Transitions Physical Therapy

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

TRANSITIONS PHYSICAL THERAPY, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at TRANSITIONS PHYSICAL THERAPY, LLC, please contact Sean Fitzgerald, PT, and Privacy Officer at (802)-899-5200. **Effective Date of this notice: September 1, 2012**

I. How TRANSITIONS PHYSICAL THERPAY, LLC, may use or disclose your health information:

Transitions Physical Therapy collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Transitions Physical Therapy, but the information in the medical record belongs to you.Transitions Physical Therapy protects the privacy of your health information. The law permits Transitions Physical Therapy to use or disclose your health information for the following purposes:

1. TREATMENT. Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient. An example of this would be a consultation/discussion with your physician regarding your plan of care, progress, or status.
2. PAYMENT. Payment means reimbursement for the provision of health care; determinations of eligibility or coverage; billing;, claims management, collection activities, justification of charges, protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for healthcare services to your insurance company.
3. REGULAR HEALTH CARE OPERATION. Healthcare operations are any activity related to covered functions in which we participate in the function of our office, such as conducting quality assessment activities, protocol development, case management, and care coordination, auditing functions, business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; and marketing for which an authorization is not required. An example of this would be an evaluation of customer service given to patients.
4. INFORMATION PROVIDED TO YOU
5. NOTIFICATION AND COMMUNICATION WITH FAMILY. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. REQUIRED BY LAW/LAW ENFORCEMENT. As required by law, we may use and disclose your health information, i.e.: to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
7. PUBLIC HEATH. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medication; and reporting disease or infection exposure.
8. HEALTH OVERSIGHT ACTIVITIES. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceedings.
10. WORKER'S COMPENSATION. We may disclose your health information as necessary to comply with worker's compensation laws.

II. When Transitions Physical Therapy May Not Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Transitions Physical Therapy will not disclose your health information without your written authorization. If you do authorize Transitions Physical Therapy to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Transitions Physical Therapy, LLC is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that Transitions Physical Therapy, LLC amend your health information that is incorrect or incomplete. Transitions Physical Therapy, LLC is not required to change your health information and will provide you with information about Transitions Physical Therapy, LLC denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by Transitions Physical Therapy, LLC, except that Transitions Physical Therapy does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you), 5 (directory listings), and 16 (government functions) of section I of this Notice of Privacy Practices.
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact Sean Fitzgerald, PT, Privacy Officer, Transitions Physical Therapy (802)-899-5200.

IV. Changes to this Notice Of Privacy Practices

Transitions Physical Therapy reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Transitions Physical Therapy is required by law to comply with this Notice. Revised notices will be given at any time requested.

V. Complaints

Complaints about this Notice of Privacy Practices or how Transitions Physical Therapy handles your health information should be directed to: Sean Fitzgerald, PT, Privacy Officer.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Dept. of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg, 200 Independence Ave, S.W., Room 509F HHH Building, Washington, DC 20201 or address your complain to a regional office found at www.hhs.gov/ocr/regmail.html.

Transitions Physical Therapy

Acknowledgement of Receipt of HIPAA Notice

Transitions Physical Therapy

Sean Fitzgerald, MPT, CSCS Privacy officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:
_____

Name of patient: _____

---------- ***For office use only:***

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain:
_____

Reason for refusal:
_____

Transitions Physical Therapy

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of services at Transitions Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. This consent shall be ongoing for a period not to exceed one year.

I, a Transitions Physical Therapy patient, have read this form and fully understand and accept its terms and conditions.

_____ _____

Patient (or person authorized to consent for patient/relationship) Date/Time

_____

Witness signature

COMMUNICATION CONSENT

I voluntarily consent to communication with Transitions Physical Therapy beyond the clinic setting which may include mailings to my home, email and phone calls. I understand that my contact information will only be used by Transitions Physical Therapy and will not be given to any other company or organization.

_____ _____

Patient (or authorized to consent for patient/relationship) Date/Time

CANCELLATION POLICY

In addition, I understand and agree with Transitions Physical Therapy's "no-show," / cancellation / rescheduling policy: I will be charged a $25.00 fee in the event that I miss an appointment, cancel and / or reschedule in less than a 24-hour period. Personal Training clients will be charged for a full session.

_____ _____

Signature Date/Time

Transitions Physical Therapy

PATIENT REGISTRATION FORM

DATE _____

PATIENT NAME *(FIRST)* _____ *(MI)* _____ *(LAST)* _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ Gender ID_____Pronouns_____

PHONE *(HOME)* _____ *(WORK)* _____ *(CELL)*

EMAIL ADDRESS _____(*EXERCISES ARE SHARED THROUGH EMAIL*)

EMPLOYER _____ JOB TITLE _____ *(FULL TIME)* _____ *(PART TME)* _____

STUDENT _____ NO ____ YES *(WHERE)* _____ *(FULL TIME)* _____ *(PART TME)* _____

EMERGENCY CONTACT _____ *(PHONE)*_____ *(RELATIONSHIP)* _____ INJURY / ACCIDENT DATE _____/_____

REFERRING DOCTOR:*(FIRST)* _____*(LAST)* _____ ___ MD ___ DDS ___ DO ___ DC__NP__ND__PA-C *(CITY)* _____ *(STATE)* _____next visit with referring provider?_____

PRIMARY CARE PHYSICIAN:*(FIRST)* _____ (*LAST)*_____ MD ___DDS ___ DO ___ DC __NP__ND__ PA-C *(CITY)* _____ *(STATE)* _____

HOW DID YOU HEAR ABOUT US?

_____ FAMILY _____ FRIEND _____DOCTOR _____ NEWSPAPER AD _____ CHURCH BULLETIN _____ OTHER_____

IF A FRIEND OR FAMILY MEMER REFERRED YOU, PLEASE TELL US WHO SO WE MAY THANK THEM.

_____

PRIMARY INSURANCE INORMATION:

INSURANCE COMPANY NAME _____

IDENTIFICATION # _____ GROUP # _____

INSURED / POLICY HOLDER NAME *(FIRST)* _____ *(MI)* ____ *(LAST)* _____

RELATIONSHIP ___SELF___SPOUSE ___MOTHER ___FATHER___OTHER

*(ADDRESS)*_____ *(CITY)* _____ *(STATE)* _____ *(ZIP)* _____

(HOME PHONE) _____ *(DATE OF BIRTH)*_____ EMPLOYER _____

WORKERS COMP INFORMATION:

INSURANCE COMPANY NAME _____

ADDRESS _____

TELEPHONE # _____ CASE MANAGER NAME _____

CLAIM # _____

Transitions Physical Therapy

www.transitionspt.com

Patient Health Information

Name_____ Today's Date_____

Age_____ Date of Birth _____ Height_____ Weight_____

Employer_____Occupation_____Regular Exercise_____ Dominance: hand___leg___

Chief Complaint: What brings you to physical therapy? _____

Were you Referred to us?_____ If so when is your next visit with referring provider?_____

Have you been to Physical Therapy before?_____ Have you been to us before?_____ **Are you taking any medications?** ☐ YES ☐ NO (If Yes, please list on next page or provide a list)

Are you allergic to LATEX? ☐ YES ☐ NO

Do you take blood thinners? ☐ YES ☐ NO

Do you now have, or have you had, any of the following?

High blood pressure	☐ YES	☐ NO	Pace Maker	☐ YES	☐ NO
Heart disease/attack	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Angina/chest pain	☐ YES	☐ NO	Metal Implants	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO	Fibromyalgia	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Chronic Headaches	☐ YES	☐ NO
Pregnant (Recent or currently)	☐ YES	☐ NO	Prior Physical Therapy	☐ YES	☐ NO
Previous surgeries	☐ YES	☐ NO	Tooth or jaw pain	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Knee support/brace	☐ YES	☐ NO
Osteoporosis	☐ YES	☐ NO	Back support/brace	☐ YES	☐ NO
Rheumatoid Arthritis	☐ YES	☐ NO	Allergies/Asthma	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO	Osteoarthritis	☐ YES	☐ NO
Liver Disease	☐ YES	☐ NO	Lung Disease	☐ YES	☐ NO
Smoking/tobacco use	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO
Sexually Transmitted Disease	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Recent change in vision or glasses	☐ YES	☐ NO	Foot Problems	☐ YES	☐ NO
Recent visits to the ER or MD	☐ YES	☐ NO	Recent Dental work	☐ YES	☐ NO
Family History for any of these	☐ YES	☐ NO	Recent Illness	☐ YES	☐ NO
			Recent infection	☐ YES	☐ NO

If you answered YES to any of the above, please explain and give approximate dates: _____

_____

Currently I am experiencing (circle all that apply): Fever/chills/sweats ☐ Poor balance (falls) ☐

Unexplained weight loss ☐ Numbness or Tingling ☐ Changes in appetite ☐ Difficulty swallowing ☐

Depression ☐ Shortness of breath ☐ Dizziness ☐ Headaches ☐

Changes in bowel or bladder function ☐ Fatigue ☐ Nausea /Vomiting ☐ Increased pain at night ☐

Incontinence Leaking during exercise Pelvic Floor Pain Constipation Painful Intimacy

Are you interested in learning about our Pelvic Health services? YES NO

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

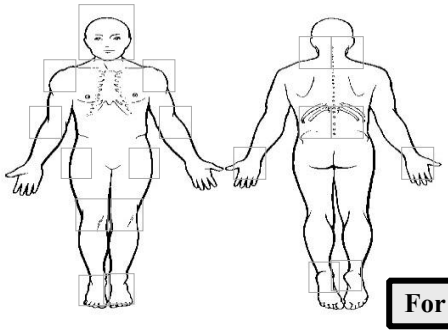
Current Medications

Please list the following: - Prescription Medications - Over-the-Counter Medications - Herbals - Vitamin/Mineral/Dietary Nutritional Supplements

Medication	Dosage	Frequency	Route of Administration	Reason for taking Medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Patient Name: _____ Date: _____

Verified by: _____ Date: _____



1) Please indicate on the picture the location of your pain.

2) Please indicate your level of pain for the follow categories:

Worst____ Best___ Current___

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

3) How much has your pain interfered with your daily activities this week? ___

None = 0 1 2 3 4 5 6 7 8 9 10 =Unable to do activities

For the therapist: Cough/Sneeze, + / Saddle Anesth, + /- Bwl/Blddr Chnge,+ /- Numb/Ting.

Current Symptoms:

How did your pain start and when? _____

How would you describe your pain? ❑Sharp ❑ Dull ❑Aching ❑Burning ❑Radiating ❑Shooting ❑ Tingling ❑Stabbing ❑Sore ❑Strained ❑Stiff

Your symptoms are currently: ❑Getting better / ❑About the same / ❑Getting worse

How often (% of your day) are your symptoms present: constant ❑76-100% Frequently ❑51-75%
occasionally ❑26-50% Intermittently ❑0-25%

Easing Factors: Identify up to 3 positions or activities that make your symptoms better:
(Examples: rest, hot or cold, activity) 1. _____ 2._____ 3._____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Evening ❑ Night ❑Being still ❑ With Activity

When are your symptoms the best? ❑ Morning ❑ Evening ❑ Night ❑Being still ❑ With Activity

Treatment History and Goals:

Have you seen anyone else for this problem (MD, Chiropractor, other)? Please list 1_____

Have you had an x-ray, MRI, or other imaging study done? Yes___ NO___ 2 _____

Have you ever had this problem before? Yes___ NO_____ 3 _____

What are your goals and expectations for therapy? _____ 4_____

Is there anyone that you would like us to coordinate care with? _____

Patient Specific Functional Scale : Please identify up to three important activities that you are unable to do or are having difficulty with as a result of your current problem and score those activities with your current level of being able to perform that task.

0 1 2 3 4 5 6 7 8 9 10

I am unable to perform the activity at all. I can perform the activity at the same level as before the current problem.

Activity 1_____ score-__ ***Activity 2***. _____ score- __ ***Activity 3***. _____ score-___

Transitions Physical Therapy

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Transitions Physical Therapy and understand that I am financially responsible for non-covered services. I understand that if Transitions Physical Therapy does not contract with my insurance company, I am responsible for the fee for service charges. I also authorize the physician and/or Transitions Physical Therapy to release any information necessary to process this claim. All the information provided below is correct and true to the best of my knowledge.

Your initials and signature below indicate you agree with the Assignment and Release policy.

_____ I understand that I have a copay of_____ which is due on date of service.

OR

_____I understand that I am paying $40 per visit on date of service towards my coinsurance balance. This payment will be applied to my account. I understand that I will receive a monthly statement with remaining patient responsibility as processed by my insurance.

_____I understand that upon receipt of my statement, I am required to pay the balance within 15 days of the statement date.

_____ _____

Signature Date/Time

Payment Options

Please mark how you plan to pay for the patient responsibility charges as processed by your insurance.

_____ I will provide payment with check. (* Please note - A credit card on file is still required.)

_____ I will provide payment with credit card.

_____ I will provide payment using an HSA account.

_____ I will provide payment through my employer.

Employer payment program name: _____

Employer: _____

HSA/Credit Card Information

Transitions Physical Therapy does require a health savings account card or credit card to be kept on file to ensure copayment on date of service, coinsurance fees and remaining account balances that fall to patient responsibility.

_____

Card Number Expiration Date

_____

Name on Card

I would like to speak the Practice Manager about cost of physical therapy services based on my insurance.

_____ Yes _____ No Insurance: _____