Patient Questionnaire

Returning Patient? Yes ___No ___ Date: _____
Patient's Name: _____ Date of Birth: _____
Form completed by: _____ Relationship to Patient: _____
Guarantor's Name (required if patient under 18yrs old): _____DOB: _____
Physical Address: _____
Mailing Address (if different): _____
Email Address: _____ Occupation: _____

Home Phone #: _____Cell Phone #: _____ Work Phone#: _____
Preferred contact: Home □ Cell □ Work □ E-mail □
Appointment Reminders: None □ E-mail □ Text □ Voice □
Emergency Contact Name: _____ Relationship: _____
Emergency Contact's Phone Number: _____
If a new patient, how did you hear about Vantage? _____

What is the reason for your visit? _____

Referring Physician's Name: _____ Date of Next MD appointment: _____
Primary Care Physician's Name (if different than referring MD): _____

Is your injury/condition related to:

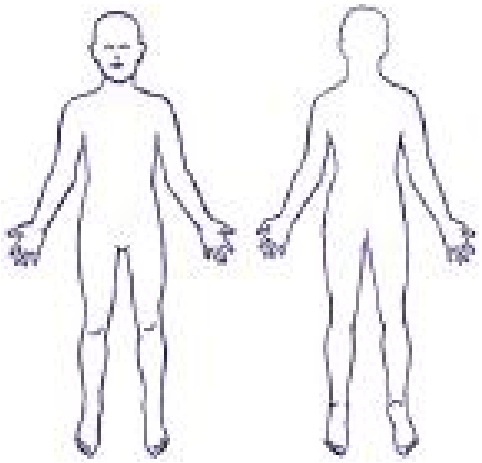
Auto Accident	**Yes** □ **No** □	Date:
Motor Cycle Accident	**Yes** □ **No** □	Date:
Work Injury	**Yes** □ **No** □	Date:
Other : _____	**Yes** □ **No** □	Date:

Have you had a similar injury/condition before? **Yes** □ **No** □
Did you receive physical therapy for this injury/condition before? **Yes** □ **No** □
Dates you received treatment: _____

Do you have pain? **Yes** □ **No** □
Circle the number that best indicates the level of pain you are feeling right now (0 – none 10 – excruciating)

0 1 2 3 4 5 6 7 8 9 10

Use the diagram to the right to indicate pain location ⇨



Please describe in detail, activities that you do for work/chores/recreation/exercise during the day:

_____

_____

Are you allergic to Latex? **Yes** □ **No** □
Please list any additional allergies: _____

Women - Are you or could you be pregnant? **Yes** □ **No** □

Please list any surgeries that you have had and the DATES they were performed: _____
_____

Present/Past Medical History (check all that apply):

Arthritis □	CHF □	TIA □	Dizziness □
Back problems □	Pacemaker □	CVA (stroke) □	Osteopenia □
Heart condition □	High blood pressure □	Diabetes □	Osteoporosis□
MI (heart attack) □	Vascular disease □	DVT/PE □	Depression □
Arrhythmias □	Seizures □	MRSA/VRE □	Anxiety □
Hearing loss □	Vision loss □		

Cancer or tumor, please specify type(s): _____
Respiratory condition, please specify type(s): _____
Please list any other medical conditions not mentioned above: _____
Please list all medications and over the counter drugs/vitamins that you take (or provide a list to be copied):
_____
_____

Have you received care for this medical condition in the past month from any of the following caregivers?

Physician □	Rehab center □	Chiropractor □
Dentist □	Skilled nursing facility □	Physical therapist□
Nurse □	Mental health provider □	Occupational therapist □
Hospital □	Home health care □	Speech therapist □

Have you received Home Care (Visiting Nurses) in the past 60 days? **Yes** □ **No** □
If yes, please provide discharge date: _____

Please indicate your living situation:

Live alone □	Home with services □	Group home □
Live with family □	Assisted living □	Other: _____

Do you have a history of falls? **Yes** □ **No** □
Do you use any of the following assistive devices?

Walker□	Crutches □	Wheelchair □	Hearing aids □	Other: _____
Cane □	Oxygen □	Scooter □	Braces/splints□	

Do you use tobacco? **Yes** □ **No** □
If yes, please specify how much? _____ How many years? _____
Do you use alcohol? **Yes** □ **No**□

Do you have any cultural or religious beliefs that would impact your care? **Yes** □ **No**□

Which method of learning do you prefer?
Pictures □ Reading □ Listening□ Demonstration□

Physical and mental abuse have become major public health issues in this country. These may take the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes □ No □

By signing below I agree that to the best of my knowledge, the above information accurately describes my medical history and the history of my current condition. Should any changes occur I will notify my PT and PTA immediately.

Patient Signature_____ Date: _____

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an “open adjusting room” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose

protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy, and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to Vantage Sports & Rehab, LLC, Dmitry Voloshinov, Compliance Officer, 1581 North Main Street, Palmer, MA, 01069.

Consent to Treatment

I, the undersigned, a patient at Vantage Sports & Rehab (VS&R), do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.
I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. There is no guarantee of payment by my insurance until my claim has been processed. It is my responsibility to understand my individual insurance benefits prior to beginning treatments. Furthermore, I understand that VS&R will prepare insurance forms, and as a courtesy will bill only my insurance company directly. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Deductibles/Percentages pays and/or Co-payments

Co-payments are to be paid at time of service, unless prior arrangements have been made with the Business Manager. Deductible and percentage payment amounts will be billed at the time that payment from your insurance company is received. Payment is due within 10 business days of the date of the invoice. Patients are to keep payments current. VS&R reserves the right to use a collection agency in the event of failure to pay or late payment. Failure to pay or late payment may also result in additional charges.

Cancellation/No-Show Policy

Appointments will be classified as a no-show if the patient fails to arrive at the scheduled time for an appointment, or if a cancellation is made the same day of the scheduled appointment. Cancellations should be made **at least 24 hours prior** to the scheduled appointment, unless extenuating circumstances prevent otherwise. **The fee for a no-show is $50**. All additional fees will be applied to the next scheduled appointment and must be paid before further treatment will be provided. Frequent failure to comply with the no-show policy will result in an indefinite suspension of treatment.

By signing below you are agreeing to all the terms and conditions.

Patient signature: _____ Date: _____

Legal Guardian signature: _____ Date: _____

Acknowledgement of Privacy Practices

I have read and understood the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Patient Name: _____

Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____