Patient Data Date: _____

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Nickname: _____ **Date of Birth:** _____/_____/_____ **Sex:** ☐Male ☐Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Cell Phone: (_____)_____-_____ **Email:** _____

Social Security Number: _____-_____-_____ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐Yes ☐ No **Occupation:** _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Cell Phone: (_____) _____-_____ **Email:** _____

Spouse's Date of Birth: _____/_____/_____ **Spouse's SS#:** _____-_____ -_____

Employer Data

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Contact Name:_____ **Contact Phone:** (_____) _____-_____

Name: _____**Date:**_____ **Primary Care Physician:**_____

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

- ❑ changes in bowel or bladder function
- ❑ nausea/vomiting
- ❑ dizziness/lightheadedness
- ❑ difficulty maintaining balance while walking
- ❑ weight loss/gain
- ❑ shortness of breath
- ❑ headaches
- ❑ changes in appetite
- ❑ fever/chills/sweats
- ❑ pain at night
- ❑ weakness/fatigue
- ❑ difficulty swallowing

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

- ❑ cancer (type)_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ asthma
- ❑ pacemaker inserted
- ❑ osteoporosis
- ❑ chemical dependency (i.e., alcoholism)
- ❑ rheumatoid arthritis
- ❑ stroke
- ❑ depression
- ❑ anemia
- ❑ lung problems
- ❑ thyroid problems
- ❑ other_____
- ❑ diabetes
- ❑ multiple sclerosis
- ❑ kidney/liver problems
- ❑ stomach ulcers
- ❑ epilepsy
- ❑ Parkinson's disease
- ❑ other_____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Do you smoke? Yes No _____ pack/day
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications:_____
Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**
ALLERGIES: _____ **Are you latex sensitive? Yes No**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

Pain at LOWEST: Rate you lowest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

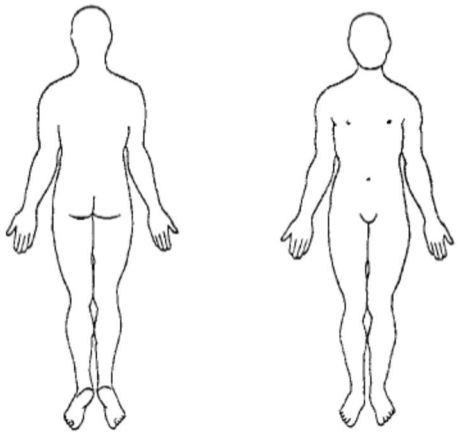
Pain at WORST: Rate your highest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning



List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. [Circle number below]**:**

_____ (ex. Stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

What is your goal for therapy at this time?_____

Patient Signature_____ **Date:**_____

(for office use only) Staff initials_____ **Date**_____

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ***Calibrate Sports*** to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____ Responsible Party Initials/date

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I agree to pay any applicable fees at the time of service as agreed between ***Calibrate Sports*** and me. I understand that **Calibrate Sports** does not accept insurance and that **I** am financially responsible for all fees for service. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, **I** will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, **I** authorize Calibrate Sports, to release all information necessary, including medical records, to secure payment.

_____ Responsible Party Initials/date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the ***Calibrate Sports*** Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to ***Calibrate Sports*** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and ***Calibrate Sports*** will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals whom ***Calibrate Sports*** may speak to regarding my treatment. Please list names.

spouse _____ father _____

mother _____ other _____

Listed below are individual(s) whom I request restriction regarding my protected health information.

☐ Not Applicable

☐ _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us?

☐ Yes: Home Mobile Work Other: _____

☐ No

_____ Responsible Party Initials/date

SIGNATURE for CONSENT

By my signature below I acknowledge that **I** have read, understand and agree to the terms and conditions contained in the ***Consent for Care and Treatment***, the ***Authorization*** to release all information necessary to secure payment and the ***Consent For Use and Disclosure of Health Information.***

Patient / Guardian/Responsible Party Signature: _____ **Date** _____

Notice of Privacy Practices
This notice describes how medical information about you may be used and disclosed and how you may have access to this information. If you have any questions about this Notice; please contact our Privacy Officer. Contact information is listed at the end of this notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail, via e-mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent
You will be asked by Calibrate Sports (CS) to sign a consent form. Once you have consented to use and disclose your protected health information for treatment, payment and health care operations, CS will use or disclose your protected health information as described in this notification. Your protected health information may be used and disclosed by your physical therapist, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of CS.

Following are examples of the types of uses and disclosures of your protected health care information that CS is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose protected health information to physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physical therapist has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider who, at the request of your physical therapist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of CS . These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students or volunteers that see patients at our office. We may call you by first name only when in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, cancellation or absence from an appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physical therapist or CS has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted & Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object
We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physical therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physical therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physical therapist or another physical therapist in the practice is required by law to treat you and the physical therapist has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physical therapist or another physical therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physical therapist determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse and Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physical therapist created or received your protected health information in the course of providing care to you.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physical therapist, referring physician and CS uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

CS is not required to agree to a restriction that you may request. If your physical therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If CS does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physical therapist and indicate this information on the CS Consent For Use and Disclosure of Health Information form.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to a front desk staff member.

You may have the right to have CS amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have any questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after **April 14, 2003.** You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us. If you received this notice on our website or via e-mail, you are still entitled to request a paper copy of this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. All complaints shall be investigated without repercussion to you. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer:
Chris Nissler
2516 W Main St.
Littleton, CO 80120
720-744-0777
chris@calibratesports.com

This notice was published and becomes effective on **April 1, 2016**.