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:			**Condition:**		
Cardiac Pacemaker	□ Yes	□ No	Peripheral Neuropathy	□ Yes	□ No
Heart Attack	□ Yes	□ No	Convulsions	□ Yes	□ No
Angina	□ Yes	□ No	Paralysis	□ Yes	□ No
Emphysema	□ Yes	□ No	Leg Cramps	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Headache	□ Yes	□ No
Diabetes	□ Yes	□ No	Depression	□ Yes	□ No
Stroke	□ Yes	□ No	Shortness of Breath	□ Yes	□ No
Severe Illness	□ Yes	□ No	Arm Pain	□ Yes	□ No
Blackouts	□ Yes	□ No	Low Blood Pressure	□ Yes	□ No
Gout	□ Yes	□ No	Indigestion	□ Yes	□ No
Nervousness	□ Yes	□ No	Ulcers	□ Yes	□ No
Joint Problems	□ Yes	□ No	Asthma	□ Yes	□ No
Sleep Interference	□ Yes	□ No	Hernia	□ Yes	□ No
Chest Pain	□ Yes	□ No	Back Pain	□ Yes	□ No
Cancer	□ Yes	□ No	Allergies	□ Yes	□ No
T.B.	□ Yes	□ No	Fever	□ Yes	□ No
Lupus	□ Yes	□ No	Osteopenia/0steoporosis	□ Yes	□ No
Rheumatoid arthritis	□ Yes	□ No	Osteoarthritis	□ Yes	□ No
Fibromyalgia	□ Yes	□ No	Multiple Sclerosis	□ Yes	□ 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	□ Yes	□ No	Diabetes	□ Yes	□ No
Stroke	□ Yes	□ No	Heart Disease	□ Yes	□ No

Height:_____ Weight:_____lbs.

Do you consume alcohol?	□ Yes	□ No	If yes, how much?_____drinks per week/month
Do you smoke?	□ Yes	□ No	If yes, how much?_____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

_____
Initials

A 24 hour notice is required for all cancellations. There will be a $60.00 charge 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 _____

VESTIBULAR
DISORDERS ASSOCIATION

5018 NE 15TH AVE · PORTLAND, OR 97211 · FAX: (503) 229-8064 · (800) 837-8428 · INFO@VESTIBULAR.ONG · VESTIBULAR.ONG

Dizziness & Balance Medical History Questionnaire

Complete this questionnaire and bring it with you when you visit your physician. You may want to reference your previous medical history records and/or ask a friend or family member familiar with your condition to help you.

Patient Name: _____ **DOB:** _____ **Date:** _____

DIZZINESS SYMPTOMS

Check all that apply *(In the space after each symptom you check, rate the severity of that symptom using a scale of 0-10, with 10 being most severe.)*

✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10
	Dizziness			Spinning			Lightheadedness			Rocking/tilting	
	Visual changes			Tumbling			Nausea			Unsteadiness	
	Falling			Ringing in ears			Fullness in ears			Fainting	
	Hearing loss			Double vision			Brain fog			Other:	

HISTORY OF PRESENT ILLNESS

1) Describe your current problem:
   a. When did your problem start (date)? _____
   b. Was the onset of your symptoms: ☐ sudden ☐ gradual ☐ overnight ☐ other (describe): _____
   c. Are your symptoms: ☐ constant ☐ variable (i.e. come and go in attacks)
   d. If variable:
      i. The spells occur every (# of): _____ hours _____ days _____weeks _____ months _____ years.
      ii. The spells last: ☐ < 1 min. ☐ 1-60 min. ☐ 1-3 hrs. ☐ 3-24 hrs. ☐ 1-3 days
   e. Do your symptoms occur when changing positions? ☐ yes ☐ no
      i. If yes, check all that apply:

√	Symptom	√	Symptom
	Rolling your body to the left		Rolling your body to the right
	Moving from a lying to a sitting position		Looking up with your head back
	Turning head side to side while sitting/standing		Bending over with your head down

   f. Is there anything that makes your symptoms worse? ☐ yes ☐ no
      i. If yes, check all that apply:

√	Symptoms	√	Symptoms
	Moving my head		Physical activity or exercise
	Riding or driving in the car		Large crowds or a busy environment
	Loud sounds		Coughing, blowing the nose, or straining
	Standing up		Eating certain foods
	Time of day		Menstrual periods (if applicable)
	Other:		Other:

Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or pleasure?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	☐	☐	☐
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
E10	Because of your problem, have you been embarrassed in front of others?	☐	☐	☐
P11	Do quick movements of your head increase your problem?	☐	☐	☐
F12	Because of your problem, do you avoid heights?	☐	☐	☐
P13	Does turning over in bed increase your problem?	☐	☐	☐
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
E15	Because of your problem, are you afraid people may think that you are intoxicated?	☐	☐	☐
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	☐	☐	☐
P17	Does walking down a sidewalk increase your problem?	☐	☐	☐
E18	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
E20	Because of your problem, are you afraid to stay home alone?	☐	☐	☐
E21	Because of your problem, do you feel handicapped?	☐	☐	☐
E22	Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
E23	Because of your problem, are you depressed?	☐	☐	☐
F24	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25	Does bending over increase your problem?	☐	☐	☐

g. Do you have difficulty walking in the dark or at dusk? ☐ yes ☐ no

h. Do you have difficulty walking on uneven surfaces (e.g. grass or gravel) compared with smooth surfaces (e.g. concrete)? ☐ yes ☐ no

i. Have you ever fallen as a result of your current problem? ☐ yes ☐ no

j. Do you have a history of:

✓	Symptom	✓	Symptom	✓	Symptom	✓	Symptom
	Migraines		Seizures		Tumor		Stroke
	MS		Neuropathy		Panic attacks		Congestive heart failure
	Concussion		Depression				

2) Describe any ear related symptoms:

a. Do you have difficulty with hearing? ☐ yes ☐ no

i. If yes, which ear(s): ☐ left ☐ right ☐ both

ii. When did this start? _____

b. Do you experience noise or ringing in your ears? ☐ yes ☐ no

i. If yes, which ear(s): ☐ left ☐ right ☐ both

c. Do you have pain, fullness, or pressure in your ears? ☐yes ☐ no

d. Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? ☐ yes ☐ no

3) When dizzy or imbalanced, do you experience any of the following:

a. Lightheadedness or a floating sensation? ☐ yes ☐ no

b. Objects or your environment turning around you? ☐ yes ☐ no

c. A sensation that you are turning or spinning while the environment remains stable? ☐ yes ☐ no

d. Nausea or vomiting? ☐ yes ☐ no

e. Tingling of hands, feet or lips? ☐ yes ☐ no

f. When you are walking, do you: ☐ veer left? ☐ veer right? ☐ remain in a straight path?

DIAGNOSTIC TESTING AND TREATMENT:

1) Have you seen other healthcare providers for your current condition? ☐ yes ☐ no

a. If yes, who: ☐ primary care doctor ☐ENT/HNS doctor ☐ neurologist ☐ cardiologist ☐ Emergency room doctor ☐ Other: _____

2) Have you had any of the following done for this condition elsewhere?

✓	Test/Therapy	When	Where	Results
	ENG/VNG			
	CT Scan			
	MRI			
	Posturography			
	Hearing test			
	Physical therapy			Did it help? ☐ yes ☐ no
	Occupational therapy			Did it help? ☐ yes ☐ no
	Canalith Repositioning			Did it help? ☐ yes ☐ no

Is there anything else that you feel is relevant to your condition?

_____

_____