Dear New Patient:

Thank you for choosing Anderson Physical Therapy for your rehabilitation needs. As a new patient, we will need you to fill out several forms. This may be done in your home or you may do so at our office. If you choose our office, please arrive approximately 15 minutes early to complete your paperwork. Please complete one of each of the following:

1. PATIENT INFORMATION
2. MEDICAL INFORMATION
3. PRIVACY POLICY
4. QUESTIONAIRE

When you arrive for your physical therapy appointment, please wear comfortable loose-fitting clothing. Please bring shorts if your injury has occurred in the lower extremities. And lastly, bring in your prescription and your insurance card (if applicable).

We are looking forward to working with you in reaching your goals for optimum health.

Thank you,

The Staff at Anderson Physical Therapy

ANDERSON PHYSICAL THERAPY

PATIENT INFORMATION

Legal Name: _____ Date of Birth: _____ Age: ___ Sex: M F (circle)

Preferred Name: _____ Height: _____ Weight: _____ _____

(Height and weight required by Medicare)

Primary Phone: _____ Other Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

SS #: _____ Responsible Party: _____

Emergency Contact: _____ Phone:_____

Email Address: _____ Status: Single / Married / Child

Referring Physician: _____ Primary Physician: _____

I authorize Anderson Physical Therapy, and all persons acting as agents therefore, as well as all treatment personnel to furnish all forms of reasonable diagnostic, and therapeutic treatments to me or my minor child/conservatee.

How did you choose our practice?

☐Physician ☐Former Patient ☐Employer ☐Flyer/Mailer ☐Yellow Pages ☐Web Site

☐Friend/Relative; whom: _____

INSURANCE INFORMATION

(Please present insurance card to receptionist to copy)

Primary Insurance: _____ Subscriber's Name: _____

Secondary Insurance: _____ Subscriber's Name: _____

Relation to Patient: _____ Date of Birth: _____ SS#: _____

I hereby give authorization for present and future payments of medical benefits to be made directly to Anderson Physical Therapy (APT) for services rendered. I understand that I am responsible for payment of physical therapy services rendered, regardless of whether or not such services are a covered benefit of my insurance. I agree to pay all co-pay and deductible amounts at the time of service unless arranged otherwise. I hereby authorize the release of any medical and personal information necessary to secure the payment of benefits.

As a courtesy to our patients, APT will bill your insurance company for you. However it is your responsibility to pay any amount not paid/covered by you insurance. APT will add a 10% per annum interest on all 'patient responsible balances' if not paid in full from 30 days past due date. In the event your account becomes seriously delinquent administration fees and interest will be added.

Patient, Parent/Guardian Signature:_____

ANDERSON PHYSICAL THERAPY

PHYSICAL THERAPY INTAKE SHEET

Name: _____ Date: _____

Occupation: _____ Age: _____

CURRENT SYMPTOMS

Location (body part):_____ Which side? Left Right N/A

How would you describe your symptoms? _____

(Circle all that apply) Ache Burn Stab Shoot Sharp Numb Pins & Needles Stiffness/Tightness Weakness

When did your symptoms begin and/or what date did your injury occur? _____

Are your symptoms due to a fall/accident/injury? **Y** **N** If ***yes***, briefly described below.

_____

Did you have surgery related to ***this*** incident? **Y** **N** If ***yes***, briefly described below.

_____ Date of surgery: ___/___/___

Did you have any functional limitations prior to this incident? N/A Mild Moderate Severe

CURRENT MEDICATION LIST

Are you currently taking any medication? □ Yes □ No

Medication	Dosage	Frequency	Method

(If additional room is needed, please use reverse side or attach additional sheet)

How do you rate your pain 0 – 10 **(0= no pain,** and **10 = extreme/unbearable pain)**

Current:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Best:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Worst:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Overall: Circle **ONE** face below that indicates your **overall** pain associated with this event

Medical history: Do you **now**, or **ever** had any of the following? **Surgeries: (Please circle/list)**

Shoulder L R Elbow L R Wrist/hand L R Hip L R Knee L R Ankle/foot L R Neck Back

_____

Circle all that apply) Heart problems Hepatitis HIV/AIDS Diabetes: Type I Type II High blood pressure Cancer Ulcers Parkinson's Multiple Sclerosis Stroke/CVA Pacemaker/Defibrillator

Other: _____

Patient, Parent/Guardian Signature: _____

PRIVACY PRACTICE POLICY

Effective date of notice: July 1, 2015

We are committed to protect your healthcare information and will not release information to anyone without your consent. It is standard medical practice to provide your physical therapy evaluation and progress reports to your referring physician(s) and authorization insurance agents. Please list any other people whom we have your permission to discuss your appointment, insurance or medical information. Do we have your permission to release information to anyone other than yourself, your referring physician, and/or authorizing insurance agents?

YES / NO (please circle one and indicate below whom)

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

I have had the opportunity to review and receive the Notice of Privacy Practices. I give my permission to *Anderson Physical Therapy* to use and disclose my health information in accordance with this notice.

Patient, Parent/Guardian Signature: _____ **Date:** _____

Northern Asset Management, Inc.
Dba Anderson Physical Therapy
2835 Childress Drive
Anderson, CA 96007
(530) 378-0998

Effective date of notification: August 1, 2006

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRACTICES PRIVACY as required by the Privacy Regulations Created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (As a patient of this practice) IS USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO YOUR individually identifiable health information.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

* How we may use and disclose your IIHI
* Your privacy right in your IIHI
* Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to place your name on a sign in sheet. Your name may be overheard by others when being called back for, or during your treatment. Your chart may be placed in a chart holder outside your treatment room or on a counter in a low traffic area to allow the therapist immediate access to your record. You may receive treatment and/or exercise instruction in the presence of others. Many of the people who work for our practice - including, but not limited to, our therapists and aides - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may sue and disclose your IIHI in order to bill and collect payment for services and items you may receive from us. For example we may contact your health insurer from our front desk (which may be overheard by others) to certify that you are eligible for benefits and for what range of benefits. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may discuss financial matters regarding your care which may be overheard by others. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may call you or leave a message for you in order to collect payment. We may disclose your IIHI to an outside collection agency in order to collect payment. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the way in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment or call you when an appointment has been missed.
5. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    a. maintaining vital records, such as births and deaths
    b. reporting child abuse or neglect
    c. preventing or controlling disease, injury or disability
    d. notifying a person regarding potential exposure to a communicable disease
    e. notifying a person regarding a potential risk for spreading or contracting a disease or condition
    f. reporting reactions to drugs or problems with products or devices

g. notifying individuals if a product or device they may be using has been recalled
h. notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
i. notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or action; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Brian Baas/Anderson Physical Therapy specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction on our use or disclosure of your IIHI, you must make your request in writing to Brian Baas/Anderson Physical Therapy. Your request must describe in a clear and concise fashion:
    a. the information you wish restricted;
    b. whether you are requesting to limit our practice's use, disclosure or both; and
    c. to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical

4. records and billing records. You must submit your request in writing to Brian Baas/Anderson Physical Therapy in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
5. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Brian Baas/Anderson Physical Therapy. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
6. **Accounting of Disclosures.** All of our patients have the right to request an accounting of disclosures. An accounting of disclosure is a list of certain non-routing disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to Brian Baas/Anderson Physical Therapy. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of the disclosure and may not include dates before April 14, 2008. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period.
7. **Right to a Paper Copy of this Notice.** You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Brian Baas/Anderson Physical Therapy.
8. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Brian Baas/Anderson Physical Therapy. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
9. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.
10. **Contact Brian Baas, PT with any questions at:** 2835 Childress Drive Anderson, CA 96007