MOST

MEDICAL HISTORY

Patient Name______________________________ Age________

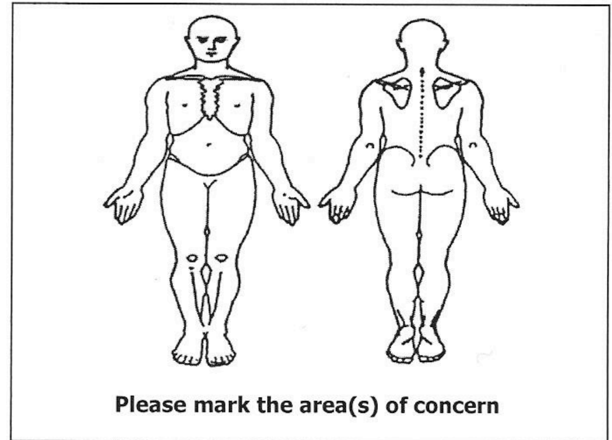
Type of Injury / Condition ______________________ Onset / Injury Date __________

Type of Surgery & Date ______________________

Next Doctor's Appointment? ______________________

Describe previous treatment for this condition______________________

____



Please mark the area(s) of concern

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No

Have you had any imaging performed:

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted:

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain At Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps In Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change In Vision Or Hearing
- ☐ Insomnia

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

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care ______________________

Explain & give approximate dates for any items indicated above______________________

____

Are you currently taking medications? Yes / No Name or Type of Medication ______________________

____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other ______________________

Rate your pain (1=minimal 10=severe): At it's <u>worst</u>: 1 2 3 4 5 6 7 8 9 10 / At it's <u>best</u>: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment?______________________

____

What are your physical or fitness goals: ______________________

____

Is there anything else you would like to include or ask your physical therapist? ______________________

____

______________________ ______________

Patient or Personal Representative Signature **Date**

Manual Orthopedic & Sports Therapy

PATIENT INFORMATION

LAST NAME: ____FIRST: ____MI________

MAILING ADDRESS: ____

CITY: _________________________________ STATE: _______________________ZIP CODE: ___________ MALE / FEMALE

DRIVER'S LIC#: _____________________________EMAIL: _____________________________HOME PHONE__________________

CELL /OTHER PHONE # ________________________________ BIRTH DATE: _______/_______/_________ AGE:____________

*SOCIAL SECURITY #: ______-______-_______ *MARITAL STATUS: Single Married Divorced/Sep Widowed

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*SPOUSE *OR* PARENT/GUARDIAN/GUARANTOR NAME: ____
ADDRESS____PH# (________)__________-____________
SS#____ BIRTHDATE: ____

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*PATIENT'S EMPLOYER NAME: ___________________________________ Work Phone (________)_________-_________________
*Occupation:__________________________ _ full time / part time / not working / retired / disabled

***IS YOUR VISIT WORKERS COMP OR AUTO ACCIDENT RELATED? YES / NO**
*IF YES, PLEASE COMPLETE: DATE OF INJURY: ____/____/______ CLAIM# ______________________ADJUSTOR:___________________
*ATTORNEY INVOLVED? YES / NO IF YES, ATTORNEY NAME: ____

INSURANCE INFORMATION

*PRIMARY INSURANCE: ________________________________ADDRESS____
*SUBSCRIBER NAME: ________________________________ID#______________________________ GROUP#___________________
*SUBSCRIBER BIRTHDATE:______________________________
*SECONDARY INSURANCE:______________________________ADDRESS____
*2NDARY SUBSCRIBER NAME:_________________________ID#______________________________________GRP#_____________

EMERGENCY CONTACT / FRIEND OR RELATIVE NAME: ____

PH # (______)__________________ADDRESS:___________________________________RELATIONSHIP TO PATIENT: ___________________

*****PLEASE COMPLETE*****
*Referring Doctor name: __________________________________phone #____
***Reason for treatment/description of injury:** ____
How did you hear about us?____ Thank you for giving us a try!

CONSENT FOR THERAPY TREATMENT / PAYMENT AGREEMENT

I HEREBY CONSENT TO PHYSICAL THERAPY TREATMENT UNDER THE CARE OF MANUAL ORTHOPEDIC AND SPORTS THERAPY.
I agree to pay for all services rendered, whether they are covered by my insurance company or not. I authorize the release of medical records to ensure payment of claims. I understand that I am responsible for any deductible, co-payments or denials from my insurance company. I realize it is ultimately my responsibility to be sure payment is received by our office no later than ninety (90) days after the date of service.

SIGNATURE: ____ DATE: ______________________________
(PATIENT SIGNATURE, GUARANTOR, OR PARENT/ GUARDIAN)

NOTICE OF INFORMATION PRACTICES

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

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

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve

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

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

If you have questions and would like additional information, you may contact our Privacy Officer at 406-862-2348. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well

as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

We will use your health information for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality & effectiveness of the healthcare and service we provide.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication. After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Enter any other uses or disclosures your office may routinely make.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

EFFECTIVE DATE ________________________________

I acknowledge receipt of a copy of this Notice ___________________________________Date___________

CONFIDENTIAL HEALTH FACTORS SCREENING QUESTIONNAIRE

The following questions are intended to assist us in your health recovery. Your answers will help us focus on and address some of the possible contributing factors to your symptoms.

NAME:____**DATE:**____________________

Stress & Anxiety

Do you feel that you currently have significant stress in your life? ……………❑ Yes ❑ No

Does your health condition / back pain give you much stress? …………………❑ Yes ❑ No

How would you rate your current level of emotional stress?

Not stressed at all 0 --- 10 *Extremely stressed*

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑

How would you rate your current level of anger in your life?

Not angry at all 0 --- 10 *Extremely angry*

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑

Job Satisfaction

Do you generally like / enjoy your current job? ………………………………❑ Yes ❑ No

Do you generally like / get along with your co-workers/ employer / boss? …………❑ Yes ❑ No

How would you rate your current level of job satisfaction?

I hate my job 0 --- 10 *I absolutely love my job*

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑

Hopefulness / Optimism

What is your level of hopefulness that your back will improve?

Not hopeful at all 0 --- 10 *Very hopeful*

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑

What is your level of hopefulness that you will return to your regular activities in the next 3 months?

Not hopeful at all 0 --- 10 *Very hopeful*

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑

Fear Avoidance

Do you fear and avoid many physical activities as they may harm your back? …..❑ Yes ❑ No

Do you feel that there is something dangerously wrong with your back? …………❑ Yes ❑ No

Do you feel that people aren't taking your back condition seriously enough? …….❑ Yes ❑ No

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Effective Date: March 1, 2004

Manual Orthopedic & Sports Therapy

I acknowledge receipt of a copy of the Notice of Privacy Practices for Manual Orthopedic & Sports Therapy. I have been given the opportunity to ask any questions that I might have regarding this notice.

____ ___________________
Patient or Patient Representative Date

Please include the names of persons with whom we are allowed to discuss your billing information and/or condition:

____ ____________________
Name Relationship

____ ____________________
Name Relationship

I authorize Manual Orthopedic & Sports Therapy to discuss my billing information and/or condition with the above named person(s).

____ ____________________
Patient or Patient Representative Date

May we leave a detailed message on your answering device if we are unable to reach you in person? _____________YES _____________NO