Summit Strength Physical Therapy, LLC

PATIENT PERSONAL INFORMATION

Today's Date________________________

Name____Birthdate____________________

Home Address____
(Street) (City) (State) (Zip)

Home Phone #___________________Y / N_ Cell Phone #_______________________Y / N__
Message OK? Message OK?

Social Security #____ (Male Female)

Email Address____

(Married Single Divorced Widowed Minor)

Employer________________________________Occupation______________________________

Employer Address_________________________________ Phone #________________Y / N
Message OK?

____

EMERGENCY CONTACT (Relationship) (Phone)

INJURY? *No* _____ *-or YES-date* ___________ *Auto* _____ *Work*_____ *Other* _____________

How did you hear about us? Prior Patient ___ Doctor ___ Friend (Name) _________ Other ______

PERSON RESPONSIBLE FOR ACCOUNT **CHECK BOX IF SAME AS ABOVE** ☐

Name__________________________Address____

Relationship to client______________________Birthdate_________________________________

Social Security #_____________________________ Phone #_____________________________

Employer__________________ Address_______________________Phone #________________

Spouse's Name______________________ Birthdate__________ Social Security #_____________

Address____ Phone #__________________

Spouse's
Employer__________________________Phone#_______________________________________

Address____

Summit Strength Physical Therapy, LLC

CONFIDENTIAL HEALTH HISTORY

Patient Name:__________________________**Referring Physician**:______________________**Primary Care Physician**:______________________

Are you aware of your diagnosis?____

Have you had any other orthopedic injuries or surgeries? If yes explain____

Have you had any prior physical or speech therapy visits this year? If yes how many visits?_________________

At the present time, would you Rate your Overall General Health as: Excellent ____ Good ____ Fair ____ Poor_____

Please circle all conditions that you have or have had in the past

MUSCULOSKELTAL
- Osteoarthritis
- Osteopenia
- Osteoporosis
- Rheumatoid Arthritis
- Lupus/SLE
- Fibromyalgia
- Headaches/Migraines
- Bulging Disk
- Leg Cramps/Restless Leg
- Jaw Pain/TMJ
- History of Falling
- Use of Cane/Walker
- Gout
- Other:________________

CIRCULATION/RESPIRATORY
- Heart Disease
- Heart Surgery
- Heart Arrhythmia
- Pacemaker
- Myocardial Infarction
- Angina/Chest Pain
- Mitral Valve Prolapse
- Aneurysm
- High Cholesterol-On Statin Meds
- Anemia
- Blood Clots/Phlebitis
- Asthma/SOB
- COPD
- Low Blood Pressure
- High Blood Pressure – Controlled Y N
- Meds for BP:______________________

ENDOCRINE/DIGESTION
- Diabetes
- Low Blood Sugar
- Kidney Dysfunction
- Irritable Bowel Syndrome
- Crohn's Disease
- Bladder Dysfunction
- Liver Dysfunction
- Thyroid Dysfunction
- Hernia
- Unexplained Weight Loss/Gain
- Other:____

INFECTIOUS DISEASE
- Tuberculosis
- Hepatitis
- Influenza
- Shingles
- STD
- Blood Transfusion
- HIV/AIDS
- Other:_______________

- **Are you currently pregnant?** Yes No
- **Do You Smoke?** Yes No
- **Do You Drink Alcohol?** Yes No
- **Illicit Drug Use?** Yes No

NERVOUS SYSTEM
- Stroke/TIA
- Polio
- Parkinson's Disease
- Multiple Sclerosis
- Epilepsy/Seizures
- Concussion
- Traumatic Brain Injury
- Numbness or Tingling
- Other:_______________

CANCER

Type Of Cancer:
____
____
Date of Diagnosis: ________________
Treatments:
____
____
____

ALLERGIES: PLEASE CIRCLE
LATEX ALLERGY
TAPE ALLERGY
OTHER ALLERGY-PLEASE

Is there anything else we should know about your health?____

TELL US ABOUT YOUR CONDITION

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates)

First episode______________________ Subsequent Episodes_________________________ Most Recent Episode____________________________

How did your symptoms/injury occur?____

Where are your symptoms located?____

What is your main problem related to this condition?____

What makes your symptoms better?_______________________________ Worse?____

Have you had any surgery for your injury/condition?_______ If yes, what kind and when?____

Have you received any injections for your injury/condition?______ If yes, when?____________________________ Did it help?___________________

Diagnostic tests performed (X-RAY, MRI, etc) ____

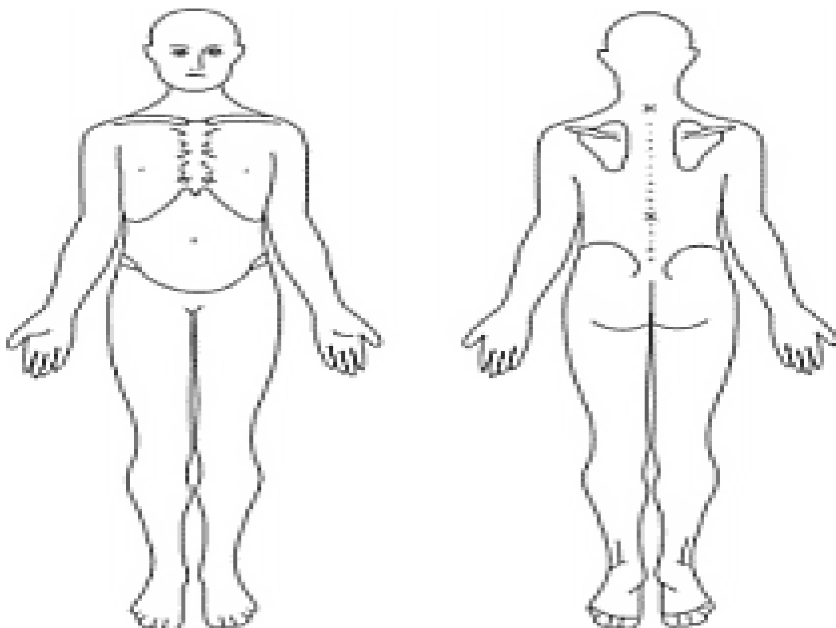
For your current injury or condition, have you seen any of the following? (Please circle all that apply and specify approximate dates of treatment)

Medical Doctor ____________________ Physical Therapist ____________________ Psychiatrist/Psychologist ___________________________

Chiropractor ______________________ Athletic Trainer _______________________ Personal Trainer __________________________________

Are you exercising? _____ Describe:_______________________ Problems with exercise?_________ Describe:______________________________

What do you hope to accomplish with physical therapy?____



On the diagram, please indicate your current symptom location (s) using they key below:

Stabbing	//////
Burning	XXXXXX
Numbness	======
Pins & Needles	000000
Aching	SSSSSS

Pain Rating Descriptions :
0 No Pain
1-3 Achy, Sore Pain/No Restriction Of Function
4 Minor Restriction of Function
5 Moderate Restriction of Function
6 Severe Restriction of Function
7 Complete Restriction of Function
8-9 Hospital, Emergency Room Pain
10 Hot Poker In The Eye Pain

Function Rating Descriptions:
0 Unable to Function or get out of bed
10 Normal Function, The day before the injury occurred

HEIGHT________ WEIGHT__________

BMI (Therapist Will Calculate)________

How often do you experience your current symptoms? Always ☐ Frequently ☐ Occasionally ☐ Seldom ☐

Are your symptoms ? Not Changing ☐ Improving ☐ Getting Worse ☐

Using this scale (0 = no pain, 10 = emergency type pain):
My average level of pain is __________
My highest pain level in the last 30 days has been __________
My lowest pain level in the last 30 days has been __________

Using this scale (0 = no function, 10 = ability to perform normal daily activity):
My average level of function __________
My highest function level in the last 30 days has been __________
My lowest function level in the last 30 days has been __________

FOR THERAPIST USE ONLY

I have reviewed past medical history with the patient/guardian prior to evaluation and treatment. The following was identified:

- ____
- ____
- ____

I have informed the patient on our plan of treatment Y N
I have informed the patient of their outcome potential prior to treatment Y N

Therapist Signature: ______________________________________Date:____________________

I, _________________________________ understand and accept the plan of care.
Patient/Guardian Signature

Patient/Guardian signature: _________________________________Date:____________________

Summit Strength Physical Therapy, LLC

MEDICATION LIST

Patient Name: ____

Food/Drug Allergies: ____

Reaction: ____

Name of Medication:	*Strength:*	*How Often Taken:*	*Comments:*

SUMMIT STRENGTH PHYSICALTHERAPY, LLC

SIGNED AUTHORIZATIONS

Phone # 816-524-7040 Fax# 816-524-7057 800 NW Main Street Ste. 100 Lee's Summit MO 64086

AUTHORIZATION FOR CARE

I/we hereby authorize to receive care at Summit Strength Physical Therapy, LLC. I/we understand that receiving physical therapy or strength and conditioning may involve stress of musculoskeletal tissue that may cause soreness, bruising, and/or swelling (like one might feel for a few days after starting a workout program such as running or lifting weights.) Furthermore, I/we understand that the provider may need to perform mobilization technique, massage technique, manual traction, distraction, ultrasound, electrical stimulation, taping, bracing, orthotic fitting, tourniquet blood flow restriction therapy, weight training and other movement modalities that may produce brief (several days) soreness and discomfort. It is my/our responsibility to communicate any difficulties that I/we are having during treatment to my/our provider. It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions.

PAYMENT POLICY

I/we understand we are responsible to pay all co-pays, coinsurance and fees that are provided by Summit Strength Physical Therapy, LLC. I/we understand that it is our responsibility to understand the percentage of coverage allowed by our insurance program and understand the coinsurance payments required.

ASSIGNMENT & RELEASE

I, the undersigned, assign directly to Summit Strength Physical Therapy, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I herby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I also understand that if I have a co-pay it will be due at the time of service.

____ ________________________

Signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICE/HIPAA (Health Insurance Portability and Accountability Act)

I acknowledge that I have received Summit Strength Physical Therapy, LLC's notice of Privacy Practices (HIPAA)

____ ________________________

Signature Date

MEDICARE AUTHORIZATION (For Medicare Patients Only)

I request that payment of authorized Medicare or Medigap benefits be made either to me on my behalf of Summit Strength Physical Therapy, LLC for any services furnished to me by a physical therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" or "Medigap" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ________________________

Signature Date

AUTHORIZATION FOR USE OF IMAGES

I, the undersigned, hereby consent without further compensation or consideration, to allow images taken of me by Summit Strength Physical Therapy, LLC to be used by Summit Strength Physical Therapy for social media posting and other promotional publications.

____ ________________________

Signature Date

SUMMIT STRENGTH PHYSICALTHERAPY, LLC

Phone # 816-524-7040 Fax# 816-524-7057 800 NW Main Street Ste. 100 Lee's Summit MO 64086

CANCELLATION POLICY

Due to the nature of our business, good communication between our staff at Summit Strength Physical Therapy and the patient is important for efficient scheduling for our clients. Our office greatly appreciates as much advance notice as possible for any reason you may need to cancel. Our staff has significant flexibility and understanding for last minute illness and issues that causes changes in the schedule. We appreciate advance notice so we can promptly call people on a waiting list and allow them to fill the spots that you have canceled. Our policy will be that if on any situation that you do not show for an appointment you will be charged $50.00 on your account for that visit. Cancellations made 48 hours in advance will not be charged. Cancellation of appointments not within 48 hours will be charged <u>$50.00 after 3 cancellations and thereafter</u>. You will also lose any prior scheduling arrangements (Preferred Continuous Time Slots) that are made.

I understand the cancellation policy for Summit Strength Physical Therapy, LLC.

____ ____________________________

Patient Name *Date*

SUMMIT STRENGTH PHYSICAL THERAPY,LLC
NOTICE OF PRIVACY PRACTICES
Effective Date: January 1 , 2005

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

If you have any questions about this notice, please contact Summit Strength Physical Therapy, LLC at 816-524-7040.

WHO WILL FOLLOW THIS NOTICE

This notice describes Summit Strength Physical Therapy, LLC and that of:

- *Any health care professional authorized to enter information into your chart.*
- *All departments of the practice.*
- *Any member of a volunteer group we allow to help you while you are at our practice.*
- *All employees, staff and other practice personnel.*

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your physicians, physical therapist or others working in this office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- *Make sure that medical information that identifies you is kept private.*
- *Give you this notice of our legal duties and privacy practices with respect to medical information about you.*
- *Follow the terms of the notice that is currently in effect.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: *We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other therapists, doctors, nurses, technicians, or medical students who are involved in taking care of you in our practice. For example, your doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, x-rays, or other treatments. We may also disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. We may also take and use treatment photos and video tape.*

For Payment: *We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your care received so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.*

For Health Care Operations: *We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of medical information so others may use it to study health care delivery without learning who our specific patients are.*

Health-Related Services and Treatment Alternatives: *We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.*
As Required By Law: *We will disclose medical information about you when required to do so by federal, state, or local law.*

To Avert a Serious Threat to Health or Safety: *We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.*

SPECIAL SITUATIONS

Military and Veterans: *If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.*

Worker's Compensation: *We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.*

Public Health Risks: *We may disclose medical information about you for public health activities. These activities generally include the following:*

- *To prevent or control disease, injury or disability.*
- *To report births and deaths.*
- *To report child abuse or neglect.*
- *To report reactions to medications or problems with products.*
- *To notify people of recalls of products they may be using.*
- *To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.*

- *To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.*

Health Oversight Activities: *We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.*

Lawsuits and Disputes: *If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.*

Law Enforcement: *We may release medical information if asked to do so by a law enforcement official:*

- *In response to a court order, subpoena, warrant, summons, or similar process.*
- *To identify or locate a suspect, fugitive, material witness, or missing person.*
- *About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.*
- *About a death we believe may be the result of criminal conduct.*
- *About criminal conduct at our facility.*
- *In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.*

Coroners, Medical Examiners, and Funeral Directors: *We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.*

National Security and Intelligence Activities: *We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.*

Protective Services for the President and Others: *We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.*

Inmates: *If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.*

YOU'RE RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: *You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.*

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Summit Strength Physical Therapy, LLC. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. The cost for copying will be determined on how many pages are in your medical chart. You will receive your copy within 30 days of receipt of your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: *If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the practice.*

To request an amendment, your request must be made in writing and submitted to Summit Strength Physical Therapy, LLC at 800 NW Main Street Ste 100 Lee's Summit, MO 64086. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- *Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.*
- *Is not part of the medical information kept by this practice.*
- *Is not part of the information, which you would be permitted to inspect and copy.*
- *Is accurate and complete.*

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to Request Restrictions: *You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medial information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had to your spouse.*
We are not required to agree to your request. *If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.*
To request restrictions, you must make your request in writing to Summit Strength Physical Therapy, LLC at 800 NW Main Street Ste 100 Lee's Summit, MO 64086. In your request, you must tell us (1) what information you want to limit: (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: *You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.*

To request confidential communications, you must make your request in writing to Summit Strength Physical Therapy, LLC at 800 NW Main Street Ste 100 Lee's Summit, MO 64086. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: *You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Summit Strength Physical Therapy, LLC at 800 NW Main Street Ste 100 Lee's Summit, MO 64086 816-524-7040.*

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page, second line from the top.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with this practice, contact Scott Knoche, PT at 800 NW Main Street Ste 100 Lee's Summit, MO 64086. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

OTHER USES OF MEDICAL INFORMATION

Sending out information to patients, i.e. billing statements, appointment reminders, etc.
Calling patients to remind them of their appointment date and time.
Patients are announced over a loud speaker/intercom when they arrive for their appointment.
Other uses and disclosures of medial information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.