Name: ____ SSN:__________________ Date:_____________

Leisure activities, including exercise routines:____

Occupation, including activities that comprise your workday:______________________________________

Age: Height: Weight:
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No
Do you smoke? Yes No Do you have a pacemaker? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: ____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ______________________ 2.__________________________ 3.______________________________

4. ______________________ 5. __________________________ 6.______________________________

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. ______________________ 2.__________________________ 3.______________________________

What date (roughly) did your present symptoms start?____

What do you think caused your symptoms? ____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, etc) ____________________________

Please list special tests performed for this problem (x-ray, MRI, labs, etc) ___________________________

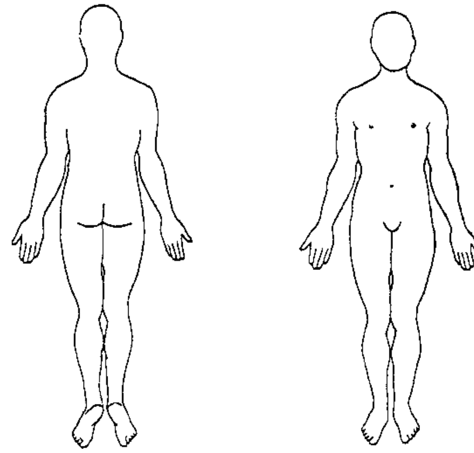
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**__________ **Treatment rec'd**_____________

How long did it take for you to feel better? ____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

---

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. ____
2. ____
3. ____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. ____
2. ____
3. ____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

---

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

The worst your pain has been during the past 24 hours: __________

Your current level of pain while completing this survey:__________

The best your pain has been during the past 24 hours: __________

Steppin' Up Physical Therapy

Attendance Policy

We are excited to have the opportunity of helping you improve your physical well-being. Consistency with session attendance as well as consistency with the home program you receive from us will play a key role in your rate of progress. We do understand that you may need to cancel an appointment due to unforeseen circumstances. If you do need to cancel, please call at least 24 hours prior to your appointment. No-shows and same-day cancellations will be assessed a $25 fee which must be paid prior to being seen for the next scheduled appointment.* The limit for the abovementioned occurrences is three after which discharge from our facility will be necessary. These guidelines are enforced to help us stay on schedule and to help ensure that you receive the consistency of care required to efficiently provide you with the results you deserve.

*This Attendance policy is pursuant to any regulations your insurance company may have in place regarding attendance and cancellation/no-show fees.

_______________________________________ _______________

Signature of Patient or Legal Guardian Date

Steppin' Up Physical Therapy, Inc.

5800 Fairfield Ave., Suite 150
Fort Wayne, IN 46805

CONSENT FOR CARE AND TREATMENT

By signing this form, I authorize Steppin' Up Physical Therapy (Provider) to furnish medical care and treatment to ______________________________________ (Patient). This includes any services the Provider feels are necessary in treating Patient and are in cooperation with the referring physician.

____
Initials

FINANCIAL POLICY STATEMENT

We are happy to bill your health insurance company as a courtesy to you. Payment of your estimated share is required at each visit (co-pay, co-insurance, and/or deductible). If your insurance company does not remit payment within sixty (60) days, the balance will be due from you. In the event your insurance company requests a refund of payment or denies coverage for your service, you will be responsible for the balance due. Denials based on "Usual and Customary" will be your responsibility pursuant to any managed care contract in place. If payment is made to you for services provided by Steppin' Up Physical Therapy, you are obligated to promptly pay for those services. **Pre-certification is not a guarantee of payment of benefits. Non-payment (after 60 days of first invoice) will result in the use of a collection agency and/or attorney. Any fees associated with debt collection including collection agency fees, reasonable attorney fees and/or court costs will be extended to Patient (or legal guardian/responsible party).**

____
Initials

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company to Steppin' Up Physical Therapy, Inc.

____
Initials

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy (NP) is included in this packet of forms. You may read the NP and take it with you. The NP describes how your health information may be used or disclosed and your rights under the Health Insurance Portability and Accountability Act (HIPAA). **Please initial that this form has been offered to you:**

____
Initials

I am giving my consent for release of health or financial information to the following individuals:
(If one of your family members or friends calls in to ask how you are recovering or comes to pick up medical records for you, we cannot give them this information without your consent.)

Name	**Relationship**	**Date of birth**
____________________________	________________________	_________________
____________________________	________________________	_________________
____________________________	________________________	_________________

____
Initials

I understand that I have the right to change (in writing) the above named individuals at any time.

____ ___________________________

Patient/Guardian/Responsible Party Date

Steppin' Up Physical Therapy, Inc.
5800 Fairfield Ave., Suite 150
Fort Wayne, IN 46805

Auto Accident/Personal Injury Claims

We are sorry to learn that you have had an injury at the fault of someone else. These types of injuries are considered "third party claims." Third party insurance companies will not pay us for services we provide while caring for you. They may eventually pay you directly once you submit your medical bills if the claim is found in your favor. For this reason, Steppin' Up Physical Therapy will not file third party claims. This gives you three options:

-Billing your personal auto insurance provided you have sufficient "med pay coverage."

-Billing your personal health insurance. Any deductibles, co-pays and/or co-insurances would apply.

-Personal pay. If paying out of pocket, a minimum of $25/visit and a signed Letter of Protection from your attorney is required.

We hope that one of these options will accommodate you well.

"I have read, understand, and agree to the above."

____ ________________

Signature of Patient/Guardian/Responsible Party Date

Steppin' Up Physical Therapy, Inc.

Summary of

HIPAA NOTICE OF PRIVACY PRACTICES

Effective 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. PLEASE REVIEW IT CAREFULLY.

A full version (7 page) of this Privacy Notice is available to you at the front desk of our office.

Under the Health Insurance Portability and Accountability Act of 1996 (" HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.
We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, a revised notice will be made available to you within 60-days of such revision. If you should have any questions or require further information, please contact our External Privacy Officer at (260) 422-7524.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information. Disclosures for treatment, payment, operational and required by law do not require authorization from you. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.
Treatment: We may use or disclose your health information to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record and that record may be shared with other providers involved in your care.
Payment: We may use or disclose your health information in order for services you receive at our office to be paid by your insurance carrier. For example, we may disclose appropriate information for reimbursement, collection or payment purposes.
Health Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, an outside auditing firm may audit your chart to assess our compliance for billing standards.
Communications: We may either phone your home or mail information to your home in order to communicate with you. An example would be calling to remind or reschedule an appointment. There may be an occasion that we would leave a message with someone in your home or on the answer machine.
Business Associates: There may be instances where services are provided to our office through contracts with third party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates. An example of a Business Associate would be a consultant that may audit our charts.
Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.
Communication with Family or Friends: We 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. The office may also disclose your condition to family or friends who accompany you to our offices.
Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.
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.
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.

To Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Veterans: If you are a member of the armed forces, we may disclose health information about you as required by military command.
Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.
Protective Services for the President, National Security and Intelligence Activities: 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, or for intelligence, counterintelligence, and other national security activities authorized by law.
Law Enforcement: We may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law.
Inmates: We may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official.
Breach Notification: Under certain circumstances we may be required to notify the Indiana Attorney General and/or the Department of Health and Human Services of a breach of your patient information. You would also receive notification of this breach.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer at Steppin' Up Physical Therapy 5800 Fairfield Ave., Suite 150, Fort Wayne, IN 46807.
Right to Request Restrictions. You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction.
Right to Receive Confidential Communications. You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable.
Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. If copies are requested or you agree to a summary or explanation of such information, we *may* charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying; postage; and preparation cost of an explanation or summary, if such is requested. The cost may be up to $1 per page for pages 1-10, $.50 per page for pages 11-50 and $.25 per page for pages 51 and higher. You may also request an electronic version of your records at a reasonable cost for copying. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.
Right to Amend. You have the right to have us amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not available for inspection as specified by law, or is accurate and complete.
Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; communications with family and friends; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or disclosures made prior to the HIPAA compliance date of April 14, 2003. Your first request for accounting in any 12-month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same 12-month period.
Right to Obtain a Paper Copy. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

How to File a Complaint if You Believe Your Privacy Rights Have Been Violated

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

Steppin' Up Physical Therapy
Attn: Jason Hazelett
5800 Fairfield Avenue Suite 150
Fort Wayne, IN 46807

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.