Olender Physical Therapy

Strength in Motion • www.olenderphysicaltherapy.com

Olender Physical Therapy HIPAA Privacy Policy: It is the policy of Olender Physical Therapy that all providers and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and it's providers and staff have the necessary medical and PHI to provide the highest quality physical therapy care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should be confident to provide information to our practice and it's providers and staff for purposes of treatment, payment and healthcare operations (TPO), knowing that our practice and it's staff will adhere to the standards set forth in the Notice of Privacy Practices. Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and it's providers and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient. Use and disclose PHI to remind patients of their appointments only with their consent. Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and it's providers and staff will: Implement reasonable measures to protect the integrity of all PHI maintained about patients. Recognize that patients have a right to privacy. Our practice and it's providers and staff respect a patients dignity at all times. Our practice and it's providers and staff will respect patients privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility. As as responsible information stewards and treat all PHI as sensitive an confidential. Consequently, our practice and it's providers and staff will - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements. Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release, or the release is otherwise authorized by law. Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and it's providers and staff will - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform that patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patient's appeals. Provide patients with an opportunity to request the correction of inaccurate or incomplete PHI in accordance with the law and professional standards, All providers and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice. All providers and staff of our practice must adhere to this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practices' personnel rules and regulations. Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patient upon request.

Patient Signature:_____ Date: _____

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Consent for Treatment

I, the undersigned, a patient at Olender Physical Therapy, do hereby agree and give my consent to medical treatment in treating my physical condition. I authorize the release of any medical information about me and/or discuss issues of my care to any relevant persons excluding: _____.

Cancellations/No Show Policy

I understand the need for curtesy to give my therapist at least 24 hours notice if I need to cancel my appointment and agree to pay a $25 cancellation fee if I fail to give sufficient notice.

Payments

Payments are due on the date of service.

Patient Signature:_____ Date: _____

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New Patient Form

Name:_____

DOB: _____ Male/Female: _____ Date of first visit: _____

Adress:_____

_____

_____

Cell phone: _____ Home phone: _____

Email address: _____

Emergency Contact:

Name: _____ Relationship:_____Number: _____

Referencing MD: _____ Phone: _____

PCP: _____ Phone: _____

Is condition related to:

Employment: _____ Auto Accident: _____ Other: _____

Date issues began (within last 3 months): _____

How did you hear about this practice?: _____

BCBS Number: _____ Subscriber: _____

Subscriber Date of Birth: _____Relationship to subscriber: _____

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Patient Intake Form

Date: _____

Name: _____ Birthdate: _____

Reason for Care: _____

_____

When and how did the symptoms start?: _____

_____

Quality of Symptoms/Pain (Check all that apply):

( ) Achy ( ) Dull ( ) Stiff ( ) Sharp ( ) Constant ( ) Off/On ( ) Throbbing ( ) Shooting

( ) Burning ( ) Stabbing ( ) Numb ( ) Tingling ( ) Burning ( ) Other

What makes the symptoms worse?: _____

_____

What makes the symptoms better?: _____

_____

Does the problem radiate to other parts of your body?: _____

Any functional problems on a daily basis? (Dressing, Chores): _____

_____

What were you able to do before this injury that you can't do now?: _____

_____

What is your pain level from 0-10? (0=None,10=Severe):

Best: _____Worse: _____Usual: _____

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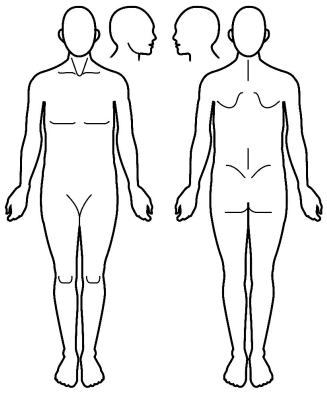
Olender Physical Therapy Patient Intake Form, Pg 2

Using the diagram below, circle or shade in the areas of pain:



Front **Back**

Please list any falls, car accidents, fractures, sprains, strains: _____

_____

_____

Please list all exercises, recreational activities and hobbies: _____

_____

Goals
What do you hope to achieve with care?: _____

_____

Review of Systems:
Please check all of the conditions that you have had or are currently experiencing.

Musculoskeletal

( ) Neck Pain ( ) Back Pain ( ) Shoulder Pain ( ) Elbow/Hand Pain ( ) Hip Pain

( ) Knee/Ankle Pain ( ) Arthritis ( ) Scoliosis ( ) Osteoporosis

Last Bone Scan Date: _____

Neurological

( ) Headaches ( ) Migraines ( ) Anxiety ( ) Depression ( ) Sleep Problems

Olender Physical Therapy Patient Intake Form, Pg 3

Cardiovascular

( ) High Blood Pressure ( ) Low Blood Pressure ( ) Angina ( ) Heart Attack ( ) Stroke

( ) Poor Circulation

Respiratory

( ) Asthma ( ) Pneumonia ( ) Emphysema ( ) Sleep Apnea ( ) Allergies

Digestive

( ) Irritable Bowel ( ) Constipation ( ) Diarrhea ( ) Ulcers ( ) Food Sensitivities/Allergies

( ) Heartburn ( ) Nausea ( ) Anorexia/Bulimia

Sensory

( ) Blurred Vision ( ) Ringing/Buzzing in Ears ( ) Hearing Loss ( ) Loss of Smell

( ) Loss of Taste ( ) Loss of Touch

Integumentary

( ) Skin Cancer ( ) Psoriasis ( ) Eczema ( ) Acne ( ) Rashes ( ) Hair Loss

Endocrine

( ) Immune Disorders ( ) Diabetes ( ) Thyroid Issues ( ) Fatigue

Genitourinary

( ) Kidney Stones ( ) PMS Symptoms ( ) Prostate Issues ( ) Bowel/Bladder Control Issues

Surgeries: _____

_____

_____

Please list any medications you are currently taking

_____

_____

_____

Vitamins and Supplements: _____

_____

Other: _____