TAYLOR PHYSICAL & OCCUPATIONAL THERAPY

PATIENT MEDICAL HISTORY

_____New Patient _____Established Patient

Name_____ Birth Date_____ Age_____
Home Address_____ City_____ State_____ Zip_____
Where Employed _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email address_____ May we contact you by email? _____Yes _____ No
Spouse's Name _____ Employer _____
Emergency Contact _____Relation_____ Phone _____

Have you been treated by a physical, occupational, speech therapist, or chiropractor at any facility within this calendar year? ___Yes ___No If so, number of visits_____

Who is your insurance provider? _____

Are you currently being seen by a Home Health Agency? _____ Name of Agency_____

Brief description of injury or illness _____
_____
Date symptoms started _____

Is your injury: Work related? ___Yes ___ No Motor vehicle accident? ___Yes ___No

What are your goals for therapy? _____
_____

Have you fallen 2 or more times in the last year or 1 fall with significant injury? Yes No

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

___Heart Problems
___Pacemaker
___High/Low Blood Pressure
___Circulatory Problems
___COPD/Emphysema
___Asthma
___Shortness of Breath
___Chronic Ulcer
___Anemia
___History of Smoking
___Diabetes
___Kidney Disease
___Cancer
___Hepatitis
___Tuberculosis
___Rheumatic Fever
___Multiple Sclerosis
___Blood Clots
___Back pain/sciatica
___Osteoporosis
___Artificial Joints/Implants
___Seizures
___Dizziness/Vertigo
___Depression/Mental Illness
___Stroke
___Hearing/Visual Difficulties
___Rheumatoid Arthritis
___Other Arthritic Conditions
___Dementia
___Currently or possibly pregnant

List any other medical information or special tests you've completed that you believe would be beneficial for us to be aware of:
_____
_____

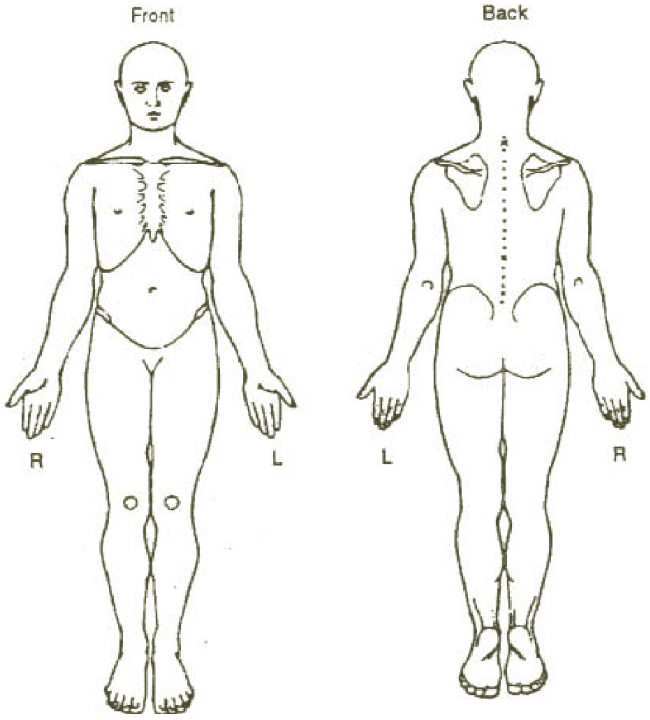
Current Medications _____
_____

Height_____ Weight_____

(**Please fill out back page**)

PATIENT MEDICAL HISTORY

Mark on the diagram below where you currently are experiencing symptoms:



Mark below the intensity of your symptoms.
(Please circle the appropriate number)

0= no symptoms, 10= worst possible symptoms

Currently: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

How restricted are you in your normal activities?
(0 = No Limitations; 10 = Totally Disabled)

0 1 2 3 4 5 6 7 8 9 10

Work capabilities since your injury:

_____ No Work Limitations
_____ Some Work Limitations
_____ Unable to Work
_____ N/A (Child, Student, Retiree, Disabled)

How often do you have these symptoms? (Please check one below)

_____Constantly (24 hours/day) _____Frequently (12-23 hours/day)
_____Occasionally (6-12 hours/day) _____Not frequently (0-6 hours/day)

Please list other treatment you have received for this condition _____

_____

Who was your referral source for therapy? ☐ Physician ☐ Self-Referral

How did you hear about Taylor Physical Therapy? (Please check both category and subcategory)

☐ Returning Patient
- ☐ Newsletter
- ☐ Postcard

☐ Advertising
- ☐ Social Media
- ☐ Commercial
- ☐ Newspaper
- ☐ Flyer
- ☐ Radio

☐ Word of Mouth
- ☐ Friend or Family
- ☐ Community Event
- ☐ Taylor Employee

INFORMED CONSENT

I hereby authorize treatment to be administered after evaluation according to the therapist's discretion. This may include, but not limited to, spinal or joint traction, ultrasound, electrical muscle stimulation, whirlpool or aquatic therapy, iontophoresis, manual therapy, instrument assisted soft tissue mobilization, and exercises. I understand that the necessary procedures to be provided will be explained along with the risks and benefits. We utilize a therapy dog in our clinic so please let us know if you have a known allergy.

Patient's Signature _____Date_____
Signature of
Personal Representative _____Date_____

Patient did not sign for the following reason: ☐ Minor ☐ Physically Unable ☐ Has Legal Guardian

TAYLOR PHYSICAL & OCCUPATIONAL THERAPY

Acknowledgment of Receipt of Notice of Privacy Practices

The Notice of Privacy practices the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Taylor Physical Therapy and Associates' health care operations. The Notice of Privacy Practices also describes my rights and Taylor and Associates' duties with respect to my protected health information. I understand that the Notice of Privacy Practices are posted in the physical therapy clinic for my review and that I can request my own copy if so desired.

Taylor Physical Therapy and Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Assignment of Insurance Benefits/ Financial Agreement

I authorize payment of my insurance benefits directly to Taylor Physical Therapy and Associates, LLC for services provided. I understand that I am financially responsible to pay the usual charges for PT/OT services, whether they are covered by my insurance or not, including any balance not covered by my insurance carrier.

Release of Information

I authorize the release of any medical or other information to process this claim. Taylor Physical Therapy and Associates, LLC may disclose all or part of my medical record to any person or corporation which may be liable under a contract to Taylor Associates, myself, a family member, or my employer for all or part of the charge for services. I authorize the release of information about my health status for continuing health care services and to the referring physician.

My signature represents that I have read and understand the terms and statements above in regards to the notice of privacy, the financial agreement, and release of information. This authorization is in effect from the signature date unless revoked by me in writing.

Patient Signature_____ Date _____

Signature of Personal

Representative _____ Date _____

Description of Personal Representative's Authority _____

Patient did not sign for the following reason: ☐ Minor ☐ Physically Unable ☐ Has Legal Guardian

I have witnessed the completion of this authorization form.

_____

Employee Signature Date

Taylor Therapy Parkersburg
(319) 346-9783
1306 Hwy 57 Ste. B
Parkersburg, IA 50665

Effective 03/2021

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.

Who will follow this notice

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

Your health information

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic record, or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, related billing activity and similar types of health related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and obligations regarding the use and disclosure of that information.

How we may use and disclose health information about you

We may use and disclose health information for the following purposes:

For Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, the therapist may also tell another therapist or doctor about your condition so that therapist or doctor can help determine the most appropriate care for you. Different personnel in our office share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as requesting a copy of your x-ray results be sent to us. Family members and other health care providers may be a part of your medical care outside this office and may require information about you that we have.

For payment. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or tho determine whether your plan will pay for the treatment.

For health care operations. We may use and disclose health information about you in order to run the office and make sure you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use the health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide your insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care services, train staff and comply with the law.

Appointment reminders. We may contact you as a reminder that you have an appointment for treatment at our office.

Treatment alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health related products and services. We may tell you about health related products or services that may be of interest to you.

*Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health related products and services. If you advise us in writing, at the address listed at the top of this notice, we will not disclose your health information for these purposes.

Special situations.

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

To avert a serious threat to health or safety . We may use or disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by law. We will disclose health information about you when required to do so by federal, state or local law.

Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the research will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about forign military personnel to the appropriate foreign military authority.

Workers compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public health risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non- accidental physical injuries, reactions to medications or problems with products.

Health oversight activities. We may disclose health information to health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state or federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Information not personally identifiable. We may use or disclose health information about you in a way that does not personally identify or reveal who you are.

Family and friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family of friends if we can infer from the circumstances, based on our professional judgement that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you to the exam room during treatment or when treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency) we may, using our professional judgement, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our judgement and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

Other uses and disclosures of health information.

We will not disclose your health information for any purpose other than those identified in the previous sections without your specific written authorization. If you give us authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered within your written authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU. You have the following rights regarding health information we maintain about you:

Right to inspect and copy. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the clinic office coordinator in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you the right to have our denial reviewed, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a *MEDICAL RECORD AMENDMENT/CORRECTION FORM* to the clinic office coordinator. We may deny your request for amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

-We did not create, unless the person or entity that created the information in no longer available to make the amendment.

-Is not part of the health information that we keep.

-You would not be permitted to inspect and copy.

- Is accurate and complete.

Right to and accounting of disclosures. You have the right to request an accounting of disclosures. This is a list of the disclosures we made of the medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will exclude any disclosures we have made based on your authorization.

To obtain this list, you must submit in writing, to the clinic office coordinator. It must state a period of time, which may not be longer than 6 years and may not include dates before 7 years from this date. Your request should indicate in what form you want the list. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdrawal or modify your request at the time before any costs are incurred.

Right to request restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the ***Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication*** to the clinic office coordinator.

Right to request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications you may complete and submit the ***Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication*** to the clinic office coordinator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a paper copy of this notice. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically you are still entitled to a paper copy. To obtain a copy contact your clinic office coordinator.

Changes to this notice. We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice online at taylorphysicaltherapy.com with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Complaints.

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Director of Business Development at our Waverly Health Center location. ***You will not be penalized for filing a complaint.***