LFPT PATIENT INFORMATION SHEET

(PLEASE PRINT)

Patient's Name:_____

Street/Mailing Address: _____ City and zip code:_____

Date of Birth: _____/_____/_____ Age:_____ Sex: [M / F] Social Security#:*(opt.)*_____

Home phone: (_____) _____ Cell phone: (_____) _____ Work phone: (_____)_____

Patient's Employer: _____

Emergency Contact: _____ Relationship to Patient: _____ phone: _____

LFPT may also contact and/or provide medical information to (if any): _____ _____
Name *Relationship*

Does a Power of Attorney exist naming someone responsible for handling your medical information?* □YES** □**NO** *If so, please provide a copy.**

PLEASE PRESENT YOUR INSURANCE CARD(S) & PHOTO I.D. TO OUR OFFICE COORDINATOR

Primary Insurance: _____ Secondary Insurance: _____

Referring Doctor: _____

Are you currently receiving any IN-HOME therapy? (*ie: speech, occupational, physical*) □**YES** □**NO**

How did you hear about us? □Doctor □Family/Friend □Insurance Co. □Yellow Pages □Location □Website
□Other _____

WERE YOU REFERRED HERE FOR TREATMENT RESULTING FROM A ….

Work Injury: YES or NO Date of Injury: _____

Have you been treated for this injury at another clinic? □**YES** □**NO**

Car Accident: YES or NO Date of Injury: _____

Fall in your home: YES or NO Date of Injury: _____

Other:_____ YES or NO Date of Injury: _____

Attorney involved?: YES or NO Name and phone#:_____

PAYMENT POLICY

Payment is required in full at the time of service, unless you have made other arrangements with this office prior to receiving services. As a courtesy, we will bill your primary insurance for you. Your insurance may not pay any or only a part of your bill. I understand that a re-billing fee/finance charge complying with Washington State Law will be applied to any overdue balance. Medicare: I understand my provider agrees to accept the Medicare allowed charge, and I am only responsible for the deductible, co-insurance, and non-covered services. If a referral from a primary doctor is required by my insurance, this referral must be received by this office prior to the services rendered. I am responsible for obtaining the appropriate referral. I consent to treatment by authorized personnel of LFPT as dictated by prudent medical practice

INSURANCE REQUIREMENTS

I understand that I am responsible for knowing and understanding my insurance policy including benefits, co-pays, deductibles, covered providers including laboratory and radiology services, medication formularies and any other medical service requirements.

- **I have read, understand and agree to the above payment and insurance policies.**
- **I authorize this provider or my insurance company to release any information required to process all claims.**
- **"If either party seeks the counsel of a lawyer for the enforcement of any provision of this contract, then the prevailing party shall be entitled to reasonable attorney fees, any collection costs and/or court costs."**
- **I acknowledge that I have read the Medical Record Privacy Policy and understand that I may receive a copy if so desired by myself**.

• I understand if I need to cancel my appointment, and do not give 24 hour notice, I will be charged a $30 cancellation fee.

Signed: _____ Dated: _____

FOR OFFICE USE ONLY:

Therapist: _____ Dx per Referral:_____

LFPT Acct# _____

PATIENT HISTORY

Name_____ Preferred Name_____ Male/Female Date_____

Birth Date _____ Age_____ Occupation_____ Currently off work? Y / N

Describe your symptoms: (spinning, lightheaded, off balance)_____

Date symptoms started_____ Please complete the Dizziness Handicap Inventory on the next page.

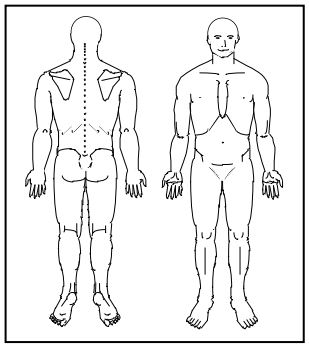
How did your symptoms start?_____

If you have pain, please rate it on the scale below. (Over the last 24 hours)

No Pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Circle painful areas on the diagram
If pain travels, draw arrows.



What decreases the pain?_____

What increases the pain? _____

Do you have any numbness/tingling? Y / N Where?_____

Have you had an x/ray, CT scan, MRI, or blood tests? Y / N

Findings?_____

Have you or a family member EVER been diagnosed with any of the following?

		WHO			
Arthritis	Yes	_____	Hepatitis	Yes	_____
Asthma	Yes	_____	Pacemaker	Yes	_____
Cancer (type)	Yes	_____	Stroke	Yes	_____
Diabetes	Yes	_____	Tuberculosis	Yes	_____
Epilepsy	Yes	_____	Are you pregnant?	Yes	How far along? _____
High Blood Pressure	Yes	_____	List Other Medical Problems		_____
Heart Problems	Yes	_____			_____

To the best of your ability, list all medications: prescription, over-the-counter, herbal, vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency, and route of administration:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you been seen by a healthcare provider, or had any injuries, surgeries, or other major medical problems in the past 5 years? Please provide approximate dates and type:

Date	Injury/Surgery/Medical Problem	Date	Injury/Surgery/Medical Problem
_____	_____	_____	_____
_____	_____	_____	_____

Your Personal Goals for Therapy. Please choose 3-4 that are most important to you.

_____Relieve/reduce vertigo
_____Improve balance
_____Resume/improve household chores, i.e. vacuuming, cleaning, etc.
_____Resume/improve self-care activities, i.e. dressing, fixing hair, etc.
_____Resume/improve yard work, gardening, etc.
_____Return to work activities: specify_____
_____Return to sports/recreation/hobbies; specify_____
_____Regain mobility/increase flexibility
_____Increase sitting tolerance
_____Increase standing tolerance
_____Increase walking distance and speed
_____Improve posture
_____Improve sleep
_____Learn self-care techniques and prevention

Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question. *Answer each question as it pertains to your dizziness or unsteadiness only.*

ITEM	Question		Y	N	S
1	Does looking up increase you problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E			
10	Because of your problem, are you embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F			
20	Because of your problem, are you afraid to stay at home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationships with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
			x4	x0	x2
		=			
		TOTAL			

P_____ E_____ F_____

☐ 100-70 = severe perception of handicap, ☐ 69-40 = moderate perception of handicap, ☐ 39-0 = low perception of handicap.

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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

If you have any questions about this notice, please contact our Privacy Officer:

Lynden Family Physical Therapy, Attn: Steve Korthuis
1824 Front Street, Suite A
Lynden, WA 98264
(360)354-0585
email@lyndenfamilypt.com

This notice describes the procedures and practices that this clinic and its professional, support and administrative staff follow to protect the privacy of your health information.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, it may be in the form of written or electronic records or spoken words, and it may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to maintain the privacy of your health information and to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We are required to abide by the terms of this notice, and to notify you of a breach of your unsecured health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

  For example, the doctor who referred you for physical therapy may be treating you for a medical or orthopedic condition and we may need to know about that and any other health problems that could complicate your treatment. We may use your medical history to decide what treatment is best for you. We will consult with your doctor and send reports about your treatment to the doctor. We do this to provide the most appropriate care for you.

  Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as telephoning your doctor and getting needed information. Family members and other health care providers may be part of your physical therapy outside this office and that may require us to provide information about you.

- **For Payment**. We may need to use or disclose health information about you in order to obtain payment for our health care services. For example, we may bill your health plan or insurance company or other third party for your treatment in this clinic. We may also need to tell your health plan or insurance company about a treatment you are going to receive in order to obtain prior approval, or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to manage the clinic and ensure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain treatments are effective for certain problems.

We may also disclose your health information to your health plan and other health care providers that care for you in order to help these plans and providers evaluate or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

OTHER CIRCUMSTANCES

We may use or disclose health information about you for the following purposes, in accordance with the requirements and limitations of state and other law:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process or under certain other limited circumstances.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report suspected abuse or neglect, non-accidental physical injuries or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** We may disclose your health information in response to a court or administrative order, subpoena, discovery request, or other legal process, subject to certain restrictions.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may release health information to a funeral directors as necessary for them to carry out their duties.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends or others involved in your care or payment if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the room during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.
- **Personal Representative.** If you have a personal representative who has authority to make health care decisions on your behalf, such as a parent or guardian, we may disclose your health information to such a personal guardian.

OTHER USES AND DISCLOSURES PURSUANT TO YOUR SIGNED AUTHORIZATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific,

written *Authorization*. We will not sell your health information, use or disclose any psychotherapy notes about you, or use or disclose your health information for marketing purposes without your *Authorization* unless otherwise permitted under federal law. If you sign an *Authorization* for us to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Privacy Officer (at the address listed at the top of this Notice) in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

  We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Correct.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request a correction as long as the information is kept by this office.

  To request a correction, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to our Privacy Officer. We will provide you with one of these forms at your request.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to correct information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the correction
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a record of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The record may also exclude any disclosures we have made based on your written authorization.

  To obtain this accounting, you must submit your request **in writing** to our Privacy Officer. It must state the time period for which you want an accounting. The time period may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  If you or someone on your behalf pays for a service in full and you request that we not disclose information about the service to your health plan for purposes of payment of health care operations, we are required to agree to your request unless the disclosure is required by law. For all other types of restriction requests, we are not required to agree to your request**.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our Privacy Officer. We will provide you with one of these forms at your request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail or e-mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

  To obtain such a copy, contact the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice or a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer (at the address listed at the top of this Notice). ***You will not be penalized for filing a complaint.***