HIGH DESERT
PHYSICAL THERAPY

PATIENT INFORMATION FORM

Name (last, first, middle)_____

If patient is a minor, parent or legal guardian _____ DOB_____

Street Address_____ City _____ Zip _____

Social Security # _____-_____-_____ Phone (h) _____ Cell_____

Birthdate_____ Male _____ Female _____ Married_____ Single_____

Email Address_____

How would you like to be reminded of your appointments? Text Email Phone None

Emergency contact not living with you _____ Phone_____

If patient is a student, Fulll time____ Part time____ School_____

Your Employer_____ Phone _____

Referring Doctor _____Primary Care Physician _____

Insurance policyholder:

Do you have a pacemaker? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Have you RECENTLY noted any of the following (check all that apply):

Fatigue	Muscle Weakness	Fever/Chills/Sweats	Diarrhea
Heartburn	Shortness of Breath	Weight Loss/Gain	Fainting
Cough	Nausea/Vomiting	Difficulty Swallowing	Headaches
Constipation	Numbness/Tingling	Dizziness/Lightheadedness	

Have you EVER been diagnosed with any of the following conditions (check all that apply):

Cancer	Depression	Asthma	High Blood Pressure
Stroke?TIA	Anemia	Diabetes	Tuberculosis
Osteoporosis	Incontinence	Gout	Bladder/UTI
Osteoarthritis	Epilepsy	GERD	Thyroid Problems
Heart Disease	Hepatitis	Blood Clots / DVT	Emphysema/Bronchitis
Arthritis (Rheumatoid, Psoriatic)			

Other medical conditions/major injuries that we should be aware of:

_____

Do you have any allergies? (ie. Latex, lotions, etc.)_____

Name _____ Date _____

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):_____

_____

How did you hear about High Desert Physical Therapy? or whom may we thank for referring you? _____

What is your personal goal that you wish to achieve from physical therapy?

_____

_____ **Cancellation Policy: We request that when possible you give us 24-hour notice if you need to cancel an appointment. We are flexible and understand that situations beyond our control do arise. We will work with you to get your appointment rescheduled without penalty if you call us prior to your appointment time. By initialing, you acknowledge that it is at our discretion to charge you a fee of $50 if you have a"no call, no show" an appointment.**

If injury is a Workers Comp case or through a Lien, please complete the following:

Is your injury job related? YES NO Date of injury _____ Claim# _____
Insurance Company_____ Phone # _____
Name of Adjuster_____ Phone# _____

Is your injury due to a motor vehicle accident? YES NO
Date of injury _____Claim# _____
Is your injury due to a Premises Liability? YES NO
Date of injury _____Claim# _____
Is your injury due to an Assault? YES NO
Date of injury _____Claim# _____
Is your injury due to a Battery? YES NO
Date of injury _____Claim# _____
Insurance Company _____Phone# _____
Attorney (if applicable) _____Phone# _____

I hereby authorize payment of medical benefits billed to my insurance to HDPT. I hereby accept responsibility for payment for any service(s) provided to me which is not covered by my insurance. I also accept responsibility for fees which exceed payment by my insurance if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

_____

Signature of patient or legal guardian/representative **Date**

CONSENT FOR PURPOSES OF TREATMENT,
PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information of High Desert Physical Therapy, LLC (HDPT) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of High Desert Physical Therapy, LLC. I understand that diagnosis or treatment of me by Jared Pugmire, DPT or one of his staff may be conditioned upon my consent as evidenced by my signature on this document. My signature of this letter of consent signifies that I will actively participate in the plan of care discussed with me by the therapist unless I verbally notify the therapist otherwise.

I also understand and promise that if my bills are not paid at all, or paid only partly by the insurance company and/or my attorney(s), that I am fully and personally responsible for all my medical expenses as presented by HDPT. I hereby authorize my attorney(s) or insurance company to pay directly to HDPT all bills in full. It was carefully explained to me and I fully understand that HDPT's charges for examination, treatment, etc. are to be paid in full by me regardless of the outcome of my suit or negotiations.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. HDPT is not required to agree to the restrictions that I may request. However, if HDPT agrees to a restriction that I request, the restriction is binding on HDPT, Jared Pugmire, DPT, and his staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jared Pugmire, DPT, or HDPT has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe that information may identify me.

I understand I have a right to request and review a copy of HDPT's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of HDPT. This Notice of Privacy Practices also describes my rights which I understand and HDPT's duties with respect to my protected health information.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me in the mail or asking at the time of my next appointment.

_____ _____

(Patient or Guardian) (Date)

_____

(Office staff)

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

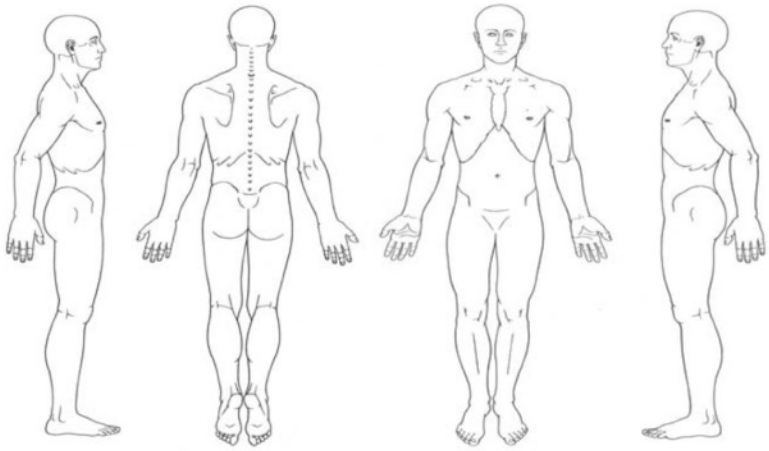
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

MEDICAL INFORMATION RELEASE

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call [ ]

_____

The best time to reach me is (day)_____ between (time)_____

You agree in order for us to service your account, collect any amounts you may owe or any other information regarding your treatment (including but not limited to appointments, insurance information, health care information, and/or balance forwards, etc.), we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by text messages or emails using any email address or any telephone number you have provided to us.

Signed: _____ Date: ____/____/_____

Office Staff:_____ Date: ___/____/_____

HIGH DESERT
PHYSICAL THERAPY

Notice of Privacy Practices

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.**

We are required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to maintain the privacy and security of your health information. Health information means information about your past or present health status, condition, diagnosis, treatment, prognosis, or payment for health care.

Your Rights

- When it comes to your health information, you have certain rights. The following section defines the rights you have pertaining to your health information.

Get access to and receive a copy of your medical record

- You have a right to view or receive a copy of your health information
- If requested, you can get an electronic copy of your health information. Ask use how to do this.
- We will provide you with access or a copy of your health information, usually within 30 days
- We may change a reasonable, cost-based fee for the copy of your records

Ask us to correct your medical record

- You have the right to ask us to correct information that you think is inaccurate or incomplete within your medical record
- We may not approve your request, but we will inform you of the outcome within 60 days

Request that we communicate with you in a confidential manner

- You have the right to request that we contact and communicate with you in a specific manner such as an alternate phone number or address
- We attempt to approve all reasonable requests, but reserve the right to decline the request

Ask use to restrict the health information that we share or use

- You have the right to request that we not use or share information with specific individuals
- We may say 'no' to your request if it will have negative effect on your patient care
- You have the right to request that we not share your information with your health plan; however, you must pay for your healthcare services in full. We will approve these requests unless law requires us to share the information.

Get access to a list of whom we have shared your health information with

- You have the right to request a list of whom we have shared your health information with for the past six years prior to the day you have asked. The list will include information on with who we shared it with and why.
- The list will include all disclosures except those made for the purposes of treatment, payment, our healthcare operations, and other disclosures such as those that you authorized us to make on your behalf.
- We will provide one free list of disclosures of your health information each year. We may charge a reasonable cost-based fee if you request multiple disclosure lists in a 12 month period of time.

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.
- In the event the individual is deceased, we may provide health information to a personal representative if it is within the scope of the law and the privacy rule permits sharing the information
- Prior to providing any information or allowing them to access rights describe in this document, 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 that your rights have been violated

- You can complain if you feel we have violated your rights by contacting our HIPAA Privacy Officer. The contact information can be found on the last page of this document.
- 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 support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Get a paper copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time. We will promptly provide you with a copy of this notice.
- You can also access a copy of this notice on our website www.highdesertphysicaltherapy.com

Your Choices

- **For certain health informatoin, you have the right to tell use your choices about what we share, and whom we share it to.** If you have clear preferences for how we share your information described below, please talk to use and tell use how you would like use to handle you information. We will do our best to handle your instructions to your health information.

In the cases listed below, you have the right and choice to tell our organization:

- How to share information with your family, friends, and others involved in your care
- How to share your information for the purposes of disaster relief situations
- Include your information in the hospital directory

In the event that you are not able to inform our organization of your preference, such as being unconscious, our organization may go ahead and share your information if we believe it is in your best interest. We may also share your information if it is needed to lessen a serious and imminent through to health and safety.

In the cases listed below, our organization will not share your information unless you give us written permission:

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

Please note that our organization will never market or sell your personal information.

For the purposes of fundraising for our organization:

- We may contact you for fundraising efforts
- You have the right to tell us not to contact you again for fundraising purposes
- If you tell us not to contact you, we will not make future communications regarding fundraising to you
- You have the right to request to receive fundraising communication at any point after you restrict communication regarding fundraising

Our Uses and Disclosures

- **We Use Health Information to Support our Healthcare Operations and Provide Services to you.** This section defines how we typcially use and share your health information. We are not required to get your authorization to share or provide you with an opportunity to agree or object in these specific scenarios.

OUR RESPONSIBILITIES TO YOUR HEALTH INFORMATION: HOW WE USE AND DISCLOSE HEALTH INFORMATION

We use your information for the purposes of treatment, payment, and healthcare operations within our organization. The following describes the typical scenarios where we use and disclose your protected health information.

To Treat You

- Our organization uses your health information and shares it with other healthcare professionals for the purposes of treatment
- *Example: We may share your information with a provider that we have referred you to for other care.*

To Bill for the Services Provided

- Our organization uses and shares your health information to bill and get payment from your health plan or other entities for the services that we have provided to you.
- *Example: We provide your insurance company with your information from a visit so it will pay for the services provided to you.*

To Run our Organization

- Our organization uses and shares your health information to run our healthcare organization, improve your care and service, and contact you when necessary.
- *Example: We use your health information to manage your treatment and services, and improve the services that we provide to our patients.*

Appointment Reminders:

- We may use and disclose your health information to provide you with appointment reminders such as voicemail message, text message, postcards or letters.

Other Ways our Organization Uses and Shares Your Health Information

We are allows and/or required to share your information in many different ways. Information shared is usually done to contribute to the public good, such and public health and research. Our organization has to meet many conditions in the law before we can share your health information for these purposes. These uses of health information does not require an authorization from you or require an opportunity to agree or object to the sharing of information. For more information, you can visit the following website: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

Our organization can share health information about you for certain situations. For these specific situations, we will use and share your health information to the appropriate authorities after proper verification has occurred. Some examples of situations are:

- Reporting and controlling diseases, injuries, or disabilities
- Helping with product recalls
- Reporting adverse reactions to medications to such organizations as the Food and Drug Administration
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety (for national security purposes)

Please note this is not a comprehensive list, but it provided to give you some examples of how we would share your information for public health and safety issues.

Conduct Research

- We can use or share your information for health research. Your medical record may be reviewed and data included in a research study. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process.

Comply with the law

- We will share information about you if state or federal laws require it
- We may share your information with the Secretary of the Department of Health and Human Services for purposes of compliance and enforcement of the HIPAA rules.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations. Prior to sharing information, our organization has a process of verification of the requestor that takes place.

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. Prior to sharing information with a coroner, medical examiner, or funeral director, our organization has a process of verification of the requestor that takes place.

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 or a court order.

Our Responsibilities to Your Health Information

- 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.
- Other uses and disclosures not described in the notice will be made only with the individual's written authorization
- You have the right to revoke any authorization you have provided our organization to use or share your health information. If you change your mind about using or sharing your information, let us know your decision in writing.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

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, in our office, and on our website.

HIPAA PRIVACY CONTACT PERSON

HIPAA Privacy Officer: Jared Pugmire

Mailing Address: 345 A Yellowstone Ave, Pocatello, ID 83201

Phone Number: 208-240-6017

Fax: 208-240-6023

E-mail Address: jaredhdpt@gmail.com

EFFECTIVE DATE: This Notice of Privacy Practices is Valid as of 10/16/2017