

ATLAS PHYSICAL THERAPY NEW PATIENT INFORMATION

(Upper Section for Office Use Only)

Today's Date ____/____/____

Initial Evaluation Date ____/____/____

Time: _____

Last Name _____ First Name _____ MI _____

Referring Physician _____ Phone _____ Body part to be treated: _____

Primary Care Physician _____ Phone _____ Would you like reports forwarded to PCP? Y N

Date of Birth ____/____/____ Age _____ Sex: M F (please circle) Marital Status: S M W D P (please circle)

Email Address _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Emergency Contact _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____

How did you learn about Atlas Physical Therapy? _____

Employer _____ Occupation _____ Employed: Full time Part Time

Employer's Address _____ City _____ State _____ Zip _____

Were you injured on the job? Y N Date of Injury ____/____/____ Claim No. _____

Name of Adjustor _____ Phone (____) _____ - _____

Were you injured in a car accident? Y N Date of Injury ____/____/____ Claim No. _____

Name of Attorney _____ Phone (____) _____ - _____

FOR MEDICARE RECIPIENTS ONLY:

Have you had or are you currently receiving home health? Y N Date of discharge: _____

Home health agency name: _____ Phone (____) _____ - _____

Primary Insurance

Secondary Insurance

Complete blanks using <i>INSURED'S</i> information	Complete blanks using <i>INSURED'S</i> information
Insured's Name _____	Insured's Name _____
Sex: M F Birth Date ____/____/____	Sex: M F Birth Date ____/____/____
Patient's relationship to insured _____	Patient's relationship to insured _____
Employer _____	Employer _____
Employer's Address _____	Employer's Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Insurance Company _____	Insurance Company _____
Phone (____) _____ - _____	Phone (____) _____ - _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Insured's ID #: _____	Insured's ID #: _____
Group #: _____	Group #: _____

PATIENT: _____ AGE: _____

 Are you on any medications? YES NO Please list all prescription, over the counter and herbal medicines below as well as dosage, frequency and route of administration i. e. oral or injected

Height: ____ft ____ inches Weight: _____ lbs.

2 or more falls in the past year? ____ Y ____ N Any fall in the last year resulting in injury ____ Y ____ N

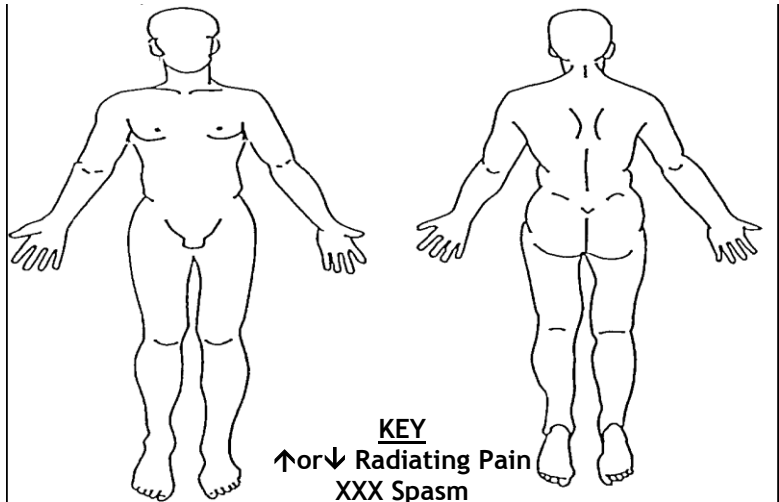
Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizzy Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fainting Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently pregnant	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Osteoporosis/Osteopenia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Back injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bleeding disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fracture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Metallogy (implants)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Respiratory problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis A,B,C	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MRSA	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HIV/AIDS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bowel/bladder problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sudden weight loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
List:		

Please circle all that may apply. My pain is worse:
 In the morning/during the day/at night/constantly/
 with activity/during rest.

On a scale of 0 to 10,
 0 being no pain and 10 being unbearable pain requiring hospitalization,
 rate your pain at its best _____ and worst _____.

Using the key provided, draw the symbol representing your pain
 over the area of the body as it relates to your **present** condition.



KEY
 ↑ or ↓ Radiating Pain
 XXX Spasm
 ZZZ Tenderness
 ///// Numbness/Tingling
 0000 Ache/Pain

 As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? **Check all that apply?**

- | | | | | |
|---|--|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Getting in/out of bed | <input type="checkbox"/> Personal hygiene activities | <input type="checkbox"/> Eating | <input type="checkbox"/> Shaving | <input type="checkbox"/> Cleaning |
| <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Bathing/shower | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Lifting | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Getting in/out of chair | <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Sitting | <input type="checkbox"/> Cooking | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Walking up/down stairs | <input type="checkbox"/> Dressing | <input type="checkbox"/> Standing | <input type="checkbox"/> Laundry | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Getting in/out of shower | <input type="checkbox"/> Work activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Vacuuming | |
| <input type="checkbox"/> Other _____ | | | | |

Patient Signature: _____ Date: _____



HEALTH INFORMATION PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Document Carefully.

1. About Protected Health Information (PHI).

In this Notice, “we”, “our” or “us” means this FACILITY and our workforce of employees, contractors and volunteers. “you” and “your” refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identify you. Because we must protect this health information we call this Protected Health Information---or “PHI”. In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

2. Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call “health care operations”. We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

Cont. 2. Uses and Disclosures

- Treatment

We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optical care is rendered.

- Payment

After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payor may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

- Health Care Operations

We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of real patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

- Special Uses

We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

- i. Remind you of appointments
- ii. Carry out follow ups on home programs that you have been taught
- iii. Advise you of new or updated services or home supplies

Cont 2. Uses and Disclosures

- Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

- i. If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
- ii. We may use your PHI in an emergency if you are not able to express yourself
- iii. If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research

Required:

- i. When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
- ii. For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
- iii. To report neglect, abuse or domestic violence
- iv. To the government regulators or its agents to determine whether we comply with applicable rules and regulations
- v. In judicial or administrative proceedings such as a response to a valid subpoena
- vi. When properly requested by law enforcement officials or other legal requirements such as reporting gun shot wounds
- vii. To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- viii. Deemed necessary by appropriate military command authorities if you are in the Armed Forces
- ix. In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

We will follow any and all State regulations should they be stricter than these federal privacy regulations

3. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication
You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing
- Your Right to Inspect and Copy
You have the right to inspect and copy your PHI. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record

Cont. 4 Your Privacy Rights and How To Exercise Them

- Your Right to Know Who Else Sees your PHI
You have the right to request an accounting of certain disclosure that we have made over the past six years; however you may not ask for disclosures that occurred prior to April 14, 2003. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually, we have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.
- Your Right to Complain
You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint with us please contact the person identified below in this Notice. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

5. Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you Notice of our Privacy Practices. This document is our Notice. If you did not get a paper copy of this Notice, you may request one. We will abide by the privacy practices set forth in this Notice. However, we reserve the right to change this Notice and our Privacy Practices when permitted or required by law.

If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

6. Contact Information

If you have questions about this Notice, or if you have a complaint or concern, please contact:

Name: Vicky Bledsoe
Address: 190 Talisman Dr., Suite C-5
Pagosa Springs, Co 81147
Phone: 970-73-3755

7. Effective Date: This notice takes effect on August 1, 2019

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Atlas Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Atlas Physical Therapy to release any of my protected healthcare information.

Patient's or Authorized Representative's Printed Name & Date

Patient's or Authorized Representative's Signature