Clinton 509 S. 30th Street Clinton, OK 73601 (580) 323-8778	**TheraWest Aquatic & Physical Therapy**	Weatherford 424 N.State St Weatherford, OK 73096 (580) 772-8778

PATIENT INFORMATION			Date:
First Name:	Last Name:		Middle Initial:
Address:	City:	State:	Zip:
Birth Date:	Age:	□ Male □ Female	S.S.#:
Home Phone:	Cell:		Spouse:
E-mail Address:			
Chose Clinic Because: □Doctor □Newspaper Ad □Family/Friend □Former Patient □Radio Ad □Yellow Pages □Other:_____			
Whom may we thank for your referral:			
Have you been on Home Health in the past 3 months? □No □Yes:_____			
WORK INFORMATION			
Employer:	Work Phone:	Ext.	
Occupation:	Employee Status: □FT □PT □Retired □Not Employed		
CARE PROVIDER INFORMATION			
Referring Dr.:	Regular Dr./PCP:		
INSURANCE INFORMATION (PLEASE GIVE YOUR INS CARD TO RECEPTIONIST)			
Primary Insurance Name:			
Subscriber Name (If different):	Birth Date:		
ID #:	Group #:		
Patient's Relationship to Subscriber: □Self □Spouse □Child □Other:_____			
Secondary Insurance Name:			
Subscriber Name (If different):	Birth Date:		
ID #:	Group #:		
Patient's Relationship to Subscriber: □Self □Spouse □Child □Other:			
AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR PRIVATE HEALTH INS FOR BACKUP)			
Insurance Name: Auto/ Workers Comp:			
Adjuster/Claim Manager:	Phone:	Ext:	
Address:	City:	State:	Zip:
Claim #:	Accident Date:	Cause:	
ATTORNEY INFORMATION			
Name:	Law Firm:	Phone:	
Address:	City:	State:	Zip:
IN CASE OF EMERGENCY			
Name of Local Friend or Relative (Not Living at Same Address):			
Relationship to Patient:	Phone Number:		

I authorize my insurance benefits be paid directly to TheraWest Physical Therapy. TheraWest will work with your insurance provider by furnishing billing information. However, if the insurance company fails to pay your bill, the obligation is left to you, the recipient of our services. I also authorize TheraWest Physical Therapy to release any information required to process my claims.

Patient/Guardian Signature **Date**

Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. What is your age? _____

2. What is your gender? ☐ Male ☐ Female

3. What is your occupation? _____

- Are you working now? ☐ Yes ☐ No

4. Have you had physical therapy before? ☐ Yes ☐ No

5. Where is your pain/problem? _____

6. What caused your pain/or problem? _____

7. Approximately when did it start? ____/____/20_____

8. Is it getting worse, better or staying the same? ☐ Getting Worse ☐ Getting Better ☐ Staying the Same

9. Have you ever had this pain/problem before? ☐ Yes ☐ No

10. Is your pain constant (never goes away)? ☐ Yes ☐ No

11. On the scale below <u>circle</u> your worst pain level in the past couple of days:

Mild *Moderate* *Severe*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

12. Are you taking medication for this pain/problem? ☐ Yes ☐ No

- If yes, what and does it help? _____

13. Are any of your usual everyday activities affected? ☐ Yes ☐ No

- If yes, describe how. _____

14. Who is your referring physician? _____

When is your next appointment? _____/ _____/ 20_____

15. List all past surgeries with dates: _____

_____

16. List all medical conditions you have (or were told you have)? _____

Patient Name: _____

TheraWest Rehabilitation Center
Patient Responsibilities

Cancellation Policy

Patients are seen at TheraWest by appointment only. Scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments at least one week in advance. In the event you need to cancel an appointment, we request at least **24 hours** notice. Your appointment time is very important to us. If we do not get at least 24 hours notice of your cancellation we may not be able to schedule another patient who may need that time slot. **Less than 24 hr notice of cancellation constitutes a no-show and a $25 fee will be applied to your account.** This is detrimental to us and to the patients we try to serve, especially at high volume times such as early or late in the day. No-show due to **family emergency is excluded** from this policy. **Arriving on time** for your appointment is also critical to the optimal delivery of care to you and our other patients. Arriving more than 15 minutes late for your scheduled visit may result in your appointment being rescheduled at a later date**. Reading and signing of this policy acknowledges that I understand this policy and I understand that all no-show appointments not excluded from this policy will be charged.**

Home Healthcare Policy

Due to Medicare regulations regarding home healthcare patients, outpatient services **can not be billed** on the same date of service as **any and all** home healthcare services. As a result of this, it is your responsibility as a patient to inform us if you are currently on home healthcare services at the beginning of your treatment or if, **at any time** during your course of treatment, you become a patient of any home healthcare company. Failure to notify us of this situation will result in denial of all therapy charges. **Reading and signing of this policy acknowledges that I will inform TheraWest if I become a patient of any home health company at any point during my course of treatment and that failure to do so will result in me, the patient, being billed directly for any and all charges denied by my insurance company for this reason.**

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and or physicians. I acknowledge that no guarantees have been made to me as to the result of these services. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from our services. Therefore, if any treatment is not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Signed: _____

Date: _____

TheraWest Physical and Aquatic Therapy

Statement of HIPPA Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

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 medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Photographs, videotapes, digital photos, or other images may be recorded to document your care. TheraWest Physical and Aquatic Therapy will retain ownership rights to these photographs, videotapes, digital photos, or other images, but you do have the right to view them or obtain copies. These images will be stored in a secure manner that will protect your privacy. Images that identify you will be released and/or used outside TheraWest Physical and Aquatic Therapy for reasons other than treatment and/or payment only upon written authorization from you or your legal representative.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- 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 to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are 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 your privacy rights, please contact us by calling this office at **(580) 323-8778**. If our HIPPA Compliance Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our HIPPA Compliance Officer by calling this office at **(580) 323-8778**. If our HIPPA Compliance Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date