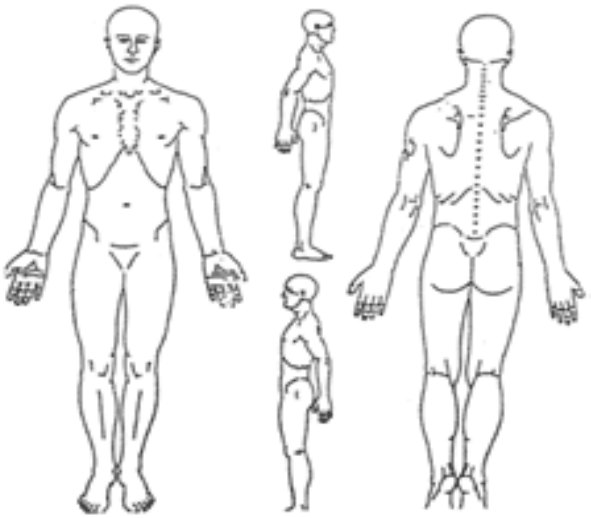
PHYSICAL THERAPY INNOVATIONS

PAIN SCALE

1. Please rate your pain with **0 as No Pain** and **10 as Unbearable** for:

   Pain at its WORST _____
   Pain at its BEST _____
   Pain CURRENTLY (TODAY) _____

Indicate where you have pain on the diagram



2. **How often do you experience your symptoms?**
   - Constantly (76-100% of the day)
   - Frequently (51-75% of the day)
   - Occasionally (26-50% of the day)
   - Intermittently (0-25% of the day)

3. **Type of Pain:**
   - Sharp
   - Shooting
   - Dull Ache
   - Numb
   - Burning
   - Tingling

4. **How are your symptoms changing?**
   - Getting Better
   - Not Changing
   - Getting Worse

5. **When did your symptoms begin?**
   _____
   _____

6. **How did your symptoms begin?**
   _____
   _____

7. **What tests have you had for your symptoms and when were they performed?**
   - **X-RAYS**: date taken: _____
   - **MRI**: date taken: _____
   - **CT SCAN**: date taken: _____
   - **OTHER:** date taken: _____

9. **Have you received Physical Therapy treatment this year?** YES NO

10. **If so how many visits:**_____

    For what diagnosis: _____

11. **Who have you seen for your current symptoms?**
    - No One
    - Chiropractor
    - Medical Doctor
    - Physical Therapist
    - Other

12. **What is your occupation?**
    _____

13. **What sports, exercise, or physical activities do you regularly participate in?**
    _____
    _____
    _____

Patient Name:_____

Date: _____

Medical History

Name:_____ Date:_____

1. Do you currently or have you ever had any of the following **Health Issues**? ***PLEASE CHECK ALL THAT APPLY***.

- ☐ Cancer (List Type or Location) _____
- ☐ Diabetes
- ☐ Heart Attack/Heart Disease
- ☐ Cardiac Pace Maker
- ☐ Stroke
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Infectious Disease (describe): _____
- ☐ Seizures/Epilepsy/Fainting
- ☐ Osteoporosis or Osteopenia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pregnancy (Current or Possible)
- ☐ Liver Disease
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Tobacco Use
- ☐ Stomach Issues / GERD
- ☐ Kidney Problems
- ☐ Bowel or Bladder Dysfunction
- ☐ Circulatory Problems or Blood Clots
- ☐ Bleeding Disorder/Blood Thinners
- ☐ Arthritis (Please list type or area) _____
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Cerebral Palsy
- ☐ Muscular Dystrophy
- ☐ Alcohol or Drug Abuse
- ☐ Alzheimer's or Dementia
- ☐ Depression or Anxiety
- ☐ Other (describe): _____ _____

2. Do you have any **Allergies**? Please Circle Yes or No If so please list:_____
How do you treat a reaction:_____

3. Please describe any and all **Surgical Procedures or Traumas** you have had that required medical treatment. Details such as dates of surgeries or hospitalizations are helpful to include:

_____
_____
_____
_____

3. Please list any and all **Medications** you take on a regular basis including over the counter meds or supplements:

_____
_____
_____
_____

4. Please list any **Physical Therapy, Occupational Therapy, Chiropractic or Massage Therapy** that you have received in the past with approximate dates and what conditions were or are currently treated:_____

_____
_____

5. Please describe how you spend your **Workday** (sitting at a desk, standing, driving, manual labor, climbing, etc.):

_____
How long is your commute to work (minutes): _____ How many hrs a day do you sit at a desk:_____
(*If you do not work, please describe your typical day's tasks or activities, i.e. household chores, child care, etc.)*

6. Please list any **Other** past or current health information we should know: _____

_____
_____

PHYSICAL THERAPY
INNOVATIONS

Patient Name: _____ Date: _____/_____/_____

Please indicate any medications you are currently taking, why you take those medications, any surgeries or medical issues (past or present), and any previous physical therapy you have had in the columns below:

Current Medications	Reason(s) for Medications	Surgeries/Medical Issues	Previous Physical Therapy

PHYSICAL THERAPY INNOVATIONS
489 Washington Street, Suite 200
Auburn, MA 01501
508.721.0000

PRACTICE AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

By signing, I authorize **Physical Therapy Innovations, Inc.** to obtain or release certain protected health information (PHI) about me from or to the following:

PTI to Obtain ☐ **PTI to Release** ☐

Name: Address: Phone #:

_____

_____

_____

If PTI is given authorization to release your PHI to the indicated name(s) above, please provide the relationship to the patient: (1) _____ (2) _____ (3) _____.

I request the following **restrictions** to be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

_____

I have the right to revoke this authorization in writing, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Physical Therapy Innovations, Inc.
489 Washington Street, Suite 200
Auburn, MA 01501
508.721.0000

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Patient's Name — Date

_____
Print Name of Legal Guardian, if applicable

Effective October, 2011

CONDITIONS AND CONSENT FOR PHYSICAL THERAPY

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial evaluation concerning the treatment and options available for my condition.

Potential Benefits: These may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential Risks: I understand I may experience an increase in my current level of pain and discomfort, or an aggravation of my existing injury. This discomfort is usually temporary. If it does not subside within 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist at Physical Therapy Innovations, Inc. cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her/his opinions regarding potential results from physical therapy treatment for my condition and will discuss treatment options with me.

Alternatives: If I do not wish to participate in physical therapy, I will discuss my medical, surgical, or pharmacological alternatives with my physician.

I have read the above information and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood, and will abide by the conditions and policies noted on this consent form.

☐ (Check if Applicable) **Consent to treat a minor –** I the parent/guardian of _____ authorize PTI to treat the minor patient named above while I am not present.

_____	_____	_____
PRINTED PATIENT NAME	**PATIENT/PARENT/GUARDIAN SIGNATURE**	**DATE**

_____	_____
THERAPIST SIGNATURE	**DATE**

PHYSICAL THERAPY INNOVATIONS
Trusted for our reputation. Chosen for our care.

Physical Therapy Innovations

(hereinafter referred to as "PTI")

Patient's General and Emergency Contact Information Sheet

Please complete this form by affixing a check mark at each applicable section to indicate acceptable manner(s) in which PTI can contact you.

☐ In case of an emergency I authorize PTI to contact _____

at (_____) _____-_____. My relationship to contact is: _____.

I wish to be contacted by PTI in the following manner (please check each applicable section that indicates an acceptable manner(s) in which PTI can contact you):

☐ Please contact me on my home telephone: (_____) _____-_____.

- ☐ PTI can leave their name and phone number only when they call.
- ☐ PTI can leave a detailed message when they call.

☐ Please contact me by voice or text on my cellular phone: (_____) _____-_____.

- ☐ PTI can leave their name and phone number only when they call or text.
- ☐ PTI can leave a detailed message when they call or text.

☐ Please contact me at work: (_____) _____-_____

- ☐ PTI can leave their name and phone number only when they call.
- ☐ PTI can leave a detailed message when they call.

☐ PTI can mail, email or text me communications such as a welcome letter, appointment reminders, newsletter or other information about future PTI sponsored events or programs.

- ☐ PTI can mail information to my home address or PO Box.
- ☐ PTI can mail information to my work address or PO Box.
- ☐ PTI cannot mail information to my home, work address or PO Box except statements of my account.
- ☐ PTI can send email messages such as appointment reminders or other at the following email address: _____. (Leave blank if you do not wish to be contacted via email.)
- ☐ PTI can send text messages such as appointment reminders or other at the following cellular number: (_____) _____-_____.

_____	_____	_____
Patient's Name (Please Print)	Signature of Patient, Parent or Legal Guardian	Date

PHYSICAL THERAPY
INNOVATIONS

FINANCIAL AGREEMENT

1. I understand that health insurances, worker's compensation, motor vehicle/personal injury and other third party payer policies are arrangements by and between insurance carriers and the subscriber. Furthermore, **I understand that it is my responsibility to be aware of the PHYSICAL THERAPY benefits available to me through my insurance carrier and that it is in my best interest to call my health insurance company to verify my individual benefits.** I understand that I am responsible for acquiring a prescription for physical therapy from my primary care physician (PCP) and/or referring physician. I also understand that I am responsible for securing a referral, pre-authorization and/or claim number from my health insurance carrier, worker's compensation carrier, and or motor vehicle/personal injury third party payor. **If this information is not provided to Physical Therapy Innovations, Inc. (hereinafter PTI) at the time of my first visit, I agree that I am responsible to pay out-of-pocket for the services rendered to me until such time the information (referral, claim number, pre-authorization, and prescription) is provided to PTI.**
2. I authorize the release of any and all medically necessary information to process all claims related to services rendered at PTI, **including but not limited to all relevant insurance companies, 3rd party administrators, PCP's and referring physicians**.
3. I authorize payment of medical benefits directly to PTI for professional services rendered.
4. I understand that payment for all services rendered to me is ultimately my individual responsibility.
   a. Co-payment and payments toward deductibles/co-insurances are due and payable at time of service.
   b. Any and all unpaid balances for professional services are due within 30 days of discharge from services at PTI.
5. **PTI requires a 24 hour cancellation notice. There is a $75.00 service fee for no-shows or cancellations without proper notice. This charge is not covered by your medical insurance and is billed directly to the patient and will be collected at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care. _____(patient initials).**
6. Your appointment may be cancelled and you may be charged for the cost of your treatment session, if you are more than 10 minutes late for your appointment.
7. There is a $35.00 returned check fee.
8. **If there are any changes to your health insurance benefits or carrier, it is your responsibility to notify and update PTI within 10 business days.**
9. If your injury is related to a motor vehicle accident, personal injury or a worker's compensation injury, it is your responsibility to inform PTI.
10. It is your responsibility to inform PTI if you have secondary insurance.

☐ **(Check if applicable) Consent to Financial Responsibility of a Minor**

I the parent/guardian of _____ authorize PTI to bill my insurance for treatment of minor patient named above while I am not present for the treatment.

I have read and agree with the provisions within PTI's financial agreement. I further acknowledge that all the information given, whether oral or written by me to Physical Therapy Innovations, Inc. is true.

_____ _____ _____

Signature of Patient | Signature of Responsible Party | Date

_____ _____

Signature of Authorized Clinic Representative | Date

PHYSICAL THERAPY INNOVATIONS
Trusted for our reputation. Chosen for our care.

Notice of 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.

Our Obligation to You

We collect information from you and use it to provide you with quality care, and to comply with certain legal requirements. We are required by law to maintain the privacy of your health information, and to give you this Notice of our legal duties, our privacy practices, and your rights. We are required to follow the terms of our most current Notice. When we disclose information to other persons and companies to perform services for us, we will require them to protect your privacy. There are other laws we will follow that may provide additional protections, such as laws related to mental health, alcohol and other substance abuse, and communicable disease or other health conditions.

How We May Use and Disclose Your Health Information

Treatment: We may use and disclose your health information to provide treatment or services, to coordinate or manage your health care, or for medical consultations or referrals. We may use and disclose your health information among all personnel who are involved in taking care of you at our facilities or with such persons outside our facilities. We may use or share information about you to coordinate the different services you need. We may disclose information about you to people outside our facilities who may be involved in your care after you leave. We may give information to your health plan or another provider to arrange a referral or consultation.

Payment: We may use and disclose your health information so that we can receive payment for the treatment and services that were provided. We may contact and share this information with your insurance company to verify eligibility, benefits, and authorizations needed to process billing information. If you pay for your health care entirely out-of-pocket, you may request that we not share your information with your insurance company. We may disclose information to third parties who may be responsible for payment. We may disclose information to third parties that help us process payments.

Healthcare Operations: We may use and disclose your health information as necessary to operate our facilities and make sure that all of our patients receive quality care. We may use health information to improve our performance or to evaluate the competence of our health care professionals. We may use your health information to decide what additional services we should offer. We may disclose information to students and professionals for review and learning purposes. We may combine our health information with information from other health care facilities to compare how we are doing and see where we can make improvements. We may use health information for business planning. We may remove health information that identifies you so that others may use the de-identified information to study health care and health care delivery without learning who you are.

Health Information Exchanges: We may participate in health information exchanges to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes.

Appointment Reminders and Service Information: We may use or disclose your health information to contact you to provide appointment reminders or other health related services or benefits that may be of interest to you.

Individuals Involved in Your Care: We may give your health information to people involved in your care unless you ask us not to. We may give your information to someone who helps pay for your care. We may share your information with other health care professionals, government representatives, or disaster-relief organizations.

Fundraising Activities: We may use your name and other limited information to contact you, including the dates of your care, but not your treatment information, so that we may provide you with an opportunity to make a donation to our fund raising programs. If we do contact you for fundraising purposes, you will be told how you may ask us not to contact you in the future.

Research: We may use or disclose your health information for research that has been approved by one of our official research review boards, which has evaluated the research proposal and established standards to protect the privacy of your health information. We may use or disclose your health information to a researcher preparing to conduct a research project.

Organ and Tissue Donation: We may use or disclose your health information in connection with organ donations, eye or tissue transplants or organ donation banks, as necessary to facilitate these activities.

Public Health Activities: We may disclose your health information to public health or legal authorities whose official activities include preventing or controlling disease, injury, or disability. We may disclose health information to coroners, medical examiners, and funeral directors as allowed by the law to carry out their duties. We may use or disclose heath information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using. We may use or disclose health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.

Serious Threat to Health and Safety: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. We will only disclose health information to someone reasonably able to help prevent or lessen the threat, such as law enforcement or government officials.

Required by Law, Legal Proceedings, Health Oversight Activities, and Law Enforcement: We will disclose your health information when we are required to do so by federal, state and other law in such instances like abuse, neglect, or domestic violence. We will disclose your health information when ordered in a legal or administrative proceeding, such as a subpoena, discovery request, warrant, or summons. We may disclose health information to a law enforcement official to identify or locate suspects, fugitives, witnesses, victims of crime, or missing persons. We may disclose health information to a law enforcement official about a death we believe may be the result of criminal conduct, or about criminal conduct that may have occurred at our facility. We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure.

Specialized Government Functions: If you are in the military or a veteran, we will disclose your health information as required by command authorities. We may disclose health information to authorized federal officials for national security purposes. We may disclose health information to make medical suitability determinations for Foreign Service.

Correctional Facilities: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or law enforcement official. We may release your health information for your health and safety, for the health and safety of others, or for the safety and security of the correctional institution.

Workers Compensation: We may disclose your health information as required by applicable workers compensation and similar laws.

Uses and Disclosures Requiring Your Written Authorization

Other uses and disclosures of your health information not covered by this Notice, or the laws that govern us, will be made only with your written authorization. Sending marketing materials to you and the disclosure of highly confidential information are subject by law to requiring your written authorization. You may revoke your authorization in writing at any time, and we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you.

Your Privacy Rights Regarding Your Health Information

Right to Obtain a Copy of This Notice: We will post a copy of our current Notice in our facilities. To request a copy of our current Notice of Privacy Practices, please call 508-721-0000.

Right to See and Copy Your Health Record: You have the right to look at and receive a copy of your health record or billing record. You may be required to make your request in writing. If you would like a copy of your health record, a fee may be charged for the cost of copying or mailing your record, as permitted by law. We may deny your request, in writing, our reasons for the denial and explain your right to have the denial reviewed.

Right to Update Your Health Record: You have the right to request that we add an amendment to your record. Your request must be in writing, and it must contain the reason for your request. We may deny your request to amend your record if the information being amended was not created by us, if we believe that the information is already accurate and complete, or if the information is not contained in records that you would be permitted by law to see and copy. Even if we accept your amendment, we will not delete any information already in your records.

Right to Get a List of the Disclosures We Have Made: You have the right to request a list of the disclosures that we have made of your health information. The list will not contain disclosures from paper medical records that we have made for the purposes of treatment, payment and health care operations. It will not contain disclosures that were authorized by you, and certain other disclosures excluded by law. The list will not contain disclosures that were made before April 14, 2003. If your records are kept using electronic medical records, the list of disclosures will include those we have made for the purposes of treatment, payment and health care operations starting with all disclosures made after January 1, 2014. The list will be limited to disclosures for a three-year period prior to the date of your request. Your request must be in writing. The first list you request in a 12-month period is free. For additional lists, we may charge a fee, as permitted by law.

Right to Request a Restriction on Certain Uses or Disclosures: You have the right to request that we limit how we use and disclose your health information. We are legally required to accept certain requests to not disclose health information to your health plan for payment or healthcare operations purposes if you have paid in full out of your own pocket for the item or service. We are not legally required to accept any other request for a restriction, but we will consider your request. If we do accept it, we will comply with your request, except if you need emergency treatment. Your request must be in writing.

Right to Choose How You Receive Your Health Information: You have the right to request that we communicate with you in a certain way. We will try to honor your request if we reasonably can. Your request must be in writing, and it must specify how or where you wish to be contacted.

Changes to This Notice of Privacy Practices

We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in common areas throughout our clinics. You may also obtain any new notice by contacting our Privacy Officer.

Contact Person

If you believe your privacy rights have been violated, you may file a complaint in writing with the contact person listed below. We will take no retaliatory action against you if you file a complaint about our privacy practices. If you would like to file a complaint with us or with the Secretary of the Department of Health and Human Services, please contact our Privacy Officer listed below.

If you have questions about this Notice, or would like to exercise your Privacy Rights, please contact the facility where you received treatment, or contact our Privacy Officer, Colleen Friesl at 508.721.0000. You may also submit all complaints in writing to the Practice at Physical Therapy Innovations, Inc., 489 Washington Street, Suite 200, Auburn, MA 01501.