

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician 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.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight; Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement; Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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.

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.

Your physician is not required to agree to a restriction that you may request. If physician 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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may authorize certain parties the right to have access to your medical information (e.g., parents, spouses).

I authorize that _____ may have access to my medical information.

I also have the right to authorize that this access be terminated.

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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

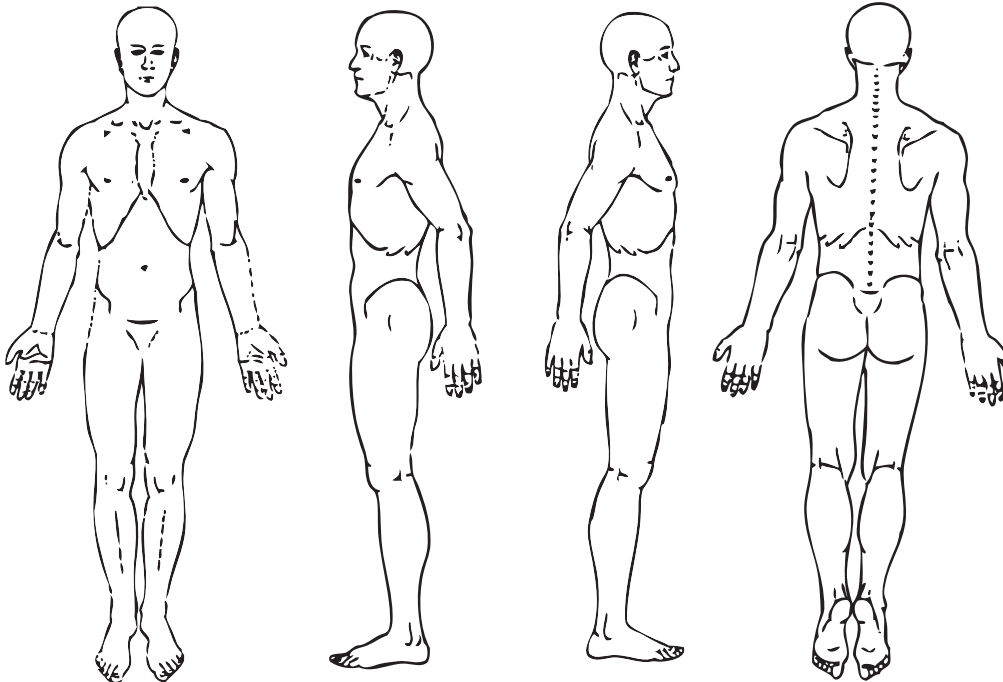
Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Name: _____

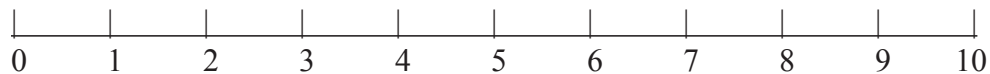
Instructions

1. On the diagram below, please indicate where you are experiencing your pain or altered sensation by labelling the affected areas. Use the letter key to the right and be as specific as possible.



- A -- Achiness**
- D -- Dull Pain**
- P -- Sharp Pain**
- B -- Burning Pain**
- T -- Tingling**
- N -- Numbness**
- S -- Stiffness**

2. On the pain scale below, please rate your **MAXIMUM** and **MINIMUM** pain over the past week. Zero (0) is no pain while ten (10) is maximum pain.



Is your pain constant? Yes _____ No _____

What increases your pain? _____

What decreases your pain? _____

Signature: _____ Date: _____

Name: _____

Instructions

Please date the first column and use this column to describe your ability to do the listed tasks (use the scale shown). Only fill in the areas that relate to your problem; leave areas blank that do not pertain to you. There are empty slots at the bottom of this sheet for any limitations not listed; if applicable, please fill them in and grade.

Scale:	
0	Unable to do
1	Significant limitation
2	Moderate limitation
3	Mild limitation
4	No limitation

Date	Date	Date	Date
_____	_____	_____	_____

Dressing/Grooming

Hair Care	_____	_____	_____	_____
Bathing	_____	_____	_____	_____
Dressing	_____	_____	_____	_____
On/Off Shoes/Socks	_____	_____	_____	_____

Static Postures

Sleeping	_____	_____	_____	_____
Sitting	_____	_____	_____	_____
Standing	_____	_____	_____	_____

Mobility

Turning Head (Driving)	_____	_____	_____	_____
Reaching Over Head	_____	_____	_____	_____
Bending Over	_____	_____	_____	_____
Squatting	_____	_____	_____	_____
Walking	_____	_____	_____	_____
Stairs	_____	_____	_____	_____
Sit to Stand	_____	_____	_____	_____
In/Out of Bed	_____	_____	_____	_____

Other

Gripping	_____	_____	_____	_____
Writing	_____	_____	_____	_____
Keyboarding/Mouse	_____	_____	_____	_____
Lifting With Arm	_____	_____	_____	_____
Lifting While Squatting	_____	_____	_____	_____
Running	_____	_____	_____	_____
Other Sports (e.g. Golf)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Personal Information

Name _____
 SSN _____
 Patient Birthdate _____ Male Female
 Patient Address _____
 Patient City/State/Zip _____
 Home Phone _____
 Cell Phone _____
 Email Address _____
 Marital Status M S W D
 Spouse's Employer _____
 If a Minor Child, Parents' Names _____

Occupation _____
 Employer _____
 Employer Address _____
 Employer City/State/Zip _____
 Work Phone _____
 Is it ok to call your workplace? Yes No
 Spouse's Name _____
 Spouse's Employer Address _____

Medical History

Allergies	Yes	No	Cancer	Yes	No	Headaches	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Heart Problems	Yes	No
Arthritis	Yes	No	Digestive Dis.	Yes	No	Numbness	Yes	No
Asthma	Yes	No	Dizziness	Yes	No	Sinus Problems	Yes	No

Do you smoke? Yes No If yes, # packs per week _____ # years _____
 Do you exercise regularly? Yes No Describe _____
 Do you have any metal implants? Yes No Describe _____
 Do you have a heart pacemaker? Yes No
 Have you ever had physical therapy? Yes No For what? _____
 Are you allergic to any medications? Yes No List _____

Please list any medications you are currently taking: _____

Please list all surgeries, major illnesses, and/or fractures and the year of their occurrence: _____

Family Physician: _____

In Case of Emergency

Notify _____ Relationship _____
 Phone Number (Home) _____ (Cell) _____ (Work) _____

I understand that the taking of history and the conducting of an examination are not considered treatment; rather they are part of the process of information gathering so the provider can determine whether to accept me as a patient. I have completed this form to the best of my knowledge and find the information to be true and accurate.

Patient's Signature _____ Date: _____

Guardian's Signature _____ Date: _____

Name: _____ **Date:** _____

Date symptom/s started: _____

Describe the reason for this appointment, or how the injury started: _____

Have you had the same or similar condition before? Yes _____ **No** _____

If yes, please describe: _____

Your situation is: Improving _____ **Getting Worse** _____ **Staying the Same** _____

Medical Intervention

What medication/s are you taking to control your symptoms: _____

How long have you been taking this medication(s): _____

Is it/Are they helpful? Yes _____ **No** _____

Have you seen a specialist for this condition? Yes _____ **No** _____

If yes, please list: _____

Have you had any diagnostic tests for this condition (e.g., x-ray, MRI, CAT scan, EMG)? Please list with approximate dates: _____

Have you had any cortizone injections to treat this condition? Yes _____ **No** _____

If yes, please provide the approximate dates: _____

Have you had previous rehabilitation or physical therapy for this condition? Yes _____ **No** _____

If yes, please provide approximate dates: _____

Do you use braces or assistive devices to improve your function or comfort? Yes _____ **No** _____

If yes, please describe: _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me -- not between my insurance company and your office. As a result, I authorize Full Potential Physical Therapy to release my medical information and to complete the usual and customary reports at no charge to me to obtain payment from my insurance company.

With a personal insurance claim, I agree to pay my bill on a per treatment basis until my deductible has been met if it has not been previously satisfied through other medical claims. I understand that a debit/credit card system of payment is available for my convenience. Once my deductible has been met, I agree to render my coinsurance payment on a per treatment basis. I understand these stipulations are common to any medical office as it relates to insurance and my portion of the cost to receive medical care. If my care is stopped by my physician or I decide to not continue with physical therapy, I agree to settle any unpaid balance on receipt of a statement unless other arrangements have been made.

If I have no insurance coverage, I understand that payment is due at the time of service unless other arrangements have been established between myself and Full Potential Physical Therapy.

In addition, I agree to pay for incidental costs at the time of issuance for therabands, pulleys, etc., to allow me to perform exercises at home.

CANCELLATION AND NO-SHOW POLICY

My scheduled appointment is a specific time when my therapist will work with me. It is imperative that I attend each appointment and be on time. My goal is to get better and the only way that can be accomplished is for me to attend therapy. Failure to attend these sessions may hinder my recovery process as well as disrupt the therapist's schedule.

If I am unable to keep my appointment, I will call to cancel with at least 24 hours notice or Full Potential Physical Therapy will charge me fifty dollars (\$50). A new patient who is scheduled and does not show up for their first appointment will be charged the cost of the appointment (\$105).

In addition, if there is a continued pattern of cancelled appointments or no-shows, I will be discharged from therapy. If I desire to continue rehabilitation, I will be required to obtain a new prescription from my physician.

Patient's Printed Name: _____

Patient's Signature: _____

Date: _____

Parent or Guardian's Signature (if patient is a minor): _____

Co-Insurance is an estimated amount calculated by our billing department according to your insurance benefits.

Patients may receive a monthly bill for additional Co-Insurance due if we have underestimated the amount after your insurance begins paying your claims. We will adjust your payment amount if necessary at that time.

This is a Full Potential Physical Therapy business policy done to relieve the possible financial burden to our patients of receiving large monthly statements. Your insurance deducts the Co-Insurance you owe from their payments to Full Potential Physical Therapy for your treatment. Since physical therapy is an on-going treatment, these unpaid portions due from patients can add up quickly.

Please understand that this is a service we provide to you. Many facilities do not do this and simply send a large monthly bill for Co-Insurance due in full in 30 days. We want you to be able to concentrate on your treatment and getting well quickly, not how you will pay your bill.

Thank you for your anticipated cooperation.

I have read and I understand the above information.

Patient Signature: _____

Date: _____

JUST A QUICK LITTLE SURVEY!!!

We are very grateful that you have chosen Full Potential to provide your physical therapy. Listed below are a few questions we'd like to ask to learn more about how to best meet our patients' needs.

1. Why did you choose Full Potential for your therapy?

- _____ Physician recommendation (physician's name: _____)
- _____ Family or friend's recommendation (please include their name -- they receive a \$5 coffee card for referring you! _____)
- _____ Found clinic on the Internet (which site? _____)
- _____ Chose our name from a list, phone book, etc. (please describe: _____)
- _____ Heard of our clinic from community activities (which one? _____)

2. What have you heard about our clinic?

- _____ Effective treatments
- _____ Friendly service
- _____ Educational experience
- _____ Other (positive and negative, please describe: _____)
- _____ Convenient hours
- _____ Quick results

3. What hours work best for you for therapy?

- _____ 6:00 a.m. to 8:00 a.m.
- _____ 8:00 a.m. to Noon
- _____ Noon to 4:00 p.m.
- _____ 4:00 p.m. to 6:00 p.m.
- _____ 6:00 p.m. to 8:00 p.m.

4. What days of the week work best for you for therapy (check off the three best days)?

- _____ Monday
- _____ Tuesday
- _____ Wednesday
- _____ Thursday
- _____ Friday
- _____ Saturday

5. Were you satisfied with the scheduling of your appointment? Yes _____ No _____ (if not, please explain why: _____)

6. How would you like your newsletter sent: _____ regular mail
_____ email (email address: _____)