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**

Valley Office

Medical Profile Questionnaire

Please fill out as completely as possible. Your physical therapist will use this questionnaire to help establish a safe and appropriate plan of care for you.

Name _____ Age _____

Medical History

Do you have/Have you had any of the following? (circle all that apply)

- Asthma
- Blackouts
- Bowel/Bladder problems
- Broken bones
- Bruising easily
- Cancer
- Psychological condition
- Diabetes
- Smoking
- Thyroid problems
- Poor circulation
- Dizziness
- Latex allergy
- Shortness of breath
- Major injury to neck/spine
- Infectious disease (HIV,TB, etc)
- Osteoporosis/thinning bone
- Epilepsy/seizures
- Frequent falls
- Hearing problems
- Heart trouble/angina
- High blood pressure
- Night sweats
- Numbness/tingling
- Sharp pain
- Constant, unrelenting pain
- Throbbing pain
- Dull/Achy pain
- Weakness
- Frequent headaches
- Pain that wakes you at night
- Arthritis
- Unexplained weight loss
- Dental work (in past 6 weeks)
- Pacemaker/nitroglycerin patch
- Traumatic injury
- Gastric by-pass surgery
- Other_____ _____

Please list any surgical procedures you have had (procedure/date)

_____

_____

Please list all medications (prescription and over the counter) that you are currently taking

_____

_____

Occupation _____

Briefly describe your job activities

_____

_____

Current Complaint _____

Date of current injury/symptom onset _____

Briefly describe your symptoms_____

_____

_____

What makes your symptoms better? _____

_____

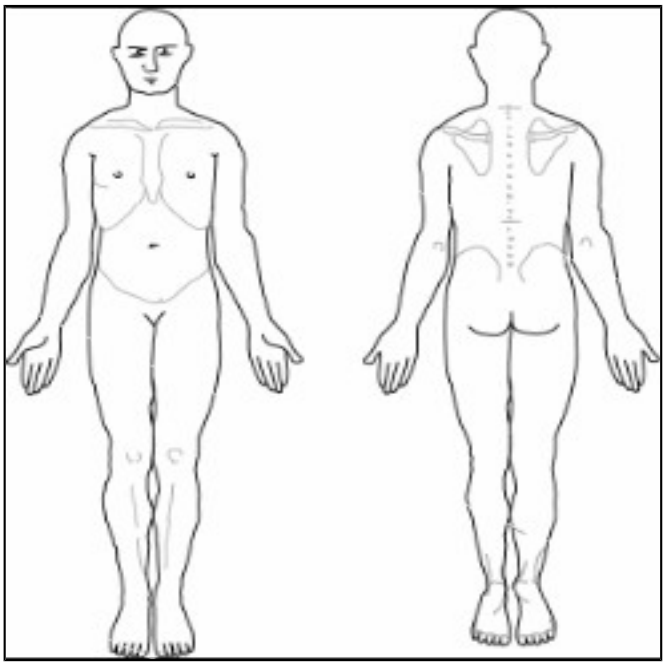
What makes your symptoms worse? _____

_____

Have you received other medical tests/or care for your current complaint? ____ no ____ yes

explain _____

Mark the areas of pain/discomfort on the body map below



Please list 1 or 2 goals you have for therapy

Examples: reach into the cupboard without pain; run 30 minutes without stopping; sleep 6 hours without waking due to pain

1 _____

2 _____

Please Rate your pain on a scale of 0 to 10

0 1 2 3 4 5 6 7 8 9 10

0 = no pain 10 = excruciating pain

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**

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 will 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.

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.