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Welcome to 1st Choice Physical Therapy

We are delighted that you will be participating in a rehabilitation program at one of our facilities.

To expedite the paperwork process, we have included in this download the following materials for your review and completion:

1. Patient Authorization Form

Please read and sign this form prior to your first visit. These forms will provide us with your consent to treatment and allow us to provide your records to your insurance companies and other health care providers involved in your medical care.

2. Medical History Form

Please review and complete this form to the best of your ability prior to your first visit. If you have any questions or special issues you would like to address with your therapist, please note them on this form.

3. Notice of Privacy Practices

This document details how we handle your personal health-related information. Please review and let us know if you have any special requests or questions about our privacy practices.

Thanks for taking the time with these forms. If you should have any questions or concerns prior to your first visit with us, please do not hesitate to contact us at your earliest convenience.

We look forward to working with you on your rehabilitation program.

The 1st Choice Physical Therapy Team

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Authorization of Payment of Benefits to Provider

I authorize payment of medical benefits to the undersigned Health Care Provider or supplier for services described below.

Name: _____

Date: _____



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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Release of Medical Information Necessary to Process Claims

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment below. I also acknowledge responsibility for any and all payments not covered by my insurance.

Name: _____

Date: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the 1st Choice Physical Therapy Notice of Privacy Practices.

Name: _____

Date: _____

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name: _____				Today's Date: _____	
Date of Birth: _____		Age: _____	Height: _____	Weight: _____	Do You Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female If female, are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> 3 rd Trimester					

Have you ever been diagnosed with any of the following?

- | | | | | | |
|-----------------|--|-----------|--|----------------------|--|
| Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Stroke | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Condition | <input type="checkbox"/> No <input type="checkbox"/> Yes | Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Respiratory Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |
- Other: _____

Who referred you to physical therapy? _____ **Primary Physician** _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Specific date) - ___/___/___

Recent flare-up? No Yes If yes, when ___/___/___

What activities are limited by this condition? (e.g. lift, reach) _____

Where and how did your injury/symptoms occur? Recreation Home Work Auto Accident Unknown Other _____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: Constant? Intermittent?

Getting Better? Getting worse? Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 10 = The Most Extreme Pain)

Worst pain rating: _____ **Best pain rating:** _____

For this injury, has your medical care included: (check those that apply)

Surgery: When? ___/___/___ What kind? _____

Injection: When? ___/___/___ Did it help? Yes No

Other treatment:

Physical therapy If yes, when? ___/___/___ to ___/___/___

Chiropractor If yes, when? ___/___/___ to ___/___/___

Medications: _____

X-ray _____ MRI _____

CT scan _____ Other: _____

Exercises: What kind? _____

Indicate on body diagrams **where** your symptoms are located

■ = Pain III = Numbness

Comments: _____

Work Information

Who is your employer? _____ **What is your job title/responsibilities?** _____

Are you currently working? No Yes If yes, numbers of hours per week _____ Full Duty Restricted Duty

How many total work days have you missed? _____ Do you have a case manager/QRC? No Yes

Additional Comments: _____

PLEASE CONTINUE ON OTHER SIDE

Functions

Please review the list below and indicate how the condition that brought you to therapy has affected your daily life. Circle the number that best applies to your current ability to function.

1 = No Problem	2 = Can Do With <i>Some</i> Difficulty	3 = Can Do With <i>Great</i> Difficulty
4 = Can't Do At All	N/A = Does Not Apply to This Condition	

Activity	Rating					Therapist Comments
Sitting (20 minutes)	1	2	3	4	NA	
Standing (20 minutes)	1	2	3	4	NA	
Squatting	1	2	3	4	NA	
Stairs	1	2	3	4	NA	
Walking	1	2	3	4	NA	
Sit to Stand	1	2	3	4	NA	
Driving	1	2	3	4	NA	
Sleeping	1	2	3	4	NA	
Bathing/Grooming	1	2	3	4	NA	
Dressing	1	2	3	4	NA	
Push/Pull	1	2	3	4	NA	
Lift/Carry	1	2	3	4	NA	
Bending	1	2	3	4	NA	
Light Work (Dust, Beds, Dishes)	1	2	3	4	NA	
Heavy Work (Lawn, Vacuum, Scrub)	1	2	3	4	NA	
Job Duties	1	2	3	4	NA	
Sports/Recreation	1	2	3	4	NA	
Other	1	2	3	4	NA	

Estimate your overall ability to perform your daily activities (0 to 100%) _____

What do you hope to accomplish in Therapy? _____

Additional Comments _____



Notice of Privacy Practices

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1st Choice Physical Therapy is dedicated to protecting your medical information. The medical record is the physical property of 1st Choice Physical Therapy, and the health information contained in the medical record is yours. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information.

We are required by law to:

- Keep medical information about you 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.

Who will follow this Notice?

1st Choice Physical Therapy provides health care to our patients and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by:

- Any health care professional who treats you at any of our locations.
- All locations included within 1st Choice Physical Therapy.
- All employed associates, staff or volunteers of our organization, including staff at our parent organizations.
- Any business associate or partner of 1st Choice Physical Therapy with whom we share health information.

Changes to this Notice

We reserve the right to change the terms of this Notice, making any revision applicable to all of the health information that we maintain. If 1st Choice Physical Therapy revises the terms of this Notice, we will post a revised Notice at all 1st Choice Physical Therapy locations and on our web site: www.1stChoiceTherapy.com.

We will also provide paper copies of this Notice upon request. You also will be asked to acknowledge in writing your receipt of this Notice.

Our pledge to you

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive and to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff, your personal physician or records disclosed to us per your authorization from other providers.

How Your Medical Information Will Be Used And Disclosed

- We may use and disclose medical information about you for treatment (such as sending medical information about you to a specialist as part of referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and for health care operations (such as review for quality assessment and the appropriateness of the care you receive).
- Subject to several requirements, we may use or disclose medical information about you without prior authorization including but not limited to public health purposes, abuse and neglect reporting, health oversight audits or inspections, research studies, worker's compensation or other similar programs.
- We may disclose medical information in specific circumstances when required by law (such as a request from law enforcement for a blood alcohol level) or in response to valid judicial or administrative orders.
- We may contact you for appointment reminders or to tell you about our recommended possible treatment options, alternatives, health-related benefits or services that may be of interest to you or to support fund-raising efforts.
- You may be asked for your comments on the care that you received at 1st Choice Physical Therapy.
- Unless you object, and with the exception of Behavioral Health Patients, 1st Choice Physical Therapy may disclose your medical information to family members, other relatives or close personal friends involved in your medical care.
- 1st Choice Physical Therapy may disclose your medical information to a public or private entity to assist in disaster relief efforts.
- 1st Choice Physical Therapy may disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.

Other uses of medical information

In any other situation not covered by this Notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Patient Rights

Your rights regarding your medical information include:

- The right to request restrictions on certain uses and disclosures of your medical information. 1st Choice Physical Therapy is not required to agree to your requested restriction.
- The right to receive communications from 1st Choice Physical Therapy in a confidential manner (such as sending mail to an address other than your home).
- The right to inspect and obtain a copy of your medical information. You may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. Your request must be in writing and may be denied if the information was not created by 1st Choice Physical Therapy; is not part of the medical information maintained by 1st Choice Physical Therapy; or if it is determined that the information in the record is accurate. You may appeal the denial in writing.
- The right to receive an accounting of the disclosures of your medical information made by 1st Choice Physical Therapy except for the disclosures made for treatment, payment or healthcare operations and for those specifically authorized by you.
- The right to receive a paper copy of the Notice.

Complaints

If you are concerned that your privacy rights may have been violated or you disagree with a decision 1st Choice Physical Therapy has made, you may register your complaint with the Privacy Officer by leaving a message on our Ethics Line at 1-800-540-0774

- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. The address can be requested from the Values Line.
- Under no circumstances will you be penalized or retaliated against for filing a complaint.