

PATIENT INFORMATION

MD Code: _____

FIRST NAME: _____ MI. _____ LAST NAME _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

WORK PHONE # _____ HOME PHONE # _____ BIRTHDATE: ____/____/____

SOCIAL SECURITY # _____ (Use signing parent's # if patient is minor under age of 19.)

SEX: M / F CONTACT IN CASE OF EMERGENCY: _____

YOUR EMPLOYER: _____ EMPLOYER ADDRESS: _____

REFERRING PHYSICIAN _____ DATE SEEN ____/____/____ NEXT APPT ____/____/____

DATE OF ILLNESS/INJURY: ____/____/____. WERE YOU PREVIOUSLY UNDER THE CARE OF ANOTHER THERAPIST FOR THIS OR ANOTHER CONDITION AT ANY TIME DURING THIS YEAR? (This may affect your insurance benefits!!) PROVIDE DETAILS BELOW:

-----PRIMARY INSURANCE INFORMATION-----

***** Please Note – if your insurance is Medicare, you can not be treated here if you are receiving ANY type of home health care services. If you are, Medicare will not pay and you will be responsible for our charges.*****

CIRCLE PRIMARY INSURANCE TYPE: MAJOR MEDICAL HMO WORK. COMP. NO-FAULT MEDICARE

INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

PHONE # _____ ID # _____ GROUP # _____

NAME OF PERSON INSURED: _____ RELATION: _____ SS# _____ - _____ - _____

INSURED EMPLOYER: _____ EMPLOYER ADD: _____

-----SECONDARY INSURANCE INFORMATION-----

CIRCLE SECONDARY INSURANCE TYPE: MAJOR MEDICAL HMO WORK. COMP. NO-FAULT MEDICARE

INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

PHONE # _____ ID # _____ GROUP # _____

NAME OF PERSON INSURED: _____ RELATION: _____ SS# _____ - _____ - _____

INSURED EMPLOYER: _____ EMPLOYER ADD: _____

-----WORKMAN'S COMPENSATION-----

DATE OF INJURY ____/____/____ CARRIER CASE # _____

W.C.B. CASE # _____ ARE YOU CURRENTLY WORKING ? Y / N

-----NO-FAULT-----

DATE OF ACCIDENT: ____/____/____ POLICY # _____

POLICY HOLDERS NAME: _____

-----PLEASE SIGN BELOW - BOTH SECTIONS MUST BE SIGNED-----

I GIVE PERMISSION TO SPORTSFOCUS PHYSICAL THERAPY TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I AUTHORIZE PAYMENT DIRECTLY TO SPORTSFOCUS PHYSICAL THERAPY FOR TREATMENT I RECEIVE

SIGNATURE REQUIRED: _____ DATE ____/____/____

(Signature of Patient or Guardian if patient is under 19)

**** Important - Please Read ****

I agree I am primarily liable for all charges for services rendered by SportsFocus Physical Therapy and agree to pay all amounts not paid by my insurance carrier(s), for any reason. If I am claiming coverage under compensation/no-fault laws I understand I am fully liable if such coverage is subsequently denied. I agree to supply major medical information in anticipation of such a denial. If I am claiming coverage through an HMO(such as IHA or Community Blue) I understand I am responsible for obtaining a valid referral prior to treatment and that treatment without such a referral will cause me to be personally liable for today's charges as well as future charges.

If I make payment to SportsFocus in cash I understand that I must obtain a receipt from SportsFocus and retain this receipt for at least three months. I understand in the event amounts are not paid when due I agree to pay all reasonable attorney's fees and collection costs you may incur to collect such past due amounts. If referred to collection, a fee of 30%(minimum fee of \$10.00) of your outstanding balance will be added to your account . COPAYS ARE DUE AT TIME OF TREATMENT. I acknowledge receipt of a copy of the SportsFocus billing/insurance policy(s) appropriate for the insurances I have shown.

*****CANCELLATIONS REQUIRE AT LEAST TWENTY FOUR HOURS ADVANCE NOTIFICATION*****

SIGNATURE REQUIRED: _____ DATE ____/____/____

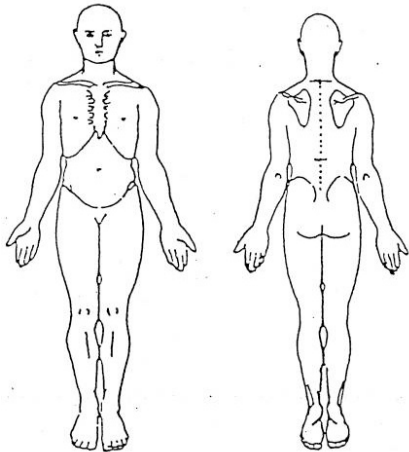
(Signature of Parent or Guardian if patient is under 19)

SportsFocus Physical Therapy

Patient Intake Form

*Please fill out **all** of the following questions as legibly as possible.
If you need more space to answer a question, please feel free to write on the back of these pages.*

Name: _____ Age: _____



Please indicate the location of your symptoms over the last week by drawing on the body diagrams to the left.

◆ On what date did your present symptoms begin? (You may give the month and year if the exact date is unknown)
 _____/_____/_____ Please check the following box if you can't recall when your symptoms began.

◆ How did your symptoms begin? specific event no apparent cause

◆ Please describe the details of your injury or any activities you feel may have contributed to the onset of your present symptoms.

◆ Have you ever had an injury to this area before or had episodes of similar symptoms? Yes No
 If you answered **yes**, please list the approximate dates of these events (you may estimate by month and year) and describe the treatment you received at that time.

Date	Treatment
_____/_____/_____	_____
_____/_____/_____	_____
_____/_____/_____	_____

◆ Did you have any limitation of function during normal daily activities before your present injury or onset of symptoms? Yes No
 If you answered **yes**, please describe those limitations below.

◆ Who did you see for initial medical care? _____

◆ What doctors, if any, were you referred to? _____

◆ Which diagnostic tests, if any, have you undergone?

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> X-ray | <input type="checkbox"/> CT | <input type="checkbox"/> EMG |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> MRI | <input type="checkbox"/> Nerve Conduction Velocity |
| <input type="checkbox"/> Blood Tests | <input type="checkbox"/> Ultrasound Doppler | <input type="checkbox"/> Myelogram |

◆Please list the medications you are presently taking for **this** problem.

◆Please list any other medications you are taking and for what purpose.

Medication

Purpose (or for what medical problem)

◆Have you received an injection or an epidural?

If so, on what date? _____ / _____ / _____

◆Have you had surgery for this problem? Yes No

If you answered yes, what was the date of your surgery? _____ / _____ / _____

◆What other treatments, if any, have you tried prior to coming to SportsFocus Physical Therapy?

- | | |
|---|--|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Massage therapy |
| <input type="checkbox"/> Self-directed exercise | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Physician-instructed home exercise | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Physical therapy at another facility | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> _____ |

◆What do you do for an occupation? _____ Retired

Please describe the physical requirements of your job as best as you can. For example: 30% of day sitting, 30% of day standing, 20% of day walking, 20% of day lifting boxes weighing between 10 and 20 pounds.

_____ % of day _____
_____ % of day _____
_____ % of day _____
_____ % of day _____

What is the length of your: typical workday? _____ hours typical workweek? _____ days

Are you presently off of work because of your problem? Yes No

If you answered yes, what is the date of your last day at work? _____ / _____ / _____

◆Please check from the list below **3** problems that you feel are currently the most important to you.

- | | | |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Sitting | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Going from Sit to Stand | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Standing | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Going Up Stairs | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Going Down Stairs | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Squatting | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Kneeling | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Running | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Jumping | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Pivoting | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Health History

Name of your Primary Physician: _____

Approximate date of last physical examination by primary physician: ____/____/____

General health status

Height: _____

Weight: _____

In general, would you say your health is:

excellent very good good fair poor

Social/Health habits

• Please rate your general level of physical activity on the following scale.

Sedentary Light Activity Moderate Activity Very Active Extremely Active

• How often do you normally exercise?

Daily >3 times/week 3 times/week <3 times/week rarely

• Do you smoke cigarettes?

Yes No

• Over the past 4 weeks, have you felt anxious?

Yes No

• Over the past 4 weeks, have you felt depressed?

Yes No

• During the past 4 weeks, has your physical health or emotional state interfered with your social activities (like visiting friends, relatives, etc)?

Yes No

Medical/Surgical history

• Do you have a previous history of orthopedic injuries not related to present condition? Yes No

If yes, please describe: _____

• Have you had any previous major surgeries? Yes No

If yes, please describe: _____

• Have you ever had an adverse reaction to any drug? Yes No

If yes, please describe: _____

• Do you have any allergies? Yes No

If yes, please describe: _____

• Have you ever had any difficulties with wounds healing more slowly than normal? Yes No

If yes, please describe: _____

• Do you have a history of fainting? Yes No

If yes, please describe: _____

• If you are a female: Are you pregnant? Yes No

Have you previously or are you now presently suffering from any of the following? Please check all appropriate boxes. If you answer "Yes" to any of the questions below please offer a description of the details of that condition in the space provided or answer the appropriate questions.

- A heart condition Yes No _____
 If yes: Has your level of physical activity ever been limited by your heart condition? Yes No
- High blood pressure Yes No _____
 If yes: What is your usual resting blood pressure? _____ over _____
 Is your blood pressure currently under control? Yes No
 Has your level of physical activity ever been limited by your blood pressure? Yes No
- Diabetes Yes No _____
 If yes: Are you: insulin-dependent or non-insulin-dependent?
 Would you say your control is: excellent good fair poor
 Have you had any difficulty controlling your blood sugar levels when exercising? Yes No
- Asthma Yes No _____
 If yes: Have you experienced exercise-induced asthma? Yes No
 Do you typically carry an inhaler? Yes No
- Seizures Yes No _____
 If yes: When was your last seizure? ____/____/____
- Stroke Yes No _____
- Rheumatoid arthritis Yes No _____
- Cancer Yes No _____
- Depression Yes No _____
- Infectious Disease Yes No _____
- Other (Is there anything else about your health that you feel we should know.) Yes No
 If yes: Please describe. _____

Patient Signature: _____ Date: ____/____/____

Physical Therapist Signature: _____ Date: ____/____/____

The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, **do you or would you** have any difficulty at all with:

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1 Any of your usual work, housework, or school activities.	0	1	2	3	4
2 Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3 Getting into or out of the bath.	0	1	2	3	4
4 Walking between rooms.	0	1	2	3	4
5 Putting on your shoes or socks.	0	1	2	3	4
6 Squatting.	0	1	2	3	4
7 Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8 Performing light activities around your home.	0	1	2	3	4
9 Performing heavy activities around your home.	0	1	2	3	4
10 Getting into or out of a car.	0	1	2	3	4
11 Walking 2 blocks.	0	1	2	3	4
12 Walking a mile.	0	1	2	3	4
13 Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14 Standing for 1 hour.	0	1	2	3	4
15 Sitting for 1 hour.	0	1	2	3	4
16 Running on even ground.	0	1	2	3	4
17 Running on uneven ground.	0	1	2	3	4
18 Making sharp turns while running fast.	0	1	2	3	4
19 Hopping.	0	1	2	3	4
20 Rolling over in bed.	0	1	2	3	4
Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points SCORE: ____ / 80

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. *Physical Therapy*. 79:371-383.

NOTICE OF PRIVACY PRACTICES REGARDING PATIENT HEALTH INFORMATION

WE ARE GIVING YOU THIS NOTICE BECAUSE FEDERAL REGULATIONS (HIPAA) REQUIRE THAT WE ADVISE YOU OF OUR PRIVACY PRACTICES WITH REGARD TO YOUR HEALTH INFORMATION.

OUR PRACTICE HAS ALWAYS BEEN COMMITTED TO MAINTAINING THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION AND WILL CONTINUE TO DO SO. THIS NOTICE DETAILS YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION AND HOW YOU MAY OBTAIN ACCESS TO IT, IF DESIRED. THIS NOTICE ALSO DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY SPORTSFOCUS PHYSICAL THERAPY, PC TO CARRY OUT YOUR TREATMENT, OBTAIN PAYMENT, AND TO PERFORM THE HEALTH CARE OPERATIONS OF THE PRACTICE AND FOR OTHER PURPOSES PERMITTED OR REQUIRED BY LAW. PLEASE READ IT CAREFULLY.

Your Individual Rights

You have certain rights under the HIPAA federal privacy standards. These include:

- ☞ the right to receive a printed copy of this notice
- ☞ the right to inspect and copy your protected health information
- ☞ the right to receive confidential communications concerning your medical condition and treatment
- ☞ the right to amend or submit corrections to your protected health information
- ☞ the right to receive a written accounting of how and to whom your protected health information has been disclosed
- ☞ the right to request restrictions on the use and disclosure of your protected health information

SportsFocus Physical Therapy, PC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Uses and Disclosures

(the examples given are not meant to include all possible types of use and/or disclosure)

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of physical therapy tests and procedures will be available in your medical record to all health professionals who may provide treatment to you or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. Information may also be given to collection agencies for pursuit of payment in the event you do not pay your charges as required.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of SportsFocus Physical Therapy, PC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Your information may also be provided to a billing or transcription services

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, if we become required to report certain communicable diseases to the state's public health department.

Additional uses of information. Appointment reminders. Your health information may be used by our staff to send you appointment reminders or make telephone reminder/follow-up calls. Our practice utilizes a sign in sheet. Your name may also be called in the waiting room when your appointment is ready or on the public address system if you are needed at the front desk.

Continued.....

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed on the preceding page requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Requests to Inspect Your Protected Health Information

You may generally inspect or request copies of the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Gina Cunningham, Office Manager or Fredrick Gill, Business Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. There will be a fee for copied records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
SportsFocus Physical Therapy, PC
3940 California Rd
Orchard Park, NY 14127

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is as shown above.

Effective Date

This notice is effective on or after April 14, 2003

****** Acknowledgement of Receipt of Notice of Privacy Practices ******

As permitted by law, SportsFocus Physical Therapy, PC reserves the right to amend or modify the privacy practices outlined in this notice. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Signature

I have received a copy of this Notice of Privacy Practices for SportsFocus Physical Therapy, PC.

Name of Patient (print or type)

Signature of Patient

_____/_____/_____
Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient