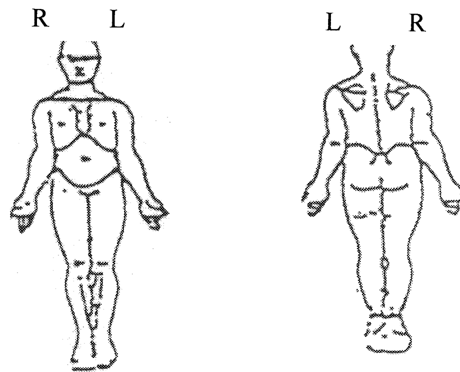
PATIENT NAME: ________________ *THERAPIST:* ______________ *TODAYS DATE:* ______________

1. Please mark your areas of discomfort on the body chart.



2. Please indicate your level of pain

At its WORST 0 1 2 3 4 5 6 7 8 9 10
No pain ◄──────────────► Worst pain

CURRENT 0 1 2 3 4 5 6 7 8 9 10
No pain ◄──────────────► Worst pain

At its BEST 0 1 2 3 4 5 6 7 8 9 10
No pain ◄──────────────► Worst pain

3. When did your problem begin? ______________________________
4. What do you feel caused your problem? ______________________________
5. What makes your symptoms worse? ______________________________
6. What makes your symptoms better? ______________________________
7. Have you had a similar problem in the past? YES NO When: ______________________________
8. Have you had treatment for this problem in the past? YES NO What: ______________________________

MEDICAL INFORMATION **WEIGHT:** ______________ **HEIGHT:** ______________

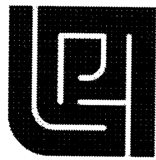
1. Please circle any of the following tests you have had for this problem:
   X-rays MRI CAT scan bone scan nerve conduction study electromyelogram Other______________
   Known results? ______________________________
2. Are you currently taking any medication? YES NO

   Name & dosage______________________________
3. Have you had any long-term use of Prednisone, Cortisone, steroids or inhalants? YES NO
4. If applicable, are you pregnant at this time? YES NO
5. Please circle any of the following that are in **YOUR** past or present medical history (**NOT FAMILY HISTORY**):
   cancer lung problems arthritis broken bones high blood pressure bowel/bladder changes

   concussion seizures blood clots allergies osteoporosis fever night sweats

   diabetes heart disorder nerve disorder asthma vomiting chills surgeries:______________

   frequent headaches nausea dialysis sprains/strains weight loss/gain other______________
6. Are you experiencing any other symptoms at this time that may be related?
   ____
7. Is your condition: Getting better Staying the same Getting worse
8. What are your goals for physical therapy?



LIFESTYLE
PHYSICAL THERAPY

Cancellation and No Show Policy

We understand that sometimes unforeseen circumstances can arise that prevent patients from keeping their scheduled appointments. We also pride ourselves on direct one on one care and value our therapists' time and resources, and want to ensure that we can accommodate as many patients as possible.

Therefore, if a patient needs to cancel or reschedule their appointment, we request at least 24 hours notice. If a patient fails to show up for their appointment without giving adequate notice, they will be charged a cancellation fee of $50.

We understand that emergencies and illness happens, and we ask that patients make every effort to inform us of any changes to their appointment schedule as soon as possible.

Thank you for understanding and if you have any questions or concerns please ask any of the staff members or management. We look forward to working with you to achieve your health and wellness goals.

I have read and acknowledge this policy (sign here):_______________________________

PATIENT NAME: ____________________ *THERAPIST:* ________________ *TODAYS DATE:* __________________

LIFESTYLE PHYSICAL THERAPY POLICIES

I, the undersigned patient and/or the responsible party have read and received a copy of Lifestyle Physical Therapy's Privacy Statement.

FINANCIAL

Lifestyle Physical Therapy is happy to bill our patients' insurance carriers as a courtesy when they present with a current insurance card. However, we are not contracted with all insurances, nor do we know your individual policy. As a courtesy, we will call your insurance to check your physical therapy benefits although we are only given a description of benefits and *not a guarantee* of payment. It is **ULTIMATELY** the ***patient's*** responsibility to know their insurance carrier's benefits and policies.

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. In the case of non-payment by contracted/non-contracted carriers, patient is ultimately responsible for payment and follow-up with carrier for services rendered. I realize that failure to keep this account current may result in my being unable to receive additional services. In the case of default on payment, I understand that my account balance may be forwarded to a collection agency.

MEDICAL SUPPLIES AND ORTHOTICS

Many insurance companies do not consider medical supplies a covered benefit. Therefore, we ask for payment in full at the time of pick-up if you are purchasing a non-covered item.

LATE CANCELLATIONS AND NO SHOWS

Cancellations or changes must be made at least 24 hours prior to the scheduled appointment. If a patient fails to show for two scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and their physician will be notified.

I acknowledge that I have read and understand the policies as stated above.

____

Signature

____

Date

PATIENT NAME: ____________________ *THERAPIST:* ________________ *TODAYS DATE:* __________________

RELEASE OF MEDICAL INFORMATION

I (we) authorize the release and disclosure of any and all information regarding my condition when under this therapist's observation and care, including: history, findings, treatment, diagnosis, medical imaging studies and reports, and prognosis. I (we) have the authority to inspect and take copy of my (our) clinical and/or hospital records which pertain to me (us), as the patient, and may include photographs taken, imaging studies, and/or medical reports.

I (we) the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patient's medical records to any entity which is, or may be, liable for all or part of the provider charges.

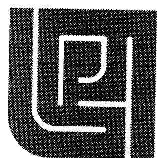
I (we) authorize the release and disclosure of any and all of my medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of me, the patient.

I (we) authorize the release of records necessary to assist in the reimbursement of benefits to which I (we) may be entitled. I (we) authorize this office and/or its employees to release via fax machine, medical records which are needed in order to provide me, the patient, with the most appropriate medical care/payment for treatment rendered.

____ ________________________

Signature **Date**

PATIENT NAME: ____________ *THERAPIST:* ____________ *TODAYS DATE:* ____________



LIFESTYLE
PHYSICAL THERAPY

Scott Randklev, DPT, TPI, CGFI-MP2
Erin Blakley, PT, DPT, OCS, BSPTS L1
Kinzie Munar, PT, DPT
Kendall Zacha Shaw, PTA
Taylor Brummer, PTA
Cody Croteau, PTA

370 E Kathleen Ave. Ste 500 • CDA, ID 83815 PHONE (208) 292-1372 FAX (208) 292-1374

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

About Us

In this Notice, we use terms like "we", "us", or "our" to refer to Lifestyle Physical Therapy and its therapists. We are an Outpatient Therapy Clinic specializing in physical therapy to help you towards your goal of good health.

This Notice applies to Lifestyle Physical Therapy.

What is "Protected Health Information" "PHI"

Protected Health Information "PHI" is information that identifies who you are and relates to you, your past, present, or future physical condition, the provision of health care to you, or your past, present, or future payment for the provision of health care to you. PHI does not include information about you that is publicly available, or that is in a summary form that does not identify who you are. If you are an employee at our office, PHI does not include your health information in your personnel file.

Purpose of this Notice

In the course of doing business, we gather and maintain PHI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This Notice describes our privacy practices and how we protect the confidentiality of your PHI. We are obligated to maintain the privacy of your PHI by implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this Notice about our legal obligations to maintain the privacy of your PHI. We must follow our Notice that is currently in effect.

How We Protect your PHI

We restrict access to your PHI to those employees who need access in order to provide services to our patients. We have established and maintain appropriate physical and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees must complete. We have also established a Privacy Officer, which has overall responsibility for developing, training and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use and disclosure.

Disclosure of PHI we May Make Without Your Authorization

When required by law: In some circumstances, we are required by federal or state laws to disclose certain PHI to others, such as public agencies for various reasons.
For lawsuit and other legal disclosures: In connection with court proceedings before administrative, agencies, or to defend us or our participating therapists in a legal dispute.
For law enforcement purposes: Such as responding to a warrant or reporting a crime.
In connection with services provided with worker's compensation laws.
Healthcare Oversight Organizations: Such as reports to agencies that are responsible for credentialing /licensing our health care providers.

Updated Release
If you pay cash for services and opt not to utilize your health insurance plan, you may instruct our clinic not to share information about your treatment with your health care plan. If you choose this option, you need to inform us in writing so we can record your request in your patient file.