Email_____

JACKSON
PHYSICAL THERAPY

PATIENT INFORMATION

_____ (____)_____

PATIENT NAME (LAST) (FIRST) (M.I.) HOME PHONE

_____

MAILING ADDRESS APT# CITY STATE ZIP CODE

_____

PHYSICAL ADDRESS (IF DIFFERENT FROM ABOVE)

_____/_____/_____ _____ _____ _____ _____

DOB AGE SEX MARITAL STATUS SOCIAL SECURITY NUMBER

GUARANTOR OF MINOR

_____

NAME (LAST) (FIRST) (M.I.)

_____

MAILING ADDRESS APT# CITY STATE ZIP CODE

(____)_____ (____)_____ (____)_____ _____

HOME PHONE WORK PHONE CELL PHONE SOCIAL SECURITY NUMBER

PATIENT EMPLOYER

_____ _____

PATIENT'S EMPLOYER OCCUPATION

_____ (____)_____

EMPLOYER'S ADDRESS CITY STATE ZIP CODE WORK PHONE

MEDICAL INFORMATION

_____ _____

TYPE OF INJURY / LOCATION OF INJURY DATE OF INJURY

THIS INJURY IS - ☐ WORK RELATED ☐ AUTO RELATED ☐ PAST INJURY ☐ OTHER

HAVE YOU ATTENDED ANY PHYSICAL THERAPY THIS YEAR - _____ IF YES, WHERE - _____

_____ (____)_____ (____)_____

REFERRING PHYSICIAN PHYSICIAN PHONE PHYSICIAN FAX

_____

ADDRESS APT# CITY STATE ZIP CODE

EMERGENCY CONTACT INFORMATION

_____ (_____)_____ _____

WHO TO NOTIFY IN CASE OF AN EMERGENCY PHONE NUMBER RELATIONSHIP

_____

ADDRESS APT# CITY STATE ZIP CODE

INSURANCE INFORMATION

JACKSON
PHYSICAL THERAPY

_____ (_____)_____
PRIMARY INSURANCE COMPANY **PHONE**

_____
ADDRESS **CITY** **STATE** **ZIP CODE**

_____ _____ _____
POLICY HOLDERS NAME **RELATIONSHIP TO PATIENT** **SOCIAL SECURITY NUMBER**

_____ (_____)_____
SECONDARY INSURANCE COMPANY **PHONE**

_____
ADDRESS **CITY** **STATE** **ZIP CODE**

_____ _____ _____
POLICY HOLDERS NAME **RELATIONSHIP TO PATIENT** **SOCIAL SECURITY NUMBER**

ATTORNEY INFORMATION

_____ (_____)_____
NAME OF ATTORNEY REPRESENTING YOU **PHONE**

_____
ADDRESS **CITY** **STATE** **ZIP CODE**

CONSENT FOR CARE

I hereby give my consent to Jackson Physical Therapy and Sports Medicine to provide care and services prescribed by my physician, both verbally and written. I also give my consent to exercise professional judgment in any additional care and services that may be necessary. My consent for care is extended to the said staff of the said agency providing physical therapy. Instructions for my care are explained to me and I understand my obligation to follow the home program and any other recommendations given to me to the best of my ability.

I am also made aware that therapy services may result in one or all of the following: increased pain, increased swelling, increased redness, burning sensations and wound bleeding.

Patient Signature:_____

Date:_____/_____/_____

Patient's History of Current Injury/Illness

Name: _____ **Today's Date**: _____

Age: _____ **Date of Birth**: _____ **Sex**: _____ **Marital Status** _____

Occupation: _____ **R- handed** ____ **L-handed**____ **Ht**._____ **Wt**___

Have you ever been a patient here before? Yes_____ No_____; If yes, for the____same or ____different problem?

Please indicate for which body region you are seeking treatment:

__Neck __Mid Back __Low Back __Shoulder __Elbow __Hand/wrist __Hip __Knee __ Ankle/foot __ Other

When did your symptoms start? Date _____ Can you identify a cause for your symptoms? Yes____ No _____

If yes, specify: _____

_____

Have you ever had similar symptoms in the past? Yes ____ No ____ If **yes**, when? _____

_____

Have you had the following tests <u>FOR THIS CONDITION ONLY</u>? Yes ____ No____ If **yes**, check all that apply:

____x-rays ____Bone Scan ____Myelogram ____ EKG
____CT Scan ____EMG ____Stress Test ___Echocardiogram
____MRI ____Blood Tests ____Pulmonary Function Test ____Other (Please list)_____

<u>Pain rating</u>: Indicate your level of pain by <u>circling</u> the appropriate number on the scales below: *"0" is no pain and "10" is unconscious pain.*

<u>0 1 2 3 4 5 6 7 8 9 10</u> CURRENT

<u>0 1 2 3 4 5 6 7 8 9 10</u> BEST

<u>0 1 2 3 4 5 6 7 8 9 10</u> WORST

Describe the character of your pain? (What does it feel like…sharp, dull, achy, etc.?)

_____

_____

Is the pain there all the time (constant)? Yes _____ No _____

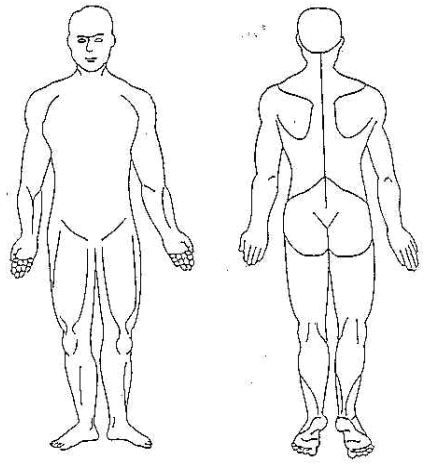
Does the pain move or radiate anywhere? Yes _____ No _____

If yes, describe location of radiation or numbness

_____

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: _____



Please use the body diagram above and *Shade Areas of Pain*

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes___No___

Describe _____

What activities/positions make your pain worse? _____

_____

What activities/positions make your pain better? _____

_____

Patient's History of Current Injury/Illness

Have you <u>previously</u> seen any other health care provider for this problem? ____ Yes ____No

___Physician ___Osteopath ___Podiatrist ___Other (Please list below)

___Physical Therapist ___Chiropractor ___Dentist _____

Are you currently seeing any other health care provider for this condition? ____Yes ____No; If Yes, please list:

_____

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ____ If yes, please describe: _____

Please check which treatments you have tried for THIS particular injury/condition:

___Physical Therapy ___Chiropractic ___Acupuncture ___Braces ___Collars ___Meds ___Injections

Medical History

<u>Past Medical History</u> (Illnesses and/or Injuries) (Please Circle)

1. **Fractures or Joint Injuries**
2. **Backache or Neckache**
3. **Arthritis or Gout**
4. **Heart Disease**
6. **Nervous or Mental Disease**
7. **Diabetes**
8. **Lung Disease, Emphysema, Asthma**
9. **Stroke**
10. **Circulation Disorder (HBP)**
11. **Cancer**
12. **Skin Disease**
13. **Kidney or Bladder Dx**

<u>Past Operations</u> (and Approximate Dates)

1. **Bone or Joint**_____
2. **Stomach or Bowel**_____
3. **Lung**_____
4. **Heart or Blood Vessel**_____
5. **Hernia**_____
6. **Other**_____

Medication	Dosage	Reason for Taking

Use additional sheet if more space is needed

Where do you currently live (or intend to live) at the conclusion of your episode of therapy?

__ Private Home __Private Apartment __Rented Room __Group Home __Assisted Living __Skilled Facility __Other

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

__Live Alone __Spouse/Significant Other __Child/Children __Other Relative __ Personal Care Attendant __Other

Do you use an Assistive Device? If so, please indicate ___Cane ___Crutch ___Walker ___ Wheelchair

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.): _____

_____

What are your goals for your course of physical therapy? _____

_____

At the present time, would you say your GENERAL health is excellent, good, fair, or poor? _____

_____ _____

Patient Signature Date

FINANCIAL POLICY

JACKSON
PHYSICAL THERAPY

JACKSON PHYSICAL THERAPY & SPORTS MEDICINE FINDS THAT COMMUNICATION WITH OUR PATIENTS REGARDING OUR FINANCIAL POLICY ASSISTS US IN PROVIDING THE SERVICES TO YOU. THE FOLLOWING TERMS AND CONDITIONS ARE ACCEPTED BY PATIENT FOR SERVICES PROVIDED BY JACKSON PT.

1. **INSURANCE:** Physical therapy services are provided directly to you, and not an insurance company. As a courtesy to its patients. JACKSON PT will bill the Patient's insurance company. If the insurance has failed to pay we will expect (YOU to pay) the balance of your bill. If problems with the insurance arise it is the responsibility of the patient (NOT this facility) to establish communications with the insurance company. (Patient's Initial) _____

2. **AGREEMENT TO PAY:** I agree to pay for all services rendered . If a collection agency's services are required, I further agree to pay for all legal fees, court costs, reasonable attorney fees, and collection agency fees in connection to my debt. If the debt is not paid within 45 days we will begin to incur interest at the rate of 1.5% monthly or 18% annually until the debt is paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given to Jackson PT. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule. (Patient's Initial)_____

3. **CO-PAYMENTS:** It is the policy of JACKSON PT to collect all applicable co-payments relating to HMO or PPO health care providers. Each co-payment shall be collected on the date of service. In the event Patient is on a Lien basis with JACKSON PT, Patient will no longer be responsible for making co-payments and all co-payments made by Patient prior to executing a Lien will be deducted from the total outstanding balance determined at the end of Patient's treatment when they are released from the therapist's care.

4. **DEDUCTIBLES:** It is the Patient's responsibility to pay for their applicable annual deductibles.

5. **MEDICARE:** JACKSON PT is a Medicare provider. In addition to submitting claims to Medicare, JACKSON PT will file your claim with your secondary carrier. The patient is responsible to pay for any required deductibles and for more than twenty percent (20%) for their balance.

6. **LIENS:** It is JACKSON PT's policy to accept Worker's Compensation and/or Personal Injury Liens. A signed and dated Lien must be on file with JACKSON PT within ten (10) days of the beginning of treatment. Please notify the receptionist if a Lien is to be used.

7. **PERSONAL INJURY CLAIMS:** In the event Patient is injured as a result of an auto accident, work related accident, personal accident or other unnatural occurrence, Patient agrees and consents that JACKSON PT may cease billing under an applicable HMO or PPO plan and directly bill Patient's applicable insurance carrier having coverage for the injury for the full costs incurred in rendering medical services,

8. **SPECIAL NEEDS:** Special circumstances are understood to occur, and as a result it may be necessary to set up a payment plan for a patient requiring extensive treatment. If this becomes the case, please notify our office at the earliest opportunity.

PATIENT RESPONSIBILITY

I have read and understand the financial policy of JACKSON PT. By signing this form, I consent to the above terms and conditions of treatment and understand that it is my responsibility for assuring that the financial obligation of my care is fulfilled.

I hereby authorize payment by my insurance carrier or other designated payer of medical benefits to JACKSON PT. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I also authorize JACKSON PT to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

Patient's Signature: _____ **Date:** _____

PERSONAL GUARANTOR FOR MINOR

(If the Patient is a minor under 18 years of age, a Responsible Party must complete the following)

I agree to the terms and conditions of this financial policy and personally guarantee to pay JACKSON PT all costs incurred by the minor Patient.

Responsible Party: _____ **Date:** _____

SCHEDULING & CANCELLATION POLICY

JACKSON
PHYSICAL THERAPY

We have a scheduling policy at Jackson Physical Therapy and Sports Medicine that allows for the highest level of patient care. When a patient comes in 30 minutes or later, this can cause a back up with patients who were able to come in at the proper time. We want to give each and every patient the time and attention that they deserve. We understand that things can come up in the course of the day, so we ask that if you know you are going to be late, call us first so we can find another time when we can see you that won't mean sacrificing anyone else's treatment time, including your own. If you are 15 or more minutes late for your appointment and have not called ahead you may be asked to reschedule. We appreciate your understanding in this matter. We want to apologize for any inconvenience and appreciate your patience. We only want to give you the very best treatment we can each and every time you come here.

If you are referred to us for treatment for a work related injury, you are required, by Nevada Statute, to attend all scheduled physical therapy appointments, as prescribed by your doctor. Failure to do so will result in us contacting both your doctor and claims examiner.

No show/ No cancellations will be charged $50.00 for the missed appointment. You as a patient will be billed for this and not your insurance company. Cancellations must be made at least 4 hours prior to the appointment.

Please help us and be responsible for your care by keeping your scheduled appointments. Thank you.

I have read and understand the scheduling and cancellation policy as set forth above.

_____ _____

Patient's Signature **Date**

4765 S. Durango Dr. #106 • Las Vegas, NV 89147 • (702) 898-7633 • (702) 898-6433
100 N Green Valley Pkwy #335 • Henderson, NV 89074 • (702) 818-4442 • (702) 818-3080

NOTICE OF PRIVACY PRACTICES HIPAA

JACKSON
PHYSICAL THERAPY

Introduction

At Jackson Physical Therapy and Sports Medicine, we are committed to treating and using protected health information about you responsibly. 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. This Notice also describes your rights as they relate to your protected health information.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, a plan for future care of treatment, and billing-related information. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that serviced billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving health of this state and the nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Our Duties and Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We are required to comply with the terms of this Notice and reserve the right to change the terms of this notice. The revised or changed notice will be effective for information we already have about you, as well as any information we receive in the future. Ensign Family Medicine is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested
- Accommodate reasonable requests you may have to communicate health information by alternative means or location

Uses and Disclosure

How we may use and disclose Health Information about you. The following describe examples of the ways we use and disclose information about you.

For Treatment: We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination and management of your health care with a third party.

For example, we may disclose your protected health information, as necessary, to a home health agency that provides care for you. Your protected health information may also be provided to a physicians or hospital to which you have been referred to ensure that the physician or hospital has the necessary information to carry-out treatment, payment and health care operations.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company, or third party. For example we may need to give your insurance company information about your office visit so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: We may use and 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. The result will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes. We may also combine health information we have with that of other health care facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy. We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To tell you about possible treatment alternatives
- To tell you about health-related benefits or services
- To call upon you by name in the waiting room when your physician is ready to see you
- To inform Funeral Directors consistent with applicable law
- For population based activities relating to improving health or reducing health care cost
- When disclosing information, primary appointment reminders and billing/collection efforts, we may -leave messages on your answering machine or voice mail.

Business Associates: There are some services we provide through contracts with business associates who work on our behalf. Examples include services in the emergency department, radiology, and laboratory tests. In such situations, we may disclose your health information so they can perform the job we ask them to do. We require all business associates to safeguard your information in accordance with applicable law.

Individuals Involved in Your Care or Payment for your Care: We may release health information about you to a family member or friend who is involved in your medical care or who helps pay for your care if submitted in writing. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

NOTICE OF PRIVACY PRACTICES HIPAA

JACKSON
PHYSICAL THERAPY

As Required by Law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensations Agents
- Organ and Tissue Donation Organizations
- Military command Authorities
- Health oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement / Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena

Other permitted and required uses and disclosure will be made only with your consent, authorization or opportunity to object unless required by law.

Your Health Information Rights

Inspect and Copy: Upon written request, you have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. However, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation or, use in, a civil, criminal, or administrative action or proceeding, and protecting health information that is subject to law that prohibits access to protected health information.

Amend: If you feel that health information we have about you is incorrect or incomplete, you have the right to request, in writing, that we amend the information. You have the right to amend your information as long as it is kept by and for the practice. We may deny your request for an amendment. If this occurs, you will be notified by our Privacy Officer of the reason for the denial.

Request Restrictions: 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 purpose of 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 payment for your care, like a family member or friend. Your request must be submitted in writing, state the specific restriction requested, and to whom you want the restriction to apply. While we will consider any request, we are not required to agree. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Request Confidential Communication: You have the right to ask that we communicate with you by alternative means or at alternative locations. For example, you can ask that we contact you on your cell phone or ask us not to leave messages at your place of employment. The practice will grant any reasonable request for confidential communications at alternative locations and or via alternative means only if the request is submitted in writing and includes a current mailing address. Please realize, we reserve the right to contact you by other means or at other locations if you fail to respond to any communication from us that requires response.

A Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

An Accounting of Disclosure: You have the right to receive an accounting of certain disclosure we have made of any of your protected health information. Please contact the Privacy Officer at 951-3400 to request an accounting.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer, or with the Office of Civil Rights, US Dept. of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Office for Civil Rights
US Dept. of Health and Human Services
200 Independence Ave SW
Room 509F, HHH Building Washington, DC 20201
Effective Date: April 15, 2003

ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES HIPPA

Jackson Physical Therapy and Sports Medicine is 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.

I hereby acknowledge that a copy of the Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Jackson Physical Therapy and Sports Medicine privacy practices or my rights with regard to my personal health information, I may contact the Privacy Officer for further information as set forth in this notice.

Patient Name (Print): _____

Patient Signature: _____

Date:____/____/_____

Note: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENTS MEDICAL RECORDS OR OTHER FILE ON PROVIDER'S PREMISES

JACKSON
PHYSICAL THERAPY

Medical Records Release Authorization

Date: _____

I, _____, give
(please print patient name)

authorization to _____
(name of office you are requesting records from)

to release any and all medical records and billing to

_____
(name of office you are sending records to)

Patient Signature: _____

4765 S. Durango Dr. #106 • Las Vegas, NV 89147 • (702) 898-7633 • (702) 898-6433
100 N Green Valley Pkwy #335 • Henderson, NV 89074 • (702) 818-4442 • (702) 818-3080