Physiotherapy WORKS L.L.C

Winter Park
1860 State Rd 436, Suite 1000
Winter Park, FL, 32792
T (407) 657 5029
F (407) 657 6320

Waterford Lakes
12301 Lake Underhill Rd, Suite 118
Orlando, FL, 32828
T (407) 218 4660
F (407) 218 4661

PATIENT INFORMATION

NAME: LAST:________________________ FIRST____________________ MI___ E-MAIL________________________

ADDRESS____

CITY:____ STATE_________________ ZIP____________________

HOME PHONE:______________________ WORK________________________ CELL__________________________

SEX M [ ] F [ ] AGE:______ DATE OF BIRTH:_________________ [ ] SINGLE [ ] MARRIED [ ]WIDOWED [ ]DIVORCED

PLACE OF EMPLOYMENT______________________________ JOB TITLE____

WORK STATUS [ ] FULL DUTIES [ ] MODIFIED DUTIES [ ] UNABLE TO WORK [ ] UNEMPLOYED [ ] DISABILITY [ ] RETIRED

EMERGENCY CONTACT NAME:__________________________________ TEL#__________________________________

HOW DID YOU HEAR ABOUT US ? ____

REFERRING DR.____ PRIMARY DR._______________________________

HISTORY OF CURRENT PROBLEM

WHAT IS YOUR PRIMARY COMPLAINT?____

DO YOU HAVE A MEDICAL DIAGNOSIS____

X- RAY RESULTS____________________________________ MRI RESULTS____________________________________

WHEN DID IT START?____

HOW DID IT START?____

WHAT AGGRAVATES IT?____

WHAT MAKES IT BETTER?____

IS IT GETTING BETTER OR WORSE? [ ] BETTER [ ] WORSE [ ] COMES AND GOES [ ] CONSTANT

WHAT DO YOU BELIEVE IS WRONG WITH YOU____

DO ANY OF THE FOLLOWING GIVE YOU RELIEF? [ ] HOT PACK [ ] COLD PACK [ ] MEDICATION [ ] REST

HAVE YOU HAD ANY OTHER TREATMENT FOR THIS CONDITION_______________________________________

OTHER AREAS OF PAIN OR CONCERN?____

HEIGHT _________________ WEIGHT ___________________

CURRENT MEDICATION

NAME OF MEDICATION	DOSAGE	WHAT IS IT FOR?	FREQUENCY (TIMES/DAY)

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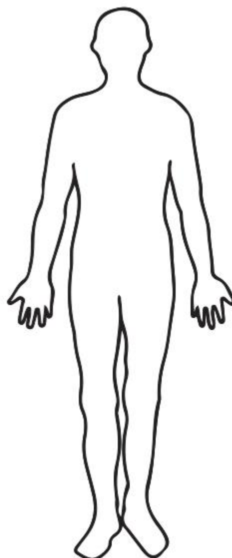
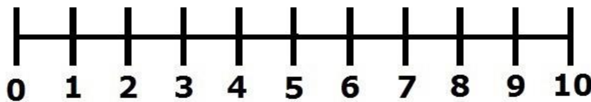
INTESITY OF YOUR PAIN - IN THE LAST 2 WEEKS

FRONT

BACK





0
very happy,
no pain

1 - 2
hurts just
a little bit

3 - 4
hurts a
little more

5 - 6
hurts even
more

7 - 8
hurts a
whole lot

9 - 10
hurts as much
as possible

PLEASE SELECT THE WORDS THAT BEST DESCRIBE YOUR SYMPTOMS

DULL	ACHING
BURNING	COLD
SHOOTING	STABBING
SHARP	PINCHING
THROBBING	SORENESS
BRUISED	CRAMPING
GRIPPING	SQUEEZING
HEAVINESS	WEAKNESS
NUMBNESS	TINGLING
TIGHT	EMPTY

CURRENT PAIN ___/10

AT BEST ___/10

AT WORST ___/10

OTHER MEDICAL HISTORY

OTHER MEDICAL PROBLEMS/DIAGNOSES____

____

____

____

____

SURGERIES/ACCIDENTS/INJURIES____

____

____

____

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FUNCTIONAL ACTIVITIES - QUESTIONNAIRE

	0	1	2	3	4
How Much Difficulty do you have with the following activities	**No difficulty 0%**	**Mild difficulty 0-25%**	**Moderate difficulty 25-50%**	**Severe difficulty 50-75%**	**Unable 100%**
Sleeping					
Turning over in bed					
Getting out of a chair					
Making you bed					
Washing/dressing					
Making meals					
Feeding yourself					
Housework					
Yard work					
Walking 2 blocks					
Walking 1 mile					
Walking on uneven ground					
Climbing 10 steps					
Travelling in a car/bus					
Getting in or out of car/bus					
Standing 1 hour					
Sitting 1 hour					
Picking up item from floor					
Reaching overhead					
Lifting groceries					
Lifting a laundry basket					
Reading					
Handling own finances					
Performing work duties					
Maintaining social contact					

How many minutes or how far can you walk? ______________________
How long can you stand for? ______________________
How long can you sit for? ______________________
How much weight can you lift from the floor? ______________________
How much weight can you carry? ______________________
Are you R or L handed [ ] **R** [ ] **L**

WHAT ARE YOUR GOALS FROM PHYSICAL THERAPY

1. ____
2. ____
3. ____

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HOME HEALTH

HAVE YOU RECENTLY OR ARE YOU NOW RECEIVING HOME HEALTH CARE FOR ANY OF THE FOLLOWING

[ ] PHYSICAL THERAPY [ ] OCCUPATIONAL THERAPY [ ] SPEECH THERAPY
[ ] IV THERAPY [ ] INJECTIONS OR MEDICATIONS [ ] BATHING OR PERSONAL CARE

BILLING POLICY

PHYSIOTHERAPY WORKS, LLC WILL BILL YOUR INSURANCE FOR TREATMENT SHOULD YOU HAVE COVERAGE. OTHERWISE WE SHALL ACCEPT $65 PER HOUR FOR MASSAGE THERAPY OR $85 FOR EACH PHYSICAL THERAPY SESSION WHEN PAID AT THE TIME OF SERVICE.

____
INITIALS

CANCELLATION POLICY

I UNDERSTAND THAT MY APPOINTMENT TIMES ARE BEING RESERVED ESPECIALLY FOR ME. AS A COURTESY TO MY THERAPISTS AND OTHER PATIENTS, IF I AM UNABLE TO MAKE THE APPOINTMENTS AT THE TIMES THAT I HAVE SCHEDULED **I WILL GIVE AT LEAST 12 HOURS NOTICE OR I WILL BE CHARGED $35 LATE CANCELLATION/NO SHOW FEE.** I ALSO UNDERSTAND THAT THIS CHARGE CANNOT BE BILLED TO MY INSURANCE.

____
INITIALS

CONSENT FOR TREATMENT

I GIVE MY CONSENT TO THE PROVISION OF EXAMINATION, TREATMENTS, THERAPIES, AND SUPPLIES AS ORDERED BY THE THERAPIST AT PHYSIOTHERAPY WORKS, LLC. I AKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE OUTCOME OF SUCH TREATMENTS, PROCEDURES AND EXAMINATIONS.

PRIVACY POLICY

I HAVE BEEN ISSUED WITH A NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE). __________
INITIALS

PATIENT/GUARDIAN SIGNATURE ____**DATE**_____________

PRINTED NAME ____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM COMPLETELY.

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ACKNOWLEDGMENT OF LIABILITY ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledge personal responsibility and liability for all the medical services, which are provided by **Eric Mason PT/Physiotherapy Works, LLC**. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays the payments shall be credited to your account. If no insurance payment is received, you may be completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority:

CONSENT FOR TREATMENT: The undersigned hereby consents to the provision of examination, treatments, therapies, and supplies to the patient as ordered by the patient's health care provider **Eric Mason PT/Physiotherapy Works, LLC,** their physical therapists, physical therapy assistants, massage therapists or staff, and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company or other person of entity. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim. The physician and/or facility is also assigned the right to request and receive a list of all payments made under any coverage, as well as a list of what bills were received, and when they were received.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the therapist/facility named above you are hereby tendered the right to demand payment in full the bill for services rendered by the therapist/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

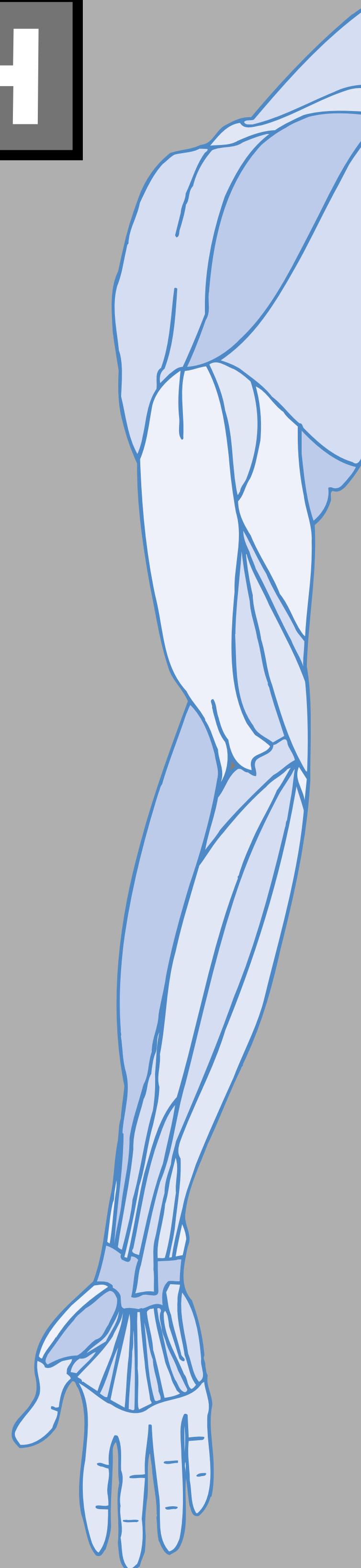
Signature of patient and/or responsible party:

Sign Here ____________________________________ Date: ________________________

Print Name Signature____________________________________ Relationship: ____________________

PATIENT'S NAME: ____________________________________ Date of Accident: __________________

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:______________________________________

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:______________________________________

❏ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may not be calculated if there are any missing items.

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ABOUT YOUR INSURANCE

It is extremely important that you understand your insurance coverage.

Please take the time to call the customer service number on the back of your insurance card.

Please inform the representative that you will be attending therapy at PHYSIOTHERAPY WORKS, LLC.

You might want to ask the following questions:

1) Do you need to have an authorization your therapy?______________
 If authorization is needed please call the referring doctors office referral coordinator and ask them to obtain an authorization for you.
2) Do you have a co-pay? ___________
3) Do you have a deductible? __________
4) Are you responsible for a portion of the bill? ___________
5) Do you have a visit limit _____________
6) What is the benefit period from_______ to ______.
7) Is PHYSIOTHERAPY WORKS, LLC or ERIC MASON, PT in network or out of network.
8) If you have Medicare, have you used any of this years Medicare allowance for outpatient therapy?________ If so how much?________.

It is the patient's responsibility to know that insurance coverage. Your insurance company will be billed and you may be responsible for any balance not covered by your insurance

Notice of Privacy Practices for

Physiotherapy Works, LLC (HIPAA Notice)

Effective Date: April 14,2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

Your Health Information Rights
Although your health record is the physical property of the healthcare organization that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record
- amend your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment purposes.
For example: Information obtained by a physical therapist, acupuncturist, chiropractor, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. The physical therapist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physical therapist will know how you are responding to treatment.

We will also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment purposes.

For example: A bill may be sent to you or a third-party payer such as an insurance company, the Medicare program or any other organization, person or program that may be responsible for paying for services. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Health care providers within the organization, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contracts with business associates. An example is a laboratory which performs certain laboratory tests or a nurse or physician who is an independent contractor. There may be additional independent contractors. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative,

or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or otherwise provide information about additional services or health care products you may find useful.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (PDA): We may disclose to the PDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Legal Matters: In the event of a claim, litigation or other legal proceeding or contemplated legal matter, we may disclose health information to our attorneys and individuals or organizations working for them.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact Eric Mason, the HIPAA Privacy Official, at the Physiotherapy Works. LLC, 1890 Semoran Blvd. Suite 251. Winter Park, PL 32792 or (407) 657 5029.

If you believe your privacy rights have been violated, you can file a complaint with the HIPAA Privacy Official for Physiotherapy Works, LLC or with the secretary of Health and Human Services.

There will be no retaliation for filing a complaint.

Other Uses of Protected Health Information

Other uses and disclosures of protected 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 medical 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 protected 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 to you.