### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

##### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

##### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

#### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

##### **Help with public health and safety issues**

We can share health information about you for certain situations such as: Preventing disease / Helping with product recalls / Reporting adverse reactions to medications / Reporting suspected abuse, neglect, or domestic violence and preventing or reducing a serious threat to anyone's health or safety

**Do research-** We can use or share your information for health research.

##### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests** -We can share health information about you with organ procurement organizations.

##### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

##### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

##### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

##### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**Changes to the Terms of this Notice** - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Please list **ALL** prescriptions, over the counter herbals and vitamin/mineral/dietary (nutritional) supplements AND each medication **must** contain the name, dosage, frequency, and route of administration.

**Medication list**

Name	Dosage	Frequency	Route of Administration

**Cancellation/No Show Policy**

\_\_\_\_\_ A 24 hour notice is required for all cancellations. There will be a \$60.00 charge  
Initials for all “no show” visits. We understand that emergencies do come up and certain  
circumstances may be excluded from the above requirement.

**I have read and agree to all terms stated on pages 1-5. I certify to the best of my knowledge the included answers are true and correct.**

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## 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
<b>Column Totals:</b>					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: \_\_\_\_ / 80

Please submit the sum of responses to ACN.

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