PATIENT INFORMATION

PATIENT DEMOGRAPHICS / INFORMATION

DATE: ______________

LAST NAME: ______________________________ FIRST NAME: ______________________

MIDDLE INT: ________ *NICKNAME: ____________________________ MALE / FEMALE

ADDRESS: ____

APT NUMBER: ________ CITY: ______________________ STATE: ______ ZIP: ________

EMPLOYER: ____

HOME PHONE: (_____) ______________ WORK PHONE: (_____) ______________ Ext: ______

*ALTERNATE PHONE: (_____) ______________ SOCIAL SECURITY NUMBER: _____ - ____ - _____

DATE OF BIRTH: _____ / _____ / _____ AGE: ______ MARITAL STATUS: M / D / S / W

EMAIL: ____________________________ REFERRING DOCTOR: ______________________

WAS THIS INJURY: _____ AUTO RELATED _____ EMPLOYMENT _____ OTHER

EMPLOYER INFORMATION / WORKERS COMP

EMPLOYER NAME: ____

ADDRESS: ____

____

____

EMPLOYER PHONE: ____

SUPERVISORS NAME: ____

DATE OF INJURY: ____

PATIENT HEALTH QUESTIONNAIRE

DATE: ____________________ NAME: ____________________

CURRENT SYMPTOM HISTORY

DESCRIBE YOUR SYMPTOMS: ____________________

HOW DID SYMPTOMS BEGIN? ____________________

DATE SYMPTOMS BEGAN: ________/ ________/ ________

NATURE OF SYMPTOMS:

- ☐ SHARP
- ☐ DULL ACHE
- ☐ NUMB
- ☐ SHOOTING
- ☐ BURNING
- ☐ TINGLING

HOW OFTEN ARE SYMPTOMS EXPERIENCED?

- ☐ CONSTANTLY (76-100% OF DAY)
- ☐ FREQUENTLY (51-75% OF DAY)
- ☐ OCCASIONALLY (26-50% OF DAY)
- ☐ INTERMITTENTLY (0-25% OF DAY)

HOW ARE YOUR SYMPTOMS CHANGING?

- ☐ GETTING BETTER
- ☐ NOT CHANGING
- ☐ GETTING WORSE

DURING PAST 4 WEEKS, INDICATE INTENSITY OF SYMPTOMS:

None — Unbearable

0 1 2 3 4 5 6 7 8 9 10

DURING PAST 4 WEEKS, HOW MUCH HAS PAIN INTERFERED WITH YOUR NORMAL WORK?

☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

DURING PAST 4 WEEKS, HOW MUCH HAS YOUR CONDITION INTERFERED WITH SOCIAL ACTIVITIES?

☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

IN GENERAL, HOW WOULD YOU SAY YOUR OVERALL HEALTH IS RIGHT NOW?

☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

DO YOU USE A? (CHECK ALL THAT APPLY)

☐ CANE ☐ WALKER/ROLLING WALKER/ROLLATOR ☐ MANUAL WHEELCHAIR ☐ MOTORIZED WHEELCHAIR

☐ OTHER ____________________

WHO HAVE YOU SEEN FOR YOUR SYMPTOMS?

☐ NO ONE ☐ CHIROPRACTOR ☐ MEDICAL DOCTOR ☐ PHYSICAL THERAPIST ☐ OTHER ____________________

What treatment did you receive and when? ____________________

What tests did you have and when?

☐ XRAYS date: ____________________ ☐ MRI date: ____________________ ☐ CT SCAN date: ____________________

☐ Other date: ____________________

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? ☐ YES ☐ NO

If yes, who did you see?

☐ THIS OFFICE ☐ CHIROPRACTOR ☐ MEDICAL DOCTOR ☐ PHYSICAL THERAPIST ☐ OTHER ____________________

PAST MEDICAL HISTORY

LIST ALL HEALTH PROBLEMS, HOSPITALIZATIONS, SURGERIES AND ALLERGIES:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A LIST TO YOUR THERAPIST:

ARE YOU A DIABETIC? ☐ YES ☐ NO
IF YES, FOR HOW LONG? ______

DO YOU HAVE A PACEMAKER? ☐ YES ☐ NO

ARE YOU PREGNANT? ☐ YES ☐ NO
IF YES, HOW MANY MONTHS? ______

PLEASE LIST OTHER PHYSICIANS WHO ARE TREATING YOU AND FOR WHAT CONDITIONS?

DEMOGRAPHIC INFORMATION

WHERE DO YOU LIVE?

☐ PRIVATE HOME ☐ PRIVATE APT. ☐ RENTED ROOM ☐ BOARD AND CARE/ASSISTED LIVING/GROUP HOME
☐ HOMELESS(WITH OR WITHOUT SHELTER) ☐ LONG-TERM CARE FACILITY ☐ HOSPICE ☐ OTHER ______

WHO DO YOU LIVE WITH? (CHECK ALL THAT APPLY)

☐ ALONE ☐ SPOUSE/SIGNIFICANT OTHER ☐ CHILD/CHILDREN ☐ OTHER RELATIVE(S)
☐ GROUP SETTING ☐ PERSONAL CARE ATTENDANT ☐ OTHER ______

WHAT IS YOUR OCCUPATION?

☐ PROFESSIONAL/EXECUTIVE ☐ FT STUDENT
☐ WHITE COLLAR/SECRETARIAL ☐ RETIRED
☐ TRADESPERSON ☐ OTHER
☐ LABORER ☐ UNEMPLOYED
☐ HOMEMAKER

EMPLOYMENT/WORK STATUS (CHECK ALL THE APPLY)

☐ FULL-TIME, OUTSIDE HOME ☐ FULL-TIME, IN HOME
☐ PART-TIME, OUTSIDE HOME ☐ PART-TIME, IN HOME
☐ SELF-EMPLOYED ☐ OTHER
☐ WORKING WITH MODIFICATION BECAUSE OF CURRENT ILLNESS/INJURY
☐ NOT WORKING BECAUSE OF CURRENT ILLNESS/INJURY

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND ACCURATE

SIGNATURE: ______

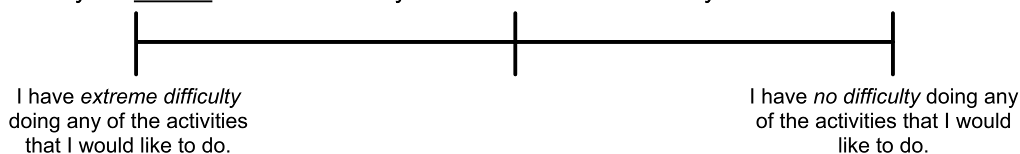
DATE: ______

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* of the activities you would like to do, please mark an “X” at the point on the line that best describes your *overall* level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 12 2. 8 3. 13*)

1.____ 2.____ 3.____

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Confidence–Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	**Fully confident in my ability to perform**	**Very confident**	**Moderate confidence**	**Some confidence**	**Not confident in my ability to perform**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* the activities you like to do, please mark an "X" at the point on the line that best describes your *overall* level of confidence in performing these activities today:

I have *no confidence* that I can do activities that I would want to do.

I have *complete confidence* that I can do activities that I would want to do.

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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.

1. About Protected Health Information—"PHI".

In this Notice, "We," "Our" or "Us" means Greater Therapy Centers and Our workforce of employees and volunteers. "You" and "Your" refers to each of Our patients who is entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of Your health information. For example, federal health information privacy regulations require Us to protect health information about You in the manner that We describe here. Certain types of health information may specifically identify You. Because We must protect this health information, We call this Protected Health Information--or "PHI." In this Notice, We tell You about:

- How We use Your PHI
- When We may disclose Your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or with a complaint

2. Some of the ways We use or disclose Your Protected Health Information.

We will use Your PHI to treat You. We will use Your PHI and disclose it to get paid for Your care. We are allowed to use, or disclose Your PHI for certain activities that We call "health care operations." Health care operations involve a lot of the administration, education and quality assurance activities in Our hospital. We will give You examples of each of these to help explain them, but space does not permit
a complete list of all uses or disclosures. That is one reason why You can contact Us and ask Us questions.

<u>Treatment</u>
We use and disclose Your PHI in the course of Your treatment. For example, if You need to be referred to another healthcare provider, We may send Your treatment notes to the Physician.

<u>Payment</u>
After We treat You, We will ask Your insurer to pay Us. We may type some of Your PHI into Our computers and send a claim to Your Insurer. Here, We use Your PHI to tell Your insurer what type of health problem You had and what We did to treat You. Your insurer may ask Us to give them Your membership number in Your employer's health plan, or Your insurer may want to review Your medical record to be sure that Your care was necessary. When We use and disclose Your PHI this way, it helps Us to get paid for Your care and treatment.

<u>Health Care Operations</u>
We also use and disclose Your PHI in Our health care operations. For example, Our therapists meet periodically to study medical records to monitor the quality of care in Our facility. Your medical record and PHI could be used in these quality assessments. Sometimes, We train students in Our facility and use the PHI of real patients to test them on their skills. Other operational uses or disclosures may involve business planning for Our facility, or the resolution of a complaint.

<u>Special Uses</u>
We also use or disclose Your PHI for purposes that involve Your relationship to Us as a patient. We may use or disclose Your PHI to:

- Remind You that You have an appointment with Us for treatment.
- Tell You about treatment alternatives and options.
- Tell you about Our other health benefits and services.

<u>Your Authorization May Be Required</u>
In many cases summarized here, We may use or disclose Your PHI either with Your consent or as required or permitted by law. In all other cases, We must ask for, and You must agree to give, a written authorization that has specific instructions and limits on Our use or disclosure of Your PHI. If You later change Your mind, You may revoke Your authorization.

3. Certain Uses and Disclosures of Your PHI that are Required or Permitted by Law.

Many laws and regulations apply to Us that affect Your PHI. These laws and regulations may either require Us or permit Us to use or disclose Your PHI. From the federal health information privacy regulations, here is a list describing required or permitted uses and disclosures.

- If You do not verbally object, We may share some of Your PHI with a family member or friend who is involved in Your care.
- We may use Your PHI in an emergency when You are not able to express Yourself.
- If We receive certain assurances that protect Your privacy, We may use or disclose Your PHI for research.

We may also use or disclose Your PHI:

- When required by law for example, when ordered by a Court to turn over certain types of Your PHI, we must do so.
- For public health activities such as reporting a communicable disease or reporting an adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To the government regulators or its agents to determine whether We comply with applicable rules and regulations.
- In judicial or administrative proceedings such as in response to a valid subpoena.
- When properly requested by law enforcement officials (such as reporting gun shot wounds), or for other legal requirements.

If We reasonably believe that to do so will avert a health hazard or to respond to a threat to public safety such as an imminent crime against another person.

- If You are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

4. Certain Stricter Requirements that We Follow.

Several state laws may apply to Your PHI that set a stricter standard than the protections required by the federal health privacy regulations. Stricter state law in Texas will, for example, limit Us from using or disclosing:

- PHI regarding individuals who are the subject of HIV related information, We may not use or disclose such HIV information except to You, Your doctor, Your insurer and a small number of additional persons without Your express written consent.
- Records that contain alcohol and drug abuse information without Your consent or a court order if the treatment program is funded by state or local government.
- Your records without Your consent or a court order if they contain information relating to inpatient mental health treatment or involuntary outpatient mental health treatment. There may be exceptions for certain government officials.

5. Your Privacy Rights and How to Exercise Them.

You have specific rights under Our federally required privacy program. Each of them is summarized here.

Your Right to Request Limited Use or Disclosure
You have the right to request that We do not use or disclose Your PHI in a particular way. However, We are not required to abide by Your request. If We do agree to Your request, We must abide by the agreement.

Your Right to Confidential Communication
You have the right to receive confidential communications from Us at a location that You provide. We require that You make Your request in writing, provide us with the other address, and explain to Us if the request will interfere with Your method of payment for Your care.

Your Right to Revoke Your Consent or Authorization
If You have granted Us Your consent or authorization to use or disclose Your PHI, You may revoke the consent or authorization in writing. However, if We have relied on Your consent or authorization, we may use or disclose Your PHI to that extent.

Your Right to Inspect and Copy
You have the right to inspect and copy Your PHI. We may refuse to give You access to Your PHI if We think it may cause You harm but We have to explain why and give You someone to contact about Our decision who will how and when to get a review of Our refusal.

Your Rights to Amend Your PHI
If You disagree with what Your PHI in Our records says about You, You have the right to request in writing that We amend Your PHI when it is in a record that We create or have maintained for Us. We are not required to respond to Your request if the records You are asking about are not Our records. We may refuse to make Your requested amendment. Then, You will have a right to submit a written statement about why You disagree. If We still disagree, We may prepare a counter-statement. Your statement and Our counter-statement must be made part of Our record about You.

Your Right to Know Who Else Sees Your PHI
You have the right to request an accounting of certain disclosures that We have made of Your PHI over the past six years. You cannot ask for disclosures before April 14,2003. We do not have to account for all disclosures, including those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting but there may be for additional accountings. We will tell You if there is a charge for Your accounting and You will have the right to withdraw Your request, or to pay to proceed.

Your Rights to Complain
If you believe that Your privacy rights have been violated, You have the right to make a complaint to Us, or to the Secretary of Health and Human Services. We will not retaliate against You if You file a complaint about Us. To file a complaint, You should submit it in writing to the contact person identified in this Notice (7, below). Your complaint should provide a reasonable amount of specific detail to enable Us to investigate a potential problem.

6. Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require Us to protect Your PHI. Those rules also require Us to give You Notice of Our privacy practices. This document is Our Notice. If You did not get a paper copy of this Notice, You may have one. We will abide by the privacy practices set forth in this Notice. However, We reserve the right to change this Notice and Our privacy practices when permitted or as required by law.

If We change Our Notice of privacy practices, We will provide Our revised Notice to You when You next seek treatment from us. You may also obtain Our most recent Notice from Our web site.

7. Contact Information

If You have questions about this Notice, or if You have a complaint, please contact:

Name: Dena Aitken
Title: Vice President
Address: 966 N. Garden Ridge, Suite 530
Lewisville, TX 75077
Phone: 972.420.6605

8. Effective Date

This Notice takes effect on April 14, 2003.

Cancellation & No-show Fee Policy Acknowledgement

As a courtesy to our staff and other patients receiving care at this clinic, we require that you keep scheduled appointments.

If you are unable to attend a scheduled appointment, please call and cancel at least two (2) hours prior to the appointment. This can be done by calling the clinic that you attend for treatment.

You may leave a cancellation message on the clinic's voicemail if cancellations are required during the weekend or holidays.

Otherwise, cancellations should be called in during regular business hours.
(**Check with your treating facility for business hours**)

Failure to cancel the appointment appropriately will result in the assessment of a no-show fee. This fee is due at your next appointment.

The No-show appointments and cancellations of less than two (2) hours fee is as follows:

- $15 for each incidence

Greater Therapy Centers, Inc. will take extraordinary circumstances into consideration on a case by case basis.

We thank you for choosing Greater Therapy Centers, Inc. to serve you for your physical/occupational therapy needs.

Arlington	Carrollton	Lewisville	McKinney	Plano	Trinity
3330 Matlock Road	3423 Trinity Mills Road	966 North Garden Ridge	2309 Virginia Parkway	3501 Midway Road	4323 N. Josey Lane
Suite 206	Suite 520	Suite 530	Suite 400	Suite 198	Suite 307
Phone - 817.472.8383	Phone - 972.662.1700	Phone - 972.420.6605	Phone - 972.542.7360	Phone - 972.781.2322	Phone - 972.492.9451
Fax - 817.472.8386	Fax - 972.662.0967	Fax - 972.436.2770	Fax - 972.542.7363	Fax - 972.781.2373	Fax - 972.492.9478

WWW.GREATERTHERAPYCENTERS.COM

CONSENT FOR TREATMENT

HIPAA ACKNOWLEDGEMENT

CONSENT FOR TREATMENT AND ADMISSION:

I agree to be admitted to GREATER THERAPY CENTERS, Inc. as an outpatient, and authorize the therapy staff to evaluate and treat within the scope of physical and occupational therapy practice as ordered by the referring physician. Initials ___________

RELEASE OF INFORMATION:

I hereby authorize GREATER THERAPY CENTERS, Inc. to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment. Initials ___________

WORKER'S COMPENSATION PATIENTS RELEASE OF INFORMATION:

I authorize GREATER THERAPY CENTERS, Inc. to discuss/forward any relevant vocational information, as related to my rehabilitation, with my worker's compensation/group insurance carrier/external case manager. Initials if applicable _________

ASSIGNMENT OF BENEFITS:

I hereby assign all of my right, title, and interest to GREATER THERAPY CENTERS, Inc. of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of GREATER THERAPY CENTERS, Inc.'s customary charges for the services provided.
Initials ___________

FINANCIAL AGREEMENT:

I, the undersigned, assume financial responsibility for the payment of all charges at the time of service unless covered under worker's compensation, Medicare, or a specific insurance carrier. Insurance carriers will be billed directly by GREATER THERAPY CENTERS, Inc. All deductibles, co-insurance portions, including non-covered services are my financial responsibility. Any account not paid will be referred to a third party collection agency to include all reasonable collection fees, not limited to attorney fees, investigative fees, and court costs.

I understand the physician charges are billed separately. Inquiries regarding physician charges should be directed to my physician.
Initials ___________

Cancellation/No-show Fee Policy:

I acknowledge that I have read and received a copy of the Cancellation/No-show fee policy of GREATER THERAPY CENTERS, Inc. and agree to its terms. Initials ___________

HIPAA ACKNOWLEGEMENT:

I___________________________________, have received the Privacy Notice of GREATER THERAPY CENTERS, Inc.'s on today's date.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient and his/her agent to execute the above and accept its terms. If patient's condition prohibits written consent, agent who is present when verbal consent is given should sign patient's name by agent's name. If patient is unable to consent or is a minor, complete the following:

If patient is a minor, how many years of age? ________

If patient is unable to give his/her consent, why?____

_______________________________________ _____________________
Patient/Relative/Authorized Agent Signature Date

____
Relationship to Patient (if signature is not the patient's)

____
Witness Signature