Transitions Physical Therapy

www.transitionspt.com

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.

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Acknowledgement of Receipt of HIPPA 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

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 will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and/or Transitions Physical Therapy to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge.

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

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PATIENT REGISTRATION FORM

DATE _____

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

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ SEX ____

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

EMAIL ADDRESS: _____

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 # _____

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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

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

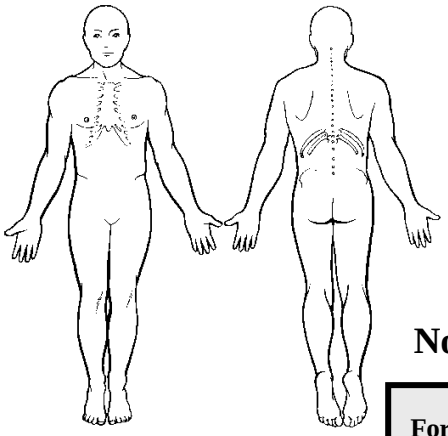
Please list the following:

- 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: _____



Please indicate on the picture to the left the locations of your pain.

Please indicate your level of pain using the scale below for the following:

Worst_____ Best_____ Average_____ Current_____

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

For the therapist: + / - Cough/Sneeze, + / - Saddle Anesth, + / - Bwl/Bldder 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

Aggravating Factors: Identify up to 3 positions or activities important to you that make your symptoms worse:
(Examples: dressing, reaching, sitting, running) 1. _____ 2._____ 3._____

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-___