LEVELLAND PHYSICAL THERAPY

Patient Information Record

1. Name: _____
2. Date of onset of symptoms: _____
3. Have you had surgery for this condition? Yes / No Date of Surgery: _____
4. What caused your symptoms? _____
5. What is your biggest complaint? _____
6. What activities could you do before, that you cannot do now due to your condition? _____
_____
7. Which activities make your symptoms worse? _____
8. Which activities make your symptoms better? _____
9. Overall, is your condition becoming worse, better, or staying the same? _____
10. Do your symptoms change throughout the day? Yes / No
11. Have you had similar episodes before? Yes / No
12. What other health care practitioners have you seen for this condition?_____
_____
13. What diagnostic tests have you had for this condition (x-rays, MRI, nerve study, etc)? _____
_____
14. What is your goal for physical therapy? _____

Medical History

1. What medications are you currently taking? _____
_____
2. What allergies do you have? _____

3. Do you have (or have you had) any of the following health conditions?

Osteoarthritis	Yes No	High Blood Pressure	Yes No
Rheumatoid Arthritis	Yes No	Heart Disease	Yes No
Back/Neck Pain	Yes No	Poor Circulation	Yes No
Osteoporosis	Yes No	Chest Pain	Yes No
Broken Bones	Yes No	Shortness of Breath	Yes No
Sleeping Difficulties	Yes No	Vision Difficulties	Yes No
Cancer	Yes No	Dizziness/Loss of Balance	Yes No
Diabetes	Yes No	Severe/Frequent Headaches	Yes No
Weakness	Yes No	Pain at Night	Yes No
Weight Gain/Loss	Yes No	Stroke/TIA	Yes No
Asthma	Yes No	Numbness/Tingling	Yes No
Bronchitis	Yes No	Bowel/Bladder Problems	Yes No
Seizures	Yes No	Loss of Appetite	Yes No
Depression/Anxiety	Yes No	Are you pregnant?	Yes No
Do you have a pacemaker?	Yes No	Do you smoke?	Yes No

4. What other health conditions do you have? _____
5. What surgeries have you had? _____
_____

Patient Signature: _____ Date

Clinician Signature: _____ Date

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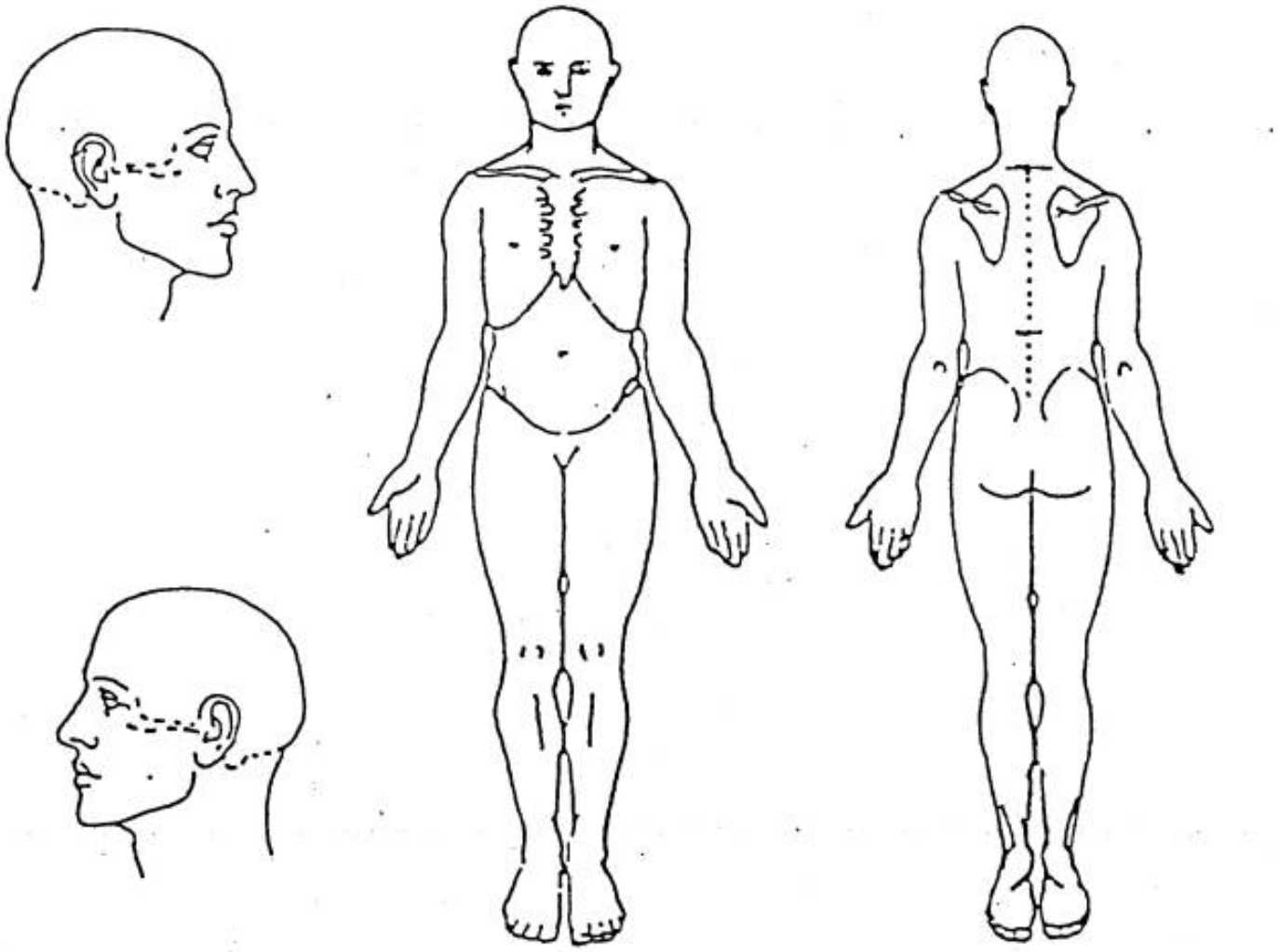
Please mark on this diagram where you are having most of your pain or other symptoms.



Please mark of the following scale how bad your pain is most of the time:

1	2	3	4	5	6	7	8	9	10
No Pain									Worst Pain

Patient Name:_____ Date:_____

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Patient Functional Questionnaire

Please list 3-5 activities that you have the most difficulty performing because of your injury/condition. Please rate your level of difficulty on the scale below each question.

1._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

2._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

3._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

4._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

5._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

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Consent for Treatment and Authorization

I,_____authorize Levelland Physical Therapy and its staff to perform the physical therapy treatments ordered by my referring physician. I have been informed of the reasons for treatment/procedures along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved. I also certify that no guarantee or assurance has been made as to the results or outcomes that may be obtained.

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider who referred me here. I request that payment of any insurance or other benefits be made directly to Levelland Physical Therapy on my behalf for any services provided by me. I authorize the holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third party payer, state medical assistance agency, or any other governments private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer or insurance company.

I understand that any co-payment/deductible and or co-insurance is due and payable at time of service.

Signature of Patient/Guardian:_____ Date:_____

Relationship to Patient:_____

Signature of Representative:_____Date:_____

LEVELLAND PHYSICAL THERAPY

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

Your confidential healthcare information may be released (on a need to know basis only) to:

- **Other healthcare professionals or other treating physicians for the purpose of providing you with quality healthcare;**
- **Your insurance carrier and/or treating vendor for the purpose of the practice receiving payment for providing you with needed healthcare services;**
- **Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence;**
- **Other healthcare providers in the event you need emergency care;**
- **A public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication);**
- **Certain parties only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.**

You may be contacted by Levelland Physical Therapy to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. If you are not home and/or unavailable, we may leave appointment information on your answering machine or in a message left with the person answering the phone.

We may use and disclose limited protected health information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

You have the right to restrict the use of your confidential healthcare information. However, Levelland Physical Therapy may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.

You have the right to receive confidential communication about your health status.

You have the right to review any/all portions of your healthcare information upon written request within the timeframes set by law.

You have the right to request changes be made to your healthcare information.

You have the right to know if certain parties have accessed your confidential healthcare information and for what purpose.

You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.

Levelland Physical Therapy is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients, upon request, a list of duties or practices that protect confidential healthcare information.

Levelland Physical Therapy will abide by the terms of this notice. The practice reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Any changes to this notice will be posted in our practice within 30 days of making any changes.

You have the right to file a complaint with Levelland Physical Therapy if you believe your rights to privacy have been violated; please mail your complaint to the facility's address at 5217 82nd St., Suite 104, Lubbock, TX 79424, in care of Spencer McCombs, Privacy Officer.

All complaints will be investigated. No personal issue will be raised for filing a complaint. For further information about this Privacy Notice, please contact: Spencer McCombs, Privacy Officer at 806-687-4311. Notice effective 4/17/2012.

LEVELLAND PHYSICAL THERAPY

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that Levelland Physical Therapy has the right to change the Notice of Privacy Practices from time to time and that I may contact Levelland Physical Therapy at any time to obtain a current copy of the Notice of Privacy Practices.

Signature of Patient/Guardian:_____Date:_____

Relationship to Patient:_____

Protected Health Information (PHI) Release Authorization

Persons who are involved in your care (spouse, children, friends, etc.) may inquire about your treatment, appointments, billing, medical records, etc. Please let us know below whom we may share your PHI with:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

PLEASE NOTE THAT LEVELLAND PHYSICAL THERAPY WILL ONLY RELEASE PHI TO THE INDIVIDUALS LISTED ABOVE

I_____ acknowledge in signing this document that I am giving Levelland Physical Therapy authorization to release or discuss PHI either in writing or verbally to the Persons specified above. This authorization is good indefinitely from the signature date below unless otherwise revoked by me in writing and a copy placed in my records at Levelland Physical Therapy.

Signature of Patient/Guardian:_____Date:_____

Relationship to Patient:_____

Revised 09/07