



Name of Patient: _____ Sex: Male Female Age: _____
Last First Middle Initial

Address: _____ SS#: _____
Street (P.O. Box) City State Zip

Date of Birth: _____ ***Home Phone #: _____ Alternate/Cell Phone #: _____

E-mail address: _____ Patient is: Married Single Divorced Widowed

Spouse's Name: _____ Referring Physician: _____ Family Physician: _____

Insurance Company: _____ Subscriber Name: _____

Address _____
Street (P.O. Box) City State Zip

Patient/Subscriber Relationship: _____ Date of Birth: _____ Sex: Male Female

SS# _____ Effective Date _____

This injury/accident due to: Sports Work Auto Other *** Date of this injury: _____

If AUTO, Name of Insured: _____ AUTO - County Accident Occurred: _____

***Name of School or Employer at the time of Injury: _____

Patient currently employed by: _____ Employer's phone #: _____
If patient is a minor, please put parent's employer

Employer's Address: _____ Job Title: _____
Street (P.O. Box) City State Zip

Spouse Employed By: _____ Employer's phone #: _____ Job Title: _____

Attorney's Name (if applicable): _____ Phone #: _____

Nearest Relative (not living at your address) _____ Phone #: _____

*****MEDICARE PATIENTS**
Are you enrolled in Home Health at this time for any Medical Condition? Yes No

I authorize insurance benefits to be paid directly to the PT PROS Physical Therapy and Sports Centers and also authorize release of any or all medical records to my insurance company and its agents including rehabilitation coordinators. By signing below, I am also authorizing PT PROS Physical Therapy and Sports Centers to treat the above referenced patient and verify that I am said patient or the parent or legal guardian thereof.

NOTICE: Interest rate of 1.5% per month will automatically be added to any unpaid balance of your account at the end of each month and by signing this agreement, you are acknowledging that you understand and accept that this interest charge will be added automatically to your account at the end of each month. Furthermore, you understand and agree that if PT PROS Physical Therapy and Sports Centers is forced to take legal action to collect any part of your account which remains unpaid, you agree that you are responsible for any and all legal fees, including but not limited to attorney fees, which PT PROS Physical Therapy and Sports Centers incurs as a result of collecting such an account. I understand that I am responsible for any remaining balance owed to PT PROS Physical Therapy and Sports Centers.

Signature of Patient (parent or guardian if minor)
Revised: 9/11/2006

Date
*****Lines must be completed**



MEDICAL SCREENING FORM

Patient Name: _____

Date: _____

CIRCLE YES OR NO. IF YOU ANSWER YES, PLEASE EXPLAIN.

Have you or any immediate family member ever been told you have...

	Self	Family
Cancer	Yes/No	Yes/No
Diabetes	Yes/No	Yes/No
High Blood Pressure	Yes/No	Yes/No
Heart Disease	Yes/No	Yes/No
Angina/Chest Pain	Yes/No	Yes/No
Stroke	Yes/No	Yes/No
Osteoporosis	Yes/No	Yes/No
Osteoarthritis	Yes/No	Yes/No
Rheumatoid Arthritis	Yes/No	Yes/No

In the past 3 months, have you had or do you experience:

A change in your health	Yes _____	No _____
Nausea/Vomiting	Yes _____	No _____
Fever/Chills/Sweats	Yes _____	No _____
Unexplained Weight Change	Yes _____	No _____
Numbness or Tingling	Yes _____	No _____
Changes in Appetite	Yes _____	No _____
Difficulty swallowing	Yes _____	No _____
Changes in bowel or bladder function	Yes _____	No _____
Shortness of breath	Yes _____	No _____
Dizziness	Yes _____	No _____
Upper Respiratory Infection	Yes _____	No _____
Urinary Tract Infection	Yes _____	No _____

Do you have a history of:

Allergies/Asthma	Yes _____	No _____
Headaches	Yes _____	No _____
Bronchitis	Yes _____	No _____
Kidney Disease	Yes _____	No _____
Rheumatic Fever	Yes _____	No _____
Ulcers	Yes _____	No _____
Sexually Transmitted Disease	Yes _____	No _____
Seizures	Yes _____	No _____
Fractures	Yes _____	No _____

Revised: 1/2/06

Are you currently:

Pregnant Yes _____ No _____
 # of previous pregnancies _____
 Depressed Yes _____ No _____
 Under Stress Yes _____ No _____

How did your injury occur? _____

Have you ever had any treatment for this injury before?

Yes No Date last treated: _____

Are your symptoms: (check one)

Getting Worse Same Improving

How are you able to sleep at night? (check one)

Fine Moderate Difficulty Not Well

Do you or have you in the past used any form of tobacco? Yes No

If yes, _____ packs per day for _____ years.

Date of last tobacco use _____

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week?
 _____/week.

Date of last physical examination: _____

List medications you are currently using:

Additional Comments:

Blood pressure: HR: BS: _____ (Initials)

Therapist Signature

Date



Personal Representative Authorization

Member Name _____

Section A – Purpose

This form allows you (the “Individual”) to give PT PROS, Inc. permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care; diagnoses; procedures; and personal information, such as your date of birth and mailing address.

Each adult family member, including each adult child (age 18 or older, or as determined by state law), who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, do not complete this form. **You are not required to name a Personal Representative, but if you do not,** we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, parent, child, friend, congressman or Union representative. You must provide the information requested in Section C for each person before we can treat that person as your Personal Representative. If you need additional forms, you may copy this form, or call us.

Please note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment of direct care decisions. Also, we will not condition enrollment, eligibility for benefits, or benefits payments on your completion of this form.

Section B – Individual’s Information

I authorize PT PROS, Inc. to treat the person(s) named in Section C as my Personal Representative(s), subject to the rights and restrictions, if any, described in Section C.

My Name _____ Date of Birth _____

Daytime Phone _____ Relationship to Member _____

Section C – Authorized Use and/or Disclosure

I understand that the PT PROS, Inc.’s privacy practice is to not disclose my personal health information, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, **I authorize you to disclose my protected health information to the person(s) named in Section C** for the purpose of assisting with or facilitating the payment of my health plan benefits. Unless I have stated otherwise in *Restrictions*, I also allow my Personal Representative for the following rights: the right to request amendment of my PHI; the right to request an accounting of disclosures of my PHI; and the right to request restrictions on disclosure of my PHI. I understand that if my Personal Representative is not a health plan, a health care provider or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my personal health information, and my Personal

Representative may further disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in *Restrictions*, in this section.

Personal Representative #1

Full Name _____ Phone Number _____
(please print)

Relationship to You _____
(such as: spouse, parent, child, HBR, friend)

Restrictions: _____

Personal Representative #2

Full Name _____ Phone Number _____
(please print)

Relationship to You _____
(such as: spouse, parent, child, HBR, friend)

Restrictions: _____

Section D -- Revocation

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named in Section C to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Official at the address shown below. I understand that my revocation of this authorization will not affect any action that you have taken or information that you have already released, based upon the authorization, before you receive my request to revoke authorization.

**PT PROS, Inc.
383 Corbin Center Drive
Corbin, KY 40701**

Section E – Signature/Authorization

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that PT PROS, Inc. may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature _____ Date _____

Please complete and sign this form, and return it to our Office Manager. You are entitled to a copy of this completed form.

HIPAA NOTICE OF PRIVACY PRACTICES

PT PROS, Inc.

Effective Date: April 13, 2003

THIS NOTICE DESCRIBES HOW HEALTH 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 Deanna Shackelford, Privacy Official at (606) 526-2915.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you;
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party.

For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local 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. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

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 activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls or products they may be using;
- to notify person or organization required to receive information on FDA-regulated products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor health care systems, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person:
 - Name and address
 - Date of birth or place of birth;
 - Social security number;
 - Blood type or rh factor;
 - Type of injury;
 - Date and time of treatment and/or death, if applicable; and
 - A description of distinguishing physical characteristics.
- about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

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 health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy notes.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Deanna Shackleford, Privacy Official. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. You have the right to request an amendment as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Deanna Shackelford, Privacy Official, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it 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 amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is no part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to Deanna Shackelford, Privacy Official. Your request must state a time period which may not be longer than six years and may not include dates before April 13, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost 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. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

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 of your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Deanna Shackelford, Privacy Official. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of a specified surgery to your spouse.

Right to Request Confidential Communications: You have the right to request that we communication with you about health 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 to a post office box.

To request confidential communications, you must make your request in writing to Deanna Shackelford, Privacy Official. 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 obtain a paper copy of this notice at any time. To obtain a copy, please request it from Deanna Shackelford, Privacy Official.

You may also obtain a copy of this notice either from our website, www.ptpros.net, or by requesting a copy of this notice be sent through electronic mail to dshackelford@ptpros.net. If we know that the electronic message has failed to be delivered, a paper copy of this notice will be provided. Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request.

If the first service delivery is delivered electronically, other than by telephone, we provide electronic notice in the same medium, automatically and contemporaneously in response to a first request for service.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Deanna Shackelford, Privacy Official. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices form PT PROS, Inc.

X _____ Date: _____

In lieu of patient signature, I, _____, a staff member of PT PROS, Inc., state that _____ has been given our current Notice of Privacy Practices.

X _____ Date: _____