Patient Information

Name: _____ Middle Initial: _____ Today's date: _____

Home Address: _____

PO Box: _____ City: _____ State: _____ Zip: _____

Patient's date of birth: _____ Patient's SSN: _____ - _____ - _____

Age: _____ Male ☐ Female ☐ Appointment reminder by: ☐ text? ☐ voice message? ☐ email?

Cell phone: _____ - _____ - _____ Home phone: _____ - _____ - _____

Work phone: _____ - _____ - _____ Email: _____

Responsible Party (if different from Patient): _____ Date of birth: _____

Address: _____

Phone: _____ - _____ - _____ SSN (required): _____ - _____ - _____

Emergency Contact: _____ Relationship: _____

Phone: _____ - _____ - _____

Have you had any other therapy in the past year? ☐ Physical Therapy ☐ Occupational therapy ☐ Speech Therapy

Is this current concern/complaint the result of an accident? Y N ☐ work ☐ auto ☐ other

Date of onset of pain/injury/incident: _____

Brief summary of the cause of pain/injury/incident: _____

_____

Primary Insurance Provider: ☐ Medicare ☐ BCBS ☐Aetna ☐ Arbor ☐ Coventry ☐ Midlands Choice
☐ United Healthcare ☐ Work Comp Other: _____
Policy Holders Name: _____ Policy Holder's date of birth: _____
Policy Holder's SSN: _____ - _____ - _____ Insurance ID #: _____

Secondary Insurance Provider: ☐ Medicare ☐ BCBS ☐Aetna ☐ Arbor ☐ Coventry ☐ Midlands Choice
☐ United Healthcare ☐ Work Comp Other: _____
Policy Holders Name: _____ Policy Holder's date of birth: _____
Policy Holder's SSN: _____ - _____ - _____ Insurance ID #: _____

Referring Physician: _____

☐ **My provider REQUIRES pre-authorization**
☐ **My provider DOES NOT require pre-authorization**

Patient or Parent/Legal Guardian's Signature

Patient History

Name: _____ Middle Initial: _____ Date: _____

Primary concern/chief complaint: _____

_____

Because of the above issue, what specific activities are you having difficulty with?

_____

_____

Have you experienced these symptoms before? Y N Date(s): _____

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current pain location:_____

Current pain description: ☐ burning ☐ sharp ☐ dull/achy ☐ shooting ☐ constant
☐ numbness/tingling ☐ intermittent worse in: ☐ AM ☐ PM

custom pain description: _____

Aggravating factors: ☐ sitting ☐ standing ☐ bending ☐ sit to stand ☐ walking ☐ voiding
☐ stairs up ☐ stairs down ☐ cough/sneeze

other: _____

Please rate your pain on a scale of 0 (no pain) to 10 (worst pain imaginable):

Most pain (with this injury)	0	1	2	3	4	5	6	7	8	9	10
Current level of pain	0	1	2	3	4	5	6	7	8	9	10
Least pain (with this injury)	0	1	2	3	4	5	6	7	8	9	10

Height:_____ Weight:_____

Do you use tobacco? (circle one): Y N If yes, how much?: _____

History of falls: N/A Y N If yes, date(s):_____

☐ Previous physical therapy: _____

_____

☐ Previous surgical history: _____

_____

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Do you have, or have you ever had any of the following conditions, check all that apply:

☐ Allergies	☐ Dizziness/fainting	☐ MRSA (staph infection)
☐ Alzheimer's	☐ Fibromyalgia	☐ Muscular Dystrophy
☐ Bladder/Bowel changes	☐ Fracture	☐ Obesity
☐ Cardiovascular disease	☐ Headaches	☐ Osteoarthritis
☐ Cauda Equina Syndrome	☐ High Blood Pressure	☐ Parkinson's
☐ Cerebral Vascular Accident	☐ History of cancer	☐ Psycho-social
☐ Current infection	☐ HIV/Hepatitis	☐ Respiratory problems
☐ Current pregnancy	☐ Huntington's	☐ Rheumatoid arthritis
☐ Diabetes (type I)	☐ Immunosuppression	☐ Seizures
☐ Diabetes (type II)	☐ Lupus	☐ Traumatic brain injury

☐ No known significant previous medical history to affect treatment

Other medical issues we should know about: _____

_____

Are you currently receiving home health care? Y N

Please list all your current medications (prescription, over the counter, herbal, vitamins/minerals):

	Dosage	Frequency	oral/injection
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____

What do you hope to improve or change with physical therapy?_____

_____

Have you had any diagnostic testing/imaging in relation to this issue? ☐ X-Rays ☐ CT ☐ MRI
Other testing: _____

Treatment side: N/A L R

Onset date/Injury date: _____ ☐ chronic ☐ insidious ☐ acute/new injury

Surgery performed: Y N Date: _____ Type: _____

Additional information: _____

How did you hear about Sandhills? _____

Authorization for Release of Information And Consent to Treat

The undersigned hereby authorizes Sandhills Physical Therapy & Sports Rehab, P.C. to provide requested medical record information or excerpts to the referring Physician, Medicare, Medicaid or any other insurance company other insurance company for the purpose of processing claims and to obtain payment of the account for services provided to the patient. By signing this authorization, the Patient, or Legal Guardian of the Patient hereby gives consent to medical treatment.

Patient or Parent/Legal Guardian's Signature **Date**

Notice of Information 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.

Sandhills Physical Therapy & Sports Rehab, P.C. is required by Federal Law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfils the "Notice" requirements of the Health Information Portability and Accountability Act of the 1997 (HIPPA) Final Privacy Rule. We provide patient education in the form of a three page Notice of Privacy Right and Practices, however if you have any questions or desire to have further information concerning privacy practices at Sandhills Physical Therapy & Sports Rehab, please call us at (308) 534-5590.

The undersigned certifies that he/she has read our Notice of Information Privacy Practices and is the patient, or is duly authorized by or on behalf of the patient to execute the above, and accept its terms.

Patient or Parent/Legal Guardian's Signature **Date**

Notice of Financial Policy

Personal Health Insurance

If your treatment will be covered by your personal health insurance, please present your insurance card(s) at the time of your initial visit. Please inform our office of any changes to your insurance that may arise during your treatment. As a courtesy, we will gladly file medical claims for you. Any co-pays are due at the time of your visit.

Covered benefits vary between plans, and it is important that you are aware of the benefits allowed for physical therapy under your policy. It is your responsibility to understand the limitations and exclusions of your policy. We will be glad to help you better understand your benefits, if you need assistance.

Medicare

In order to file your medical claims with Medicare, we must have written authorization from your medical Physician before treatment. Please present your card along with your supplemental insurance at your first visit. If a balance is remaining after Medicare and supplemental insurance have paid, the balance is the responsibility of the patient.

Medicaid/Nebraska Total Care/WellCare/UHC Community Plan

The patient must provide us with a copy of their Medicaid, NE Total Care, WellCare, or UHC Community Plan card in order for us to file claims. Share of cost and co-pays are the responsibility of the patient and must be paid in full. Patients, 21 years of age and older are allowed a maximum of 60 visits per calendar year. Pre-Authorization is required for patients 20 years old and younger.

Workers Compensation

Any patient claiming worker's compensation must bring notice from their employer to their first appointment. Worker's Compensation claims which are denied or contested become the responsibility of the patient and will be due in full or may be submitted to the patient's personal health insurance. It is the responsibility of the patient to keep our office informed of the status of the claim.

Liability Claims

As a courtesy, we will file liability claims on behalf of the patient if medical pay is available. Primary responsibility for payment however, is with the patient. Cases involving legal representation are treated as self-pay responsibility and are due upon receipt of the statement; a Medical Lien will not be filed.

Financial Agreement

As a patient and/or responsible party, you alone are responsible for payment in full of allowable expenses related to your physical therapy. **Statements are sent out on a monthly basis and are due in full upon receipt. If at any time you have to pay less than the full balance, you must contact our billing office at 308-520-8680.**

There is a $25.00 fee on all insufficient funds.

The undersigned certifies that he/she has read our financial policies and is the patient, or is duly authorized by or on behalf of the patient to execute the above, and accept its terms.

Patient or Parent/Legal Guardian's Signature **Date**

Sandhills Physical Therapy and Sports Rehab P.C.

616 West Leota
North Platte, NE 69101
Website: sandhillspt.com
Email: sandhillspt@gmail.com

Your Information. Your Rights. Our Responsibilities.

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.

continued on next page

Your Rights *continued*

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 complain if you feel we have violated your rights by contacting us using the information on page 1.
- 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 • Contact you for fundraising efforts *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.*

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

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
	  • 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.

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 web site.

October 18, 2016

This Notice of Privacy Practices applies to the following organizations.

This Notice applies to all Sandhills Physical Therapy and Sports Rehab P.C. locations.

616 West Leota, North Platte, NE 69101

700 East 1st Street, Ogallala, NE 69153

106 NW 1st Street, Mullen, NE 69152

Complaints about our privacy rights must be made in writing to Sandhills Physical Therapy and Sports Rehab P.C., 616 West Leota St., North Platte, NE 69101. If you have questions in regard to the contents of the Notice, call 308-520-8680 or write to the address above.