

Client Information
Juneau Physical Therapy

Patient Name _____
Date of Birth _____ Social Security # _____ Sex ___F ___M
Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address (optional) _____
Patient Employed by _____
Emergency Contact _____ Relationship _____
Phone (day) _____ (home) _____
Referred by _____

Primary Insurance

(Items marked * are required for primary billing)

*Insurance Company or Workers' Compensation Carrier _____
*Name of Primary Insured _____ *Birthdate _____
*Subscriber or ID# _____ *Group # _____ Date of Injury _____
Address of Insurance Company _____
Contact Person/Case Worker _____ Phone _____
Workers' Compensation Claim Number _____

Secondary Insurance

(Items marked * are required for secondary billing)

*Insurance Company or Workers' Compensation Carrier _____
*Name of Primary Insured _____ *Birthdate _____
Subscriber or ID# _____ Group # _____ *SSN # _____
Address of Insurance Company _____
Contact Person _____ Phone # _____

Assignment Release

I assign directly to Juneau Physical Therapy, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Juneau Physical Therapy to any or all billing information that is necessary to secure the payment benefits. I authorize use of this signature on my insurance submissions. In the event of legal action litigation, I acknowledge my responsibility to Juneau Physical Therapy to pay any outstanding balance with or without a Medical Lien.

Signature of Insured/Guardian

Date

Please fill out as completely as possible. Your physical therapist will use this questionnaire to help establish a safe and appropriate program for you. Your input is very important.

Name _____ Age _____ Occupation _____

1 What is your primary problem? _____

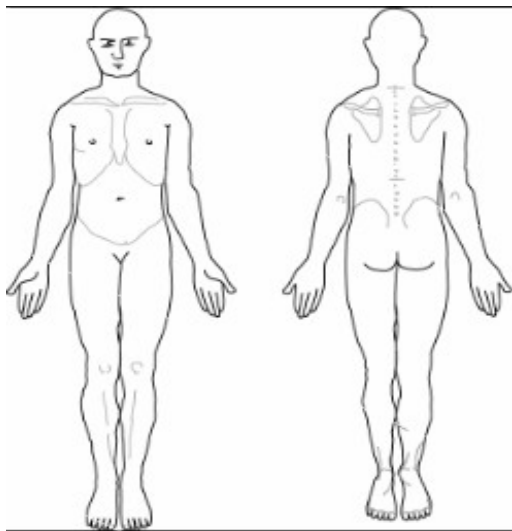
2 Date problem began _____ Date of surgery _____

3 What was the **onset** of this episode?
 gradual sudden

4 Which of the following best describes how your injury occurred? (if your condition is post-surgical, please indicate as per original injury)

<input type="checkbox"/> lifting	<input type="checkbox"/> blow to the face
<input type="checkbox"/> MVA (car accident)	<input type="checkbox"/> running
<input type="checkbox"/> a fall	<input type="checkbox"/> throwing
<input type="checkbox"/> overuse	<input type="checkbox"/> an accident at work
<input type="checkbox"/> trauma	<input type="checkbox"/> unknown
<input type="checkbox"/> degenerative process	<input type="checkbox"/> during recreation/sports
<input type="checkbox"/> Other _____	

5 Shade in region of pain/discomfort/symptoms, put a "C" for constant pain, "I" for intermittent pain. Rate Each area from 0 – 10 on the pain scale.



6 On a scale of **0-10, with 0 = "No Pain" and 10 = "Take me to the emergency room"**, rate your pain since onset of injury.

At onset: 0 1 2 3 4 5 6 7 8 9 10
 In last week: 0 1 2 3 4 5 6 7 8 9 10
 TODAY: 0 1 2 3 4 5 6 7 8 9 10

7 Nature of pain/symptoms (check all that apply)

<input type="checkbox"/> sharp	<input type="checkbox"/> dull ache
<input type="checkbox"/> constant	<input type="checkbox"/> burning
<input type="checkbox"/> occasional	<input type="checkbox"/> weakness
<input type="checkbox"/> throbbing	<input type="checkbox"/> falling asleep/numbness
<input type="checkbox"/> Other _____	

8 As the day progresses, do your symptoms (check one)

<input type="checkbox"/> increase?	<input type="checkbox"/> stay the same?
<input type="checkbox"/> decrease?	

9 Does the pain wake you at night?
 yes no
 If "yes", is it present
 while lying down both
 only when changing positions

10 Do you have pain/stiffness upon getting out of the bed in the morning?
 yes no

11 What aggravates your symptoms? (check all that apply)

<input type="checkbox"/> sitting	<input type="checkbox"/> rest
<input type="checkbox"/> lying on back	<input type="checkbox"/> lifting
<input type="checkbox"/> lying on stomach	<input type="checkbox"/> sit to stand transfer
<input type="checkbox"/> up/down stairs	<input type="checkbox"/> exercise
<input type="checkbox"/> standing	<input type="checkbox"/> stretching
<input type="checkbox"/> bending over	<input type="checkbox"/> nothing
<input type="checkbox"/> Other _____	

12 What relieves your symptoms? (check all that apply)

<input type="checkbox"/> sitting	<input type="checkbox"/> rest
<input type="checkbox"/> lying on back	<input type="checkbox"/> medication
<input type="checkbox"/> lying on stomach	<input type="checkbox"/> stretching
<input type="checkbox"/> walking	<input type="checkbox"/> heat
<input type="checkbox"/> standing	<input type="checkbox"/> cold pack/ice
<input type="checkbox"/> bending over	<input type="checkbox"/> exercise
<input type="checkbox"/> massage	<input type="checkbox"/> nothing
<input type="checkbox"/> Other _____	

FOR OFFICE USE ONLY

- 13 Which practitioners have you seen for this problem?
(check all that apply)
- | | |
|---|--|
| <input type="checkbox"/> physician | <input type="checkbox"/> massage therapist |
| <input type="checkbox"/> physical therapist | <input type="checkbox"/> acupuncturist/acupressurist |
| <input type="checkbox"/> chiropractor | <input type="checkbox"/> podiatrist |
| <input type="checkbox"/> naturopath | <input type="checkbox"/> Other _____ |
- 14 Have you had similar symptoms in the past?
 yes _____ no
If "yes", how many times _____

If "yes", what treatment was helpful?

- 15 Have you had any of the following tests?
- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> X-ray | area: _____ year: _____ |
| <input type="checkbox"/> CT scan | area: _____ year: _____ |
| <input type="checkbox"/> Bone scan | area: _____ year: _____ |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> none | |
- 16 Are you currently taking any of the following over-the-counter medications? (check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> antihistamines |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> vitamins/supplements |
| <input type="checkbox"/> Topical corticosteroids | <input type="checkbox"/> Advil/Motrin/Ibuprofen |
| <input type="checkbox"/> Other _____ | |
- 17 Please list any prescription medications you are currently taking or have recently taken (pain pills, injections, etc) _____

- 18 Physical activities at work (check all that apply)
- | | |
|---|--|
| <input type="checkbox"/> sitting | <input type="checkbox"/> heavy lifting |
| <input type="checkbox"/> standing | <input type="checkbox"/> computer use |
| <input type="checkbox"/> phone use | <input type="checkbox"/> heavy equip operation |
| <input type="checkbox"/> repetitive lifting | <input type="checkbox"/> driving |
| <input type="checkbox"/> stooping/crawling | <input type="checkbox"/> Other _____ |
- 19 Before your present problem, did you exercise in addition to normal daily activities?
- | | |
|--|---|
| <input type="checkbox"/> 5+ days/ week | <input type="checkbox"/> occasionally |
| <input type="checkbox"/> 3-4 days/week | <input type="checkbox"/> don't exercise |
| <input type="checkbox"/> 1-2 days/week | |
- consisting of _____
- 20 What exercise/activity can you do now?

- 21 What exercise/activity do you avoid?

- 22 What is your current stress level?
- | | |
|---------------------------------|-------------------------------|
| <input type="checkbox"/> low | <input type="checkbox"/> high |
| <input type="checkbox"/> medium | |
- 23 Have you ever had/been diagnosed with any of the following conditions? (check all that apply)
- | | |
|---|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> epilepsy/seizures |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> frequent falls |
| <input type="checkbox"/> bladder problems | <input type="checkbox"/> hearing problems |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> heart trouble/angina |
| <input type="checkbox"/> bruising easily | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> cancer _____ | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> coronary heart disease |
| <input type="checkbox"/> depression | <input type="checkbox"/> pain that wakes you at night |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> smoking | <input type="checkbox"/> unexplained weight loss |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> dental work (in past 6 wks) |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> pacemaker/
nitroglycerin patch |
| <input type="checkbox"/> shortness of breath | |
| <input type="checkbox"/> infectious disease (hepatitis, TB, etc) | |
| <input type="checkbox"/> major injury to neck/spine (whiplash) | |
| <input type="checkbox"/> bowel/bladder changes since symptoms began | |
| <input type="checkbox"/> Other _____ | |
- 24 Please list any recent/relevant past surgeries related to your current problem.
Surgery _____ Date _____

- 25 Has anyone in your immediate family ever been treated for any of the following?
- | | |
|--|--|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> cancer |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> stroke | <input type="checkbox"/> psychological condition |
| <input type="checkbox"/> thyroid problem | <input type="checkbox"/> Other _____ |
- 26 What are your goals with Physical Therapy?
1) _____
2) _____

AUTHORIZATION AND PRIVACY POLICY

By signing this form, I understand I am giving authorization for the treatment I will receive. Please initial and sign below.

_____ I understand that if I fail to attend physical therapy for two consecutive months without prior notice, I will be automatically discharged.

_____ I have been presented with a copy of Juneau Physical Therapy's **Notice of Privacy Policy**.

Signature (Parent or Guardian if a minor)

Date

**Authorization & Confidentiality Policy
Juneau Physical Therapy**

By signing this form, I am giving authorization for the treatment I will receive.

Please *initial* each statement and sign on the line below.

_____ I understand that I may jeopardize my future appointments if I fail to attend my scheduled treatment sessions without providing 24 hour notice.

_____ I understand that if I fail to attend physical therapy for six (6) consecutive weeks without prior notice, I will be automatically discharged.

_____ I have been presented with a copy of Juneau Physical Therapy's **Notice of Privacy Policies**.

Print Name

Signature of Insured or Parent/Guardian if a Minor

Date

Authorization to Release Medical Information Juneau Physical Therapy

JPT 641 W Willoughby Ave, Suite 206 Juneau, AK 99801 [downtown] 907-586-5951; fax 907-586-8017

JPT 8390 Airport Blvd, Suite 203 Juneau, AK 99801 [valley] 907-789-4165; fax 907-789-5882

Patient Information

Name _____

Mailing Address _____ City/State/Zip _____

Date of Birth _____ Social Security # _____ Phone _____

Information to be Released From (please do not fill out this section)

I hereby authorize _____ to release the following medical information for this patient.

Information to be Released To (please do not fill out this section)

Name of Facility/Organization/Patient _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Type of Information to be Released (this is to be filled out by the Therapist ONLY)

Purpose or need for information being released:

_____ Further medical treatment _____ Legal proceedings

_____ Insurance claim _____ Other (specify)

Dates of treatment: from _____ to _____

Specific information to be released:

_____ Permission to discuss current diagnosis

_____ Operative report _____ Area of interest _____

_____ X-ray report _____ Area of interest _____

_____ MRI report _____ Area of interest _____

_____ Other (specify)

By signing this form below, I give my authorization for release of records as indicated above.

If the information to be released pertains to alcohol or drug abuse, I understand the confidentiality if information is protected by federal law (42CFR, Part 2). Furthermore, I understand that my records may contain information regarding the diagnosis of HIV, AIDS, other sexually transmitted diseases, drug abuse, alcohol use, mental illness or psychiatric treatment.

* Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42CFR, Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose.

Patient Authorization to Release Medical Information

Signature of Patient or Legally Responsible Party

Relationship to Patient

Date

This authorization to release information expires in 90 days from the date it is signed by the patient, unless revoked in writing by the patient prior to the expiration date. To be a valid authorization, it must be signed and dated after dates of service for requested information.

No-Show Fee Notice
Juneau Physical Therapy

Dear Valued Client,

This is a friendly reminder that **a \$25 fee** will be applied to your Patient Account for any appointments considered a no-show. This also applies to appointments that are not canceled 12 – 24 hours in advance. Canceling your appointment ahead of time will allow for others to be called who wish to fill that scheduled time slot.

When life throws you a curve ball, we understand. Just give us a call in advance, and we will be happy to reschedule your appointment for another day.

We appreciate your patience and understanding.

All the Best,

Your Team at Juneau Physical Therapy

.....

Printed Name

Signature

Date

Notice of Privacy Practices

Juneau Physical Therapy

- We may disclose your health information to your insurance provider for the purpose of payment and healthcare operations.
- We may disclose your healthcare information to notify or assist in notifying a family member, or another person responsible for our care about your medical condition, in the event of an emergency or of your death.
- We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.
- We may disclose your health information in the course of any administrative or judicial proceeding.
- We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
- We may disclose your health information if required by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to applicable legal requirements.
- We may be required to disclose your health information to Federal officials or military authorities to complete an investigation related to public health or national security.
- We may contact you by phone, mail, or email to remind you of a scheduled appointment, or to schedule an appointment. Additionally, we may contact you regarding treatment options or alternatives.
- We may disclose your health information to a government agency responsible for overseeing the healthcare system or health related government benefit programs.
- We may use or disclose your health information for research, subject to conditions. Your permission will be asked before any confidential information is given out including your name, address, or any other identifying information.
- We may disclose your health information to a coroner or medical examiner.
- We may disclose your healthcare information to your family and friends if we obtain your verbal consent to do so, or if we infer from circumstances based on our professional judgment that you would not object.
- We may disclose a minor's medical information to his or her parents as long as the minor's care is not ordered by the court.
- We may also disclose information if, in our professional opinion, you are not capable of giving consent due to incapacity or a medical emergency.
- In the event Juneau Physical Therapy is sold or merged with another organization, your health information will become the property of the new owner.

Other than as stated above, or where Federal, State or Local Law requires us, we will not disclose your health information other than with your written consent. You may revoke your authorization in writing at any time.

Patient Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree with the restriction requested.
- You have the right to inspect and copy your health information. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other associated supplies.
- You have the right to amend your health records. To request a correction, submit a Medical Record Amendment Form.
- You have the right to receive an accounting of disclosures of your health information made by us.
- You have the right to a paper copy of this **Notice of Privacy Practices** at any time upon request.

We are required by law to maintain the privacy of your health information and to provide you or your representative with a copy of this **Notice of Privacy Practices**. We are required to practice the policies and procedures described in this Notice but reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice. You have the right to submit complaints to us in writing, addressed to our Privacy Officer if you believe your rights have been compromised. You may also submit a complaint to the Secretary of Health and Human Services. You will not be penalized for submitting a complaint. We encourage you to express any concerns you may have as the privacy of your healthcare information is of the utmost importance to us at Juneau Physical Therapy.