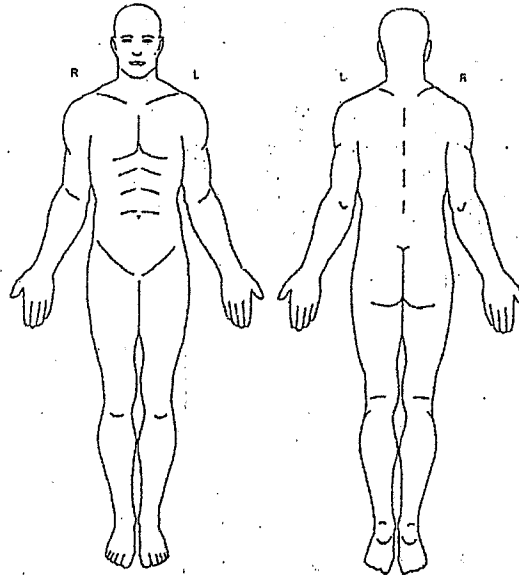


Please answer the following questions based on your current conditions:

1. What was the onset date of your injury/illness/problem? (approximately)
2. Have you been hospitalized or had surgery for your problem? Yes/No
If yes, please give dates: hospitalized from ____ to ____ . Surgery on _____.
3. Have you received therapy for this condition or a similar condition previously? Yes/No
If yes, please give dates:
4. Which positions or activities make your condition worse?
5. Which positions or activities make your condition better?
6. Are your symptoms worse in the morning or at night?
7. Please list any other medical conditions (examples: heart attack, high blood pressure, diabetes, etc.)
8. What are the names of your current medications and dosages (including prescription, over-the-counter, herbals, vitamin/mineral/dietary/health supplements)? Use back if more space is needed, or give us a written list.
9. Have you had any special tests performed regarding this condition? (for example, x-ray, MRI, etc.) If so, please list:
10. Are you currently employed? Yes/No
Is your condition related to your employment? Yes/No
11. How is your general health?
12. Have you fallen in the last year? Yes/No
If yes: how many times? _____
Did you injure anything? Yes/No
Describe the fall and injury if any:

13. Please draw on the body chart areas where you are having symptoms or complaints:
(for example, pain, numbness tingling, stiffness, weakness)



Circle the words that describe your symptoms:
sharp, dull, ache, numb, tingling, stiff, weak, other: _____

I verify that the above information is complete and accurate to the best of my knowledge.

Signature (patient or representative)

Date

MAIN STREET PHYSICAL THERAPY

381 South Main Street Yuma, AZ. 85364

Phone (928) 343-7828
FAX (928) 782-1019

MAIN STREET PHYSICAL THERAPY CONSENT FOR CARE

I grant permission to Main Street Physical Therapy, P.C. to perform examinations and medical and therapeutic procedures professionally deemed necessary or advisable for my diagnosis and treatment.

CONSENT FOR RELEASE OF INFORMATION

I authorize Main Street Physical Therapy, P.C. to release:

1. Any or all of my/the patient's medical information from and to referring physicians, health care providers, insurance companies, and other third party sponsors to facilitate healthcare, processing of claims and audit payments for treatment.
2. Basic patient information regarding date and time of appointment(s) to family members (parents, spouses, adult children, guardians), and caregivers.

FINANCIAL AGREEMENT

All patients, with the exception of Mercy Care, Evercare, APIPA, AHCCCS, and Industrial will be responsible for payment.

If this is a private insurance claim, I agree to be responsible for the full amount of charges, from the date of delivery, if my insurance does not pay for the charges in a timely manner, or if I fail to provide within thirty (30) days the information necessary to submit the claim for payment. I will notify you of any changes in insurance status. I further understand that the benefits information quoted does not warranty payment until the claim is submitted and reviewed for medical justification and benefits determination.

This offices does accept Medicare and Tricare assignment. I agree to pay all copayments or co-insurance amounts not reimbursed under the medical insurance part of the Medicare part B program and/or secondary insurance for services rendered.

For your insurance to be billed, a valid prescription and proper insurance information is required at the time services are rendered. A new prescription is required every 30 days for Medicare patients.

I have read, understand, and accept the terms above:

Signature

If signed by person other than patient, please provide relationship to patient

MAIN STREET PHYSICAL THERAPY NO-SHOW/CANCELLATION POLICY

We strive to provide all of our patients with the best care possible and use our/your time efficiently. Therefore, we do not over-schedule appointments. When scheduling your appointments, please remember the following:

*We ask that you show consideration to your therapist and other patients (that may need the appointments) and notify us 24 hours in advance if you must cancel your appointment. Cancellation without sufficient notice or no-showing for your appointment will result in a \$25 fee to your account, which your insurance will not pay for. All missed appointments will be documented in your medical record.

*We allow up to 2 missed visits, as we understand that situations occur beyond your control.

*If you no-show 3 visits you will be discharged for non-compliance and your physician will be notified.

*If you cancel 3 visits, you may be discharged. This will be determined on a case-by-case basis.

*Please remember that we can be flexible with rescheduling, but we ***must hear from you***. Our office number is (928) 580-5769 or you may leave voice messages after hours at (928) 343-7828. If a voice message is left, our office will call you on the next business day to confirm that your message was received.

I have received and understand the no-show/cancellation policy for Main Street Physical Therapy

Patient Signature

Date

NOTICE OF PRIVACY PRACTICES

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.

1) **Uses and Disclosures** We, Main Street Physical Therapy, will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Other Special Uses

Main Street Physical Therapy may use your PHI to send you an appointment reminder.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment to be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty To Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you seek treatment from us.

Privacy Contact

If you would like more information about our privacy practices or to file a complaint you may contact:

Mark or Cindy Plante
381 S. Main Street
Yuma, AZ 85364
(928) 343-7828

EFFECTIVE DATE

This Notice will take effect on April 14, 2003

Source: American Physical Therapy Association

Notice of Privacy Practices

I, _____ have read and received
Copy of the Notice of Privacy Practices.

Signature

Date