

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.

Juneau Physical Therapy

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Juneau, Alaska 99801
(P) (907) 586-5951 (F) (907) 586-8017

8390 Airport Blvd Suite 203
Juneau, Alaska 99801
(P) (907)7894165 (f) (907) 789-5882

Durable Medical Equipment Waiver

Juneau Physical Therapy is unable to bill insurances for any supplies. We do not have a DME (Durable Medical Equipment) number. As our patient, you have two options. You may either pay for the supplies out of pocket or you may attempt to purchase supplies from an authorized DME supplier.

Please read and sign the following:

“I have read and understand the above statement that Juneau Physical Therapy does not bill my insurances for any Medical supplies, splints, braces and or orthotics. I accept full financial responsibility and I acknowledge that it is my responsibility to handle any and all reimbursement needs.”

Signed: _____

Date: _____

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? _____

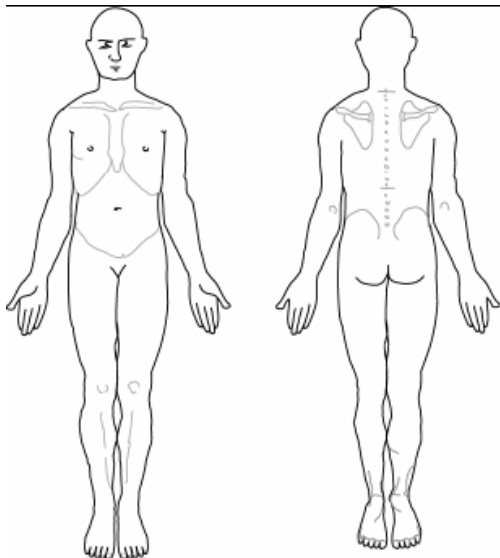
2. Date of injury (or surgery) or onset of symptoms:

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)

<input type="checkbox"/> lifting	<input type="checkbox"/> blow to the face
<input type="checkbox"/> MVA (car accident)	<input type="checkbox"/> running
<input type="checkbox"/> a fall	<input type="checkbox"/> throwing
<input type="checkbox"/> overuse	<input type="checkbox"/> an incident at work
<input type="checkbox"/> trauma	<input type="checkbox"/> unknown
<input type="checkbox"/> degenerative process	<input type="checkbox"/> during recreation/sports
<input type="checkbox"/> 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)

<input type="checkbox"/> sharp	<input type="checkbox"/> throbbing	<input type="checkbox"/> burning
<input type="checkbox"/> constant	<input type="checkbox"/> dull ache	<input type="checkbox"/> weakness
<input type="checkbox"/> occasional	<input type="checkbox"/> falling asleep/numbness	
<input type="checkbox"/> 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?

<input type="checkbox"/> sitting	<input type="checkbox"/> rest
<input type="checkbox"/> lying on back	<input type="checkbox"/> bending over
<input type="checkbox"/> lying on stomach	<input type="checkbox"/> heat
<input type="checkbox"/> walking	<input type="checkbox"/> cold pack/ice
<input type="checkbox"/> up/down stairs	<input type="checkbox"/> exercise
<input type="checkbox"/> standing	_____
<input type="checkbox"/> sit to stand transfer	<input type="checkbox"/> nothing
<input type="checkbox"/> other _____	

11. What relieves your symptoms?

<input type="checkbox"/> sitting	<input type="checkbox"/> rest
<input type="checkbox"/> lying on back	<input type="checkbox"/> medication
<input type="checkbox"/> lying on stomach	<input type="checkbox"/> stretching
<input type="checkbox"/> walking	<input type="checkbox"/> heat
<input type="checkbox"/> standing	<input type="checkbox"/> cold pack/ice
<input type="checkbox"/> massage	<input type="checkbox"/> exercise
<input type="checkbox"/> standing	_____
<input type="checkbox"/> bending over	<input type="checkbox"/> nothing
<input type="checkbox"/> 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 _____