Juneau Physical Therapy
Client Information

Patient:_____
First Name Last Name Preferred Name

Date of Birth:_____ Sex:____F____M Phone number:_____

Do you have Insurance? Y or N (please list) _____

Mailing Address:_____

City:_____State:_____Zip:_____

Best way to contact you (please circle answer and add your preferred method): Email Text Phone

_____

If you prefer text, please name your provider, this service is not available for GCI customers at this time

Patient Employed By:_____

Position:_____

Physician or Referral Source:_____

Responsible Party (if a minor):_____

Emergency contact:_____Relationship:_____ Phone:_____

Please skip this section and move onto Authorization/Confidentiality & No-show if this does not apply to you.

Is this injury a result of (circle your answer): Motor vehicle accident or work related accident/injury

We require your personal insurance as a secondary at your first scheduled appointment, to ensure payment for both parties, as no MVA or Workers Comp agency Pre-authorizes payments. Personal Insurances will only be charged if your initial claims are denied. You understand that you are liable for any remaining unpaid balances after we receive payments or denials from insurance carriers._____ (intial here)

Insurance Company or Workers Compensation Carrier:_____

Name of Insured:_____ Claim Number:_____

Claim Adjustor:_____ Fax:_____ Phone:_____

Authorization/Confidentiality & No-Show

Please initial each statement and sign on the line below

- I understand that I may jeopardize my future appointments if I fail to attend my scheduled treatment sessions without providing 24 hours' notice. Appointments that are not canceled 24 hours in advance are subject to $25 no show fee, please contact us ASAP if you need to reschedule your appointment. Canceling ahead of time will ensure you do not incur additional fees. _____
- Juneau Physical Therapy has no contracts with insurance providers for durable medical equipment, therefore any equipment or medical supplies needed will be billed to patient directly. Receipts will be provided to patient for patient's personal submission to insurance company by request. _____
- I have been presented with a copy of **Juneau Physical Therapy's Notice of Privacy Practices** and agree to all terms. _____
- I understand that legally I am responsible for any unpaid balance with Juneau Physical Therapy if my insurance carrier denies any or all payments. _____
- By signing this form, I understand that I am giving authorization for the treatment I will receive. _____

_____ _____
Signature of Insured/Guardian Date

Please continue to next page >

Medical Profile Questionnaire

Please fill out as completely as possible. Your physical therapist will use this questionnaire to help establish a safe and appropriate program for you. Your input is very important.

Name:_____ **Age:**_____ **Occupation:**_____

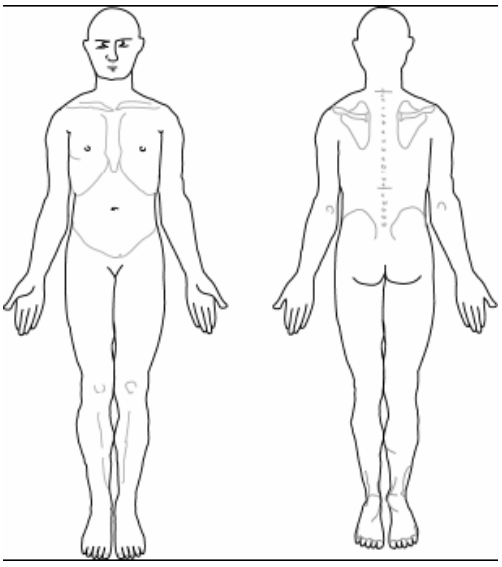
1. What is the nature of your problem? _____
   _____
   _____

2. Date of injury (or surgery) or onset of symptoms:
   _____

3. Was the **onset** of this episode gradual or sudden?
   - □ gradual
   - □ sudden

4. Which of the following best describes how your injury occurred? (If your condition is post-surgical, please indicate as per original injury)
   - □ lifting
   - □ MVA (car accident)
   - □ a fall
   - □ overuse
   - □ trauma
   - □ degenerative process
   - □ blow to the face
   - □ running
   - □ throwing
   - □ an incident at work
   - □ unknown
   - □ during recreation/sports
   - □ other_____

5. Shade in region of pain/discomfort/symptoms, put a "C" for constant pain, "I" for intermittent pain. Rate each area from 0-10 on the pain scale.



6. On a scale of 0-10, with 0 = "No Pain" and 10 = "Take me to the emergency room", rate your pain since onset

At its WORST:	0	1	2	3	4	5	6	7	8	9	10
At its BEST:	0	1	2	3	4	5	6	7	8	9	10
TODAY:	0	1	2	3	4	5	6	7	8	9	10

7. Nature of pain/symptoms (check all that apply)
   - □ sharp
   - □ throbbing
   - □ burning
   - □ constant
   - □ dull ache
   - □ weakness
   - □ occasional
   - □ falling asleep/numbness
   - □ other _____

8. Since the onset of your symptoms, have they:
   - □ worsened
   - □ improved
   - □ stayed the same

9. Does the pain wake you at night?
   - □ Yes
   - □ No

   If "yes", is it present
   - □ while lying down
   - □ only when changing positions
   - □ both

10. What aggravates your symptoms?
    - □ sitting
    - □ lying on back
    - □ lying on stomach
    - □ walking
    - □ up/down stairs
    - □ standing
    - □ sit to stand transfer
    - □ rest
    - □ bending over
    - □ heat
    - □ cold pack/ice
    - □ exercise
    - _____
    - □ nothing
    - □ other _____

11. What relieves your symptoms?
    - □ sitting
    - □ lying on back
    - □ lying on stomach
    - □ walking
    - □ standing
    - □ massage
    - □ standing
    - □ bending over
    - □ rest
    - □ medication
    - □ stretching
    - □ heat
    - □ cold pack/ice
    - □ exercise
    - _____
    - □ nothing
    - □ other _____

12. Have you had similar symptoms in the past?
    - □ Yes
    - □ No

    If "yes", how many episodes?
    _____

    If "yes", what treatment was helpful?
    _____
    _____

13. What is your current stress level?
    □ low □ medium □ high

14. Which practitioners have you seen for this problem?
    □ physician □ massage therapist
    □ physical therapist □ acupuncturist
    □ chiropractor □ acupressurist
    □ naturopath □ other _____

15. Have you had any of the following tests?
    □ none
    □ x-ray area:_____ date:_____
    □ CT scan area:_____ date:_____
    □ MRI area:_____ date:_____
    □ bone scan area:_____ date:_____
    □ other _____

16. Please list any over-the-counter or prescription medications or vitamin/mineral supplements you are currently or have recently taken.
    Over-the-counter: _____
    _____
    Prescription: _____
    _____
    _____

17. What exercise/activity do you do currently? _____
    _____
    _____
    prior to injury/surgery? _____
    _____
    _____

18. Please list any recent/relevant past surgeries or injuries.
    Surgery/Injury Date
    _____
    _____
    _____
    _____
    _____

19. Have you ever had/been diagnosed with any of the following conditions? (check all that apply)
    □ latex sensitivity □ dizziness
    □ asthma □ epilepsy/seizures
    □ blackouts □ frequent falls
    □ night sweats □ hearing problems
    □ broken bones □ heart trouble/angina
    □ bruising easily □ high blood pressure
    □ cancer □ bladder issues
    □ osteoarthritis □ coronary heart disease
    □ depression □ pain that wakes you at night
    □ diabetes □ rheumatoid arthritis
    □ smoking □ unexplained weight loss
    □ thyroid issue □ dental work (in past 6 wks)
    □ poor circulation
    □ shortness of breath
    □ infectious disease (hepatitis, TB, etc)
    □ major injury to neck/spine (whiplash)
    □ pain/stiffness upon getting out of bed in a.m.
    □ pacemaker/nitroglycerin patch
    □ other _____

Notice of Privacy Practices
Juneau Physical Therapy

- We may disclose your health information to your insurance provider for the purpose of payment and healthcare operations.
- We may disclose your healthcare information to notify or assist in notifying a family member, or another person responsible for our care about your medical condition, in the event of an emergency or of your death.
- We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.
- We may disclose your health information in the course of any administrative or judicial proceeding.
- We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
- We may disclose your health information if required by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to applicable legal requirements.
- We may be required to disclose your health information to Federal officials or military authorities to complete an investigation related to public health or national security.
- We may contact you by phone, mail, or email to remind you of a scheduled appointment, or to schedule an appointment. Additionally, we may contact you regarding treatment options or alternatives.
- We may disclose your health information to a government agency responsible for overseeing the healthcare system or health related government benefit programs.
- We may use or disclose your health information for research, subject to conditions. Your permission will be asked before any confidential information is given out including your name, address, or any other identifying information.
- We may disclose your health information to a coroner or medical examiner.
- We may disclose your healthcare information to your family and friends if we obtain your verbal consent to do so, or if we infer from circumstances based on our professional judgment that you would not object.
- We may disclose a minor's medical information to his or her parents as long as the minor's care is not ordered by the court.
- We may also disclose information if, in our professional opinion, you are not capable of giving consent due to incapacity or a medical emergency.
- In the event Juneau Physical Therapy is sold or merged with another organization, your health information will become the property of the new owner.

Other than as stated above, or where Federal, State or Local Law requires us, we will not disclose your health information other than with your written consent. You may revoke your authorization in writing at any time.

Patient Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree with the restriction requested.
- You have the right to inspect and copy your health information. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other associated supplies.
- You have the right to amend your health records. To request a correction, submit a Medical Record Amendment Form.
- You have the right to receive an accounting of disclosures of your health information made by us.
- You have the right to a paper copy of this **Notice of Privacy Practices** at any time upon request.

We are required by law to maintain the privacy of your health information and to provide you or your representative with a copy of this **Notice of Privacy Practices**. We are required to practice the policies and procedures described in this Notice but reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice. You have the right to submit complaints to us in writing, addressed to our Privacy Officer if you believe your rights have been compromised. You may also submit a complaint to the Secretary of Health and Human Services. You will not be penalized for submitting a complaint. We encourage you to express any concerns you may have as the privacy of your healthcare information is of the utmost importance to us at Juneau Physical Therapy.

Authorization to Release Medical Information
Juneau Physical Therapy

[ ] JPT 641 W Willoughby Ave, Suite 206 Juneau, AK 99801 [**downtown**] 907-586-5951; fax 907-586-8017

[ ] JPT 8390 Airport Blvd, Suite 203 Juneau, AK 99801 [**valley**] 907-789-4165; fax 907-789-5882

Patient Information

Name _____

Mailing Address _____ City/State/Zip _____

Date of Birth _____Social Security # _____ Phone _____

Information to be Released From (please do not fill out this section)

I hereby authorize _____ to release the following medical information for this patient.

Information to be Released To (please do not fill out this section)

Name of Facility/Organization/Patient _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Type of Information to be Released (this is to be filled out by the Therapist ONLY)

Purpose or need for information being released:

_____ Further medical treatment _____ Legal proceedings

_____ Insurance claim _____ Other (specify)

Dates of treatment: from _____ to _____

Specific information to be released:

_____ Permission to discuss current diagnosis

_____ Operative report Area of interest _____

_____ X-ray report Area of interest _____

_____ MRI report Area of interest _____

_____ Other (specify)

By signing this form below, I give my authorization for release of records as indicated above.

If the information to be released pertains to alcohol or drug abuse, I understand the confidentiality if information is protected by federal law (42CFR, Part 2). Furthermore, I understand that my records may contain information regarding the diagnosis of HIV, AIDS, other sexually transmitted diseases, drug abuse, alcohol use, mental illness or psychiatric treatment.

* Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42CFR, Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose.

Patient Authorization to Release Medical Information

_____ _____

Signature of Patient or Legally Responsible Party Relationship to Patient

_____

Date

This authorization to release information expires in 90 days from the date it is signed by the patient, unless revoked in writing by the patient prior to the expiration date. To be a valid authorization, it must be signed and dated after dates of service for requested information.