STEVENS & DILLINGER
PHYSICAL THERAPY SPECIALISTS

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Gender: M / F
FIRST MIDDLE LAST SUFFIX

Parent/Guardian (If Minor): _____ _____
FIRST MIDDLE LAST RELATIONSHIP

Address: _____
STREET OR P.O. BOX CITY STATE ZIP

Date of Birth: __-__-__ SSN: __-__-__

Primary Phone: (__) __-__ Secondary Phone: (__) __-__

Employer: _____ Employer Number: (__) __-__

Spouse Name: _____ Spouse DOB: __-__-__
FIRST MIDDLE LAST

Emergency contact name: _____

Phone: (__) __-__ Alternate Phone: (__) __-__

If insurance is Tricare: Sponsor SSN: _____

Date of injury : _____ Did you have an injury? ☐ Yes ☐ No
MONTH DAY YEAR

Date of Surgery: _____ Were you injured at work? ☐ Yes ☐ No
MONTH DAY YEAR

Next doctor visit: _____ Motor Vehicle Accident? ☐ Yes ☐ No
MONTH DAY YEAR

Attorney Name: _____ Phone Number: (__) __-__

Are you currently being seen by a Home Health Agency? ☐ Yes ☐ No

If yes, Home Health Agency Name: _____

Have you received Physical Therapy or Speech Therapy this year? ☐ Yes ☐ No

If yes, where: _____

Would you like to receive our monthly E-newsletter? ☐ Yes ☐ No

e-mail address: _____

How did you hear about us?

- ☐ Physician Referral
- ☐ Friend / Family Member
- ☐ I have been a patient here before
- ☐ Other: _____

STEVENS AND DILLINGER PHYSICAL THERAPY SPECIALISTS
FINANCIAL POLICY

Dear Patient:

The following is our Financial Policy. Our main concern is that you receive proper and timely treatment. We realize you have many choices when it comes to choosing a healthcare provider. We appreciate your trust in us, and we appreciate the opportunity to serve you. If you have any questions or concerns about our payment policies, please do not hesitate to ask.

We ask that all patients read and sign our Financial Policy as well as complete our patient registration forms. Your payment today will be based on your insurance plan's co-pay and deductible amounts. If you do not have insurance, you will be asked to pay the full amount of the services rendered. If you are not able to do this other payment arrangements may be made.

We accept Cash, Checks, MasterCard and Visa. Any returned checks are subject to a $20.00 returned check fee. We will be happy to file your insurance claim for you. Though we have contracts with most insurance companies, please be aware that we are not on all PPO or NETWORK plans. Please be sure to inquire as to our status with your particular insurance company, as this may affect the amount you are responsible for paying.

If you are a member of an HMO or Managed Care Program and/or have a primary care Physician (PCP), you are responsible for contacting your PCP and insurance company regarding a referral number. If you fail to do so, your visit(s) may not be covered by your insurance, making you financially responsible.

All charges are *your* responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services along with unpaid deductibles and co-payments are due at the time of treatment.

If your insurance company does not pay your claim within a reasonable time frame, we require you to follow-up with them and/or pay the balance due. By your signature below, you acknowledge you are the person responsible for this account and will allow us and our affiliates to contact you by your wireless phone including using automatic dialing systems, pre-recorded/artificial voice messages, text messages and/or e-mails.

We understand that temporary financial problems may affect timely payment of your account. We encourage you to communicate any such problems to the front office manager so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care facility.

Signature: _____ Date: _____

Print Name: _____

HIPPA NOTICE OF PRIVACY PRACTICES

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physical therapy practice, and any other use required by law.

2. Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This included the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

3. Payment:

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for physical therapy services may require that your relevant protected health information be disclosed to the health plan to obtain approval for treatment.

4. Healthcare Operations:

We may use or disclose, as needed, your PHI in order to support the business activities of your physical therapists practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to physical therapy school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI as necessary to contact you to remind you or your appointment.
We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings. : Law Enforcement: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Sections 164.500.

5. Other Permitted and Required Uses and Disclosures:

These will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapists practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature: _____ Date: _____

Print Name: _____

Your HIPPA Rights: Following is a statement of your rights with respect to your protected health information.

1. You have the right to inspect and copy your protected health information (PHI)
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and PHI that is subject to law that prohibits access to PHI.

2. You have the right to request a restriction of your PHI
This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operation. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your therapist is not required to agree to a restriction that you may request. If the therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

3. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

4. You may have the right to have your therapist amend your PHI.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
We reserve the right to change the terms of this notice and will inform you by mail of any changes, you then have the right to object or withdraw as provided in this notice.

6. Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.
This notice was published and become effective on/or before January 19, 2006.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is acknowledgement that you have received this notice of our privacy practices:

Signature: _____ Date: _____

Print Name: _____

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

This notice is provided to inform you about your Medicare benefits. There are some items and services for which Medicare will not pay.

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services provided are not Medicare benefits and Medicare will not pay for them. When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself or through a secondary insurance. Before you make a decision, you should read this entire notice carefully. Ask us to explain, if you don't understand why Medicare won't pay. Ask us how much these Items or services will cost you.

Medicare will pay 80% of physical therapy costs after you have met the $183.00 deductible. They will not pay for physical therapy services provided over the $2010.00 Medicare cap unless the beneficiary qualifies for a cap exception.

Medicare will not pay for other services/items:

1. Because it does not meet the definition of any Medicare benefit.

2. Because of the following exclusion * from Medicare benefits:

   - Orthopedic shoes and foot supports (orthotics).
   - Routine foot care and flat foot care.
   - Services required as a result of war.
   - Services paid for by a governmental entity that is not Medicare.
   - Home health services furnished under a plan of care, If the agency does not submit the claim.
   - Items or services furnished that do not have a contract with the Department of Health and Human Services (except in a case of urgent need)
   - Outpatient physical therapy services will not be covered with out a prescription from an Oklahoma Physician.

* This is only a general summary of exclusions from Medicare benefits, it is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

Signature acknowledges receipt of notice.

_____ _____
Signature Date

_____
Printed Name

Medical Intake Form

Patient Name: _____ Date: _____

Height: _____ ft _____ inches Weight: _____ lbs.

Please list all current medications. If you already have current list of medications, please provide it to us to scan into your medical record.

Medications	**Dosage**	**Frequency**	**Reason**
Example: Tylenol	500mg	2x/day	headaches

Please list all medication allergies:

_____

_____

_____

Surgical History: Please list all previous surgeries

_____

_____

_____

Current Medical Conditions (ex. high cholesterol, diabetes etc.):

_____

_____

_____

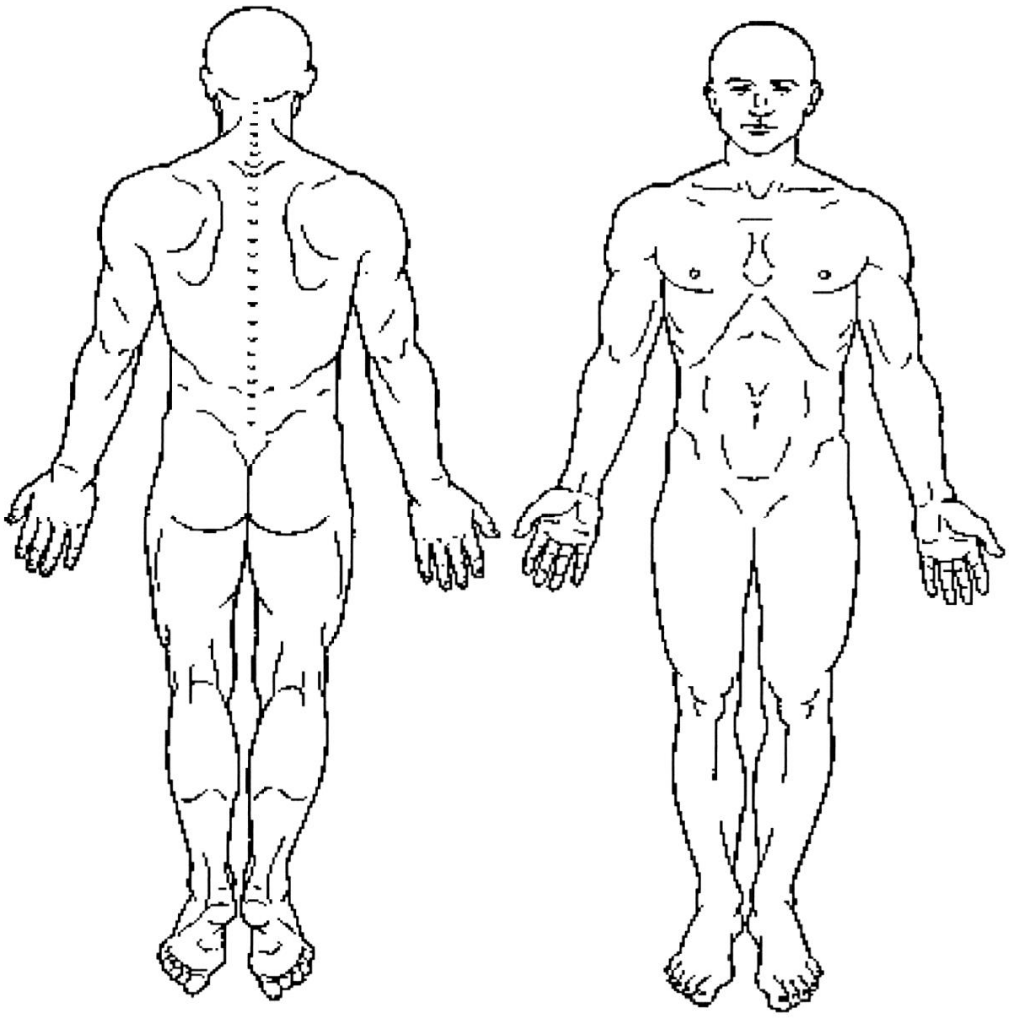
_____

_____

If you need more room for any of the above, please use the back of this page.

Visual Pain Diagram

On the diagram below, please indicate all areas of pain, discomfort or where symptoms occur. Next to the area(s) that you mark, indicate what type of pain you are having – for example: dull ache, sharp, pressure, tingling, burning, numbness etc.



On a scale of "0 – 10" where "0" is no pain and "10" is "take me to the emergency room" type pain, please indicate where your pain level is: (circle one)

At Present	1 2 3 4 5 6 7 8 9 10
At the worst level in the past week	1 2 3 4 5 6 7 8 9 10
At the best level in the past week	1 2 3 4 5 6 7 8 9 10

Signature: _____ Date: _____

Print Name: _____

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At all**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult