History of Present Condition:

PATIENT NAME: _____ *THERAPIST:* _____ *REFERRING DR:* _____

- ***Date of Injury or start of symptoms:***_____
  Circle One: *Acute / Insidious (gradual) / Chronic*
- ***History of Injury:***_____
  Surgery: *Yes or No* If yes, date:_____ Procedure:_____
- ***What is your chief complaint?***_____
- ***Before injury or pain started were you independent in the following:*** *All or circle each*

  Self Care Hygiene Sleep Activities of Daily Living Changing/Maintaining body position
  Lift/Carry Work Recreation Mobility/Ambulation
- ***List Current Functional Limitations or Circle:***_____

  Self Care Hygiene Sleep Activities of Daily Living Changing/Maintaining body position
  Lift/Carry Work Recreation Mobility/Ambulation
  - ***Pain:***

At its WORST 0 1 2 3 4 5 6 7 8 9 10
No pain ⟷ ***Worst pain***

Current Pain 0 1 2 3 4 5 6 7 8 9 10
No pain ⟷ ***Worst pain***

At its BEST 0 1 2 3 4 5 6 7 8 9 10
No pain ⟷ ***Worst pain***

- ***Pain Location:***_____
- ***Nature of pain: Please circle all that apply***
  Burning Sharp Dull Aching Throbbing Shooting Numbness
  *Other*_____
- ***What Aggravates Pain****:* _____

- ***Work Status:*** *Yes or No*
- ***Work Occupation:***_____ ***Last Day Worked:***_____

- ***Medical History(self only): Please circle all that apply***
  *Osteoarthritis Heart Disease Diabetes Allergies*_____ *Complicating Factors*_____
  *Surgical History*_____ *Previous Therapy*_____

- ***Have you had any of the following test for your current condition: please circle all that apply***
  X-rays MRI CT Scan Bone Scan Ultrasound-Imaging
  Nerve Conduction Study EMG Arthrogram ***Results****:*_____

- ***Medication: Are you currently taking any medication? Yes or No /*Please list below or attach list**
  Prescription: _____ *Non-Prescription:*_____
  *Other:*_____

- ***What are your goals for physical therapy?***_____

- ***What is your height:***_____ ***What is your weight:***_____

RIVER CITY PHYSICAL THERAPY POLICIES

I, the undersigned patient and/or the responsible party have read and received a copy of River City Physical Therapy's Privacy Statement.

FINANCIAL

River City Physical Therapy is happy to bill our patients' insurance carriers *as a courtesy* when they present with a *current* insurance card. However, we are not contracted with all insurances, nor do we know your individual policy. As a courtesy, we will call your insurance to check your physical therapy benefits although we are only *given a description of benefits and not a guarantee of payment*. It is **ULTIMATELY** the ***patient's*** responsibility to know their insurance carrier's benefits and policies.

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. In the case of non-payment by contracted/non-contracted carriers, patient is ultimately responsible for payment and follow-up with carrier for services rendered. I realize that failure to keep this account current may result in my being unable to receive additional services. In the case of default on payment, I understand that my account balance may be forwarded to a collection agency.

MEDICAL SUPPLIES AND ORTHOTICS

Many insurance companies do not consider medical supplies a covered benefit. Therefore, we ask for payment in full at the time of pick-up if you are purchasing a non-covered item.

LATE CANCELLATIONS AND NO SHOWS

Cancellations or changes must be made at least 24 hours prior to the scheduled appointment. If a patient fails to show for two scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and their physician will be notified.

I acknowledge that I have read and understand the policies as stated above.

_____ _____

Signature **Date**

RELEASE OF MEDICAL INFORMATION

I, (we) orally or in writing, as may be requested, authorize the release and disclosure of any and all information regarding my condition when under your observation, treatment of care, including history, findings, treatment, x-ray readings and diagnosis and your prognosis. You are also authorized to follow my physical therapists to inspect and take copy of your clinical or hospital records pertaining to me, and to inspect and borrow x-rays or photographs in your possession for examination.

I (we), the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patient's medical records to any entity which is, or may be liable for all or part of the provider charges.

I (we), authorize the release and disclosure of any and all my medical records to any other entity, including, but not limited to referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I (we), authorize the release of records necessary to assist in the reimbursement of benefits to which I (we), may be entitled. I (we), authorize this office and/or its employees to release via fax machine, medical records which are needed in order to provide patient with the most appropriate medical care/payment for treatment rendered.

_____ _____

Signature **Date**

PATIENT COPY

1132 E. Polston • Post Falls, ID 83854 (208) 777-7800
370 E. Kathleen Ave., Suite 500 • CDA, ID 83815 (208) 292-1372

David Hillman, PT, MPT, OCS, COMT
Eric Verhaeghe, PT, OCS
Nate Thoreson, PT, MSPT, OCS, COMT
Lucas Hammond, PT, DPT, OCS, FAAOMPT
Michael Kim, PT, CHT
Scott Randklev, PT, DPT, OCS, TPI, CGFI-MP
Dahlon Hess, PTA
Blythe Amland, PTA
Walter Wolf, PTA
Eryn Fink, PTA

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

About Us

In this Notice, we use terms like "we", "us", or "our" to refer to River City Physical Therapy and it's therapists. We are an Outpatient Therapy Clinic specializing in physical therapy to help you towards your goal of good health.

This Notice applies to River City Physical Therapy.

What is "Protected Health Information""PHI"

Protected Health Information "PHI" is information that identifies who you are and relates to you, your past, present, or future physical condition, the provision of health care to you, or your past, present, or future payment for the provision of health care to you. PHI does not include information about you that is publicly available, or that is in a summary form that does not identify who you are. If you are an employee at our office, PHI does not include your health information in your personnel file.

Purpose of this Notice

In the course of doing business, we gather and maintain PHI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This Notice describes our privacy practices and how we protect the confidentiality of your PHO. We are obligated to maintain the privacy of your PHI by implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this Notice about our legal obligations to maintain the privacy of your PHI. We must follow our Notice that is currently in effect.

How We Protect your PHI

We restrict access to your PHI to those employees who need access in order to provide services to our patients. We have established and maintain appropriate physical and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees must complete. We have also established a Privacy Officer, which has overall responsibility for developing, training and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use and disclosure.

Disclosure of PHI we May Make Without Your Authorization

When required by law In some circumstances, we are required by federal or state laws to disclose certain PHI to others, such as public agencies for various reasons.
For lawsuit and other legal disclosures In connection with court proceedings before administrative, agencies, or to defend us or our participating therapists in a legal dispute.
For law enforcement purposes Such as responding to a warrant, or reporting a crime.
In connection with services provided with worker's compensation laws.
Healthcare Oversight Organizations Such as reports to agencies that are responsible for credentialing /licensing our health care providers.

Updated Release

If you pay cash for services and opt not to utilize your health insurance plan you may instruct our clinic not to share information about your treatment with your health care plan. If you choose this option you need to inform us in writing so we can record your request in your patient file.