

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:

Previous surgeries/injuries:

Have you had physical therapy during this calendar year?

Any other medical problems? If so, please describe:

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:

 lbs.

Do you consume alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much? <hr/> drinks per week/month
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much? <hr/> 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/.
- 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 _____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 -- Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 -- Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score ____ x 2) / (____ Sections x 10) = _____ %ADL

Section 6 -- Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 -- Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 -- Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 -- Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments _____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204