PATIENT HISTORY

Name: ______________________ DOB: __________ Age: __________

Gender: M / F Height: __________ Weight: __________ Occupation: __________

Primary Care Physician: ______________________ Referring Physician: ______________________

Diagnosis: ______________________

How were you injured? (Gradually / Suddenly / New Injury): ______________________

Date of Injury: __________ Surgery for this injury? __________ Surgery Date: __________

Have you had a history of falls / balance issues?

- ☐ 2 or more falls in the past year
- ☐ Any fall in the past year that has resulted in injury
- ☐ No falls, or only one but without injury

Are you using an assistive device?

☐ Crutches ☐ Brace ☐ Walker ☐ Wheelchair
☐ Cane ☐ Splint ☐ Other__________

Current Level of Function / Able to perform:

Home Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Work Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Recreation Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Previous Level of Function (check all that apply):

Independent with: ☐ Daily Activities ☐ Self Care ☐ Work / Vocation ☐ Care Giving ☐ Ambulation/Mobility ☐ Community Access

Recreational Activities / Hobbies (Please list): ______________________

____

____

Functional Limits (check all that apply): ☐ Sleep ☐ Self Care ☐ Daily Activities ☐ Reaching / Pushing / Pulling ☐ Lifting / Carrying ☐ Sitting / Standing ☐ Mobility / Ambulation ☐ Community Access

Aggravating Factors (check all that apply): ☐ Sitting ☐ Standing ☐ Waking ☐ Stairs (up/down) ☐ Bending ☐ Voiding ☐ Lying Down ☐ Coughing / Sneezing

Current Work Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Light duty due to injury ☐ Not working due to injury Out of work since: __________

What date (approximately) did your present pain start? __________

PAIN: *(0 = None 5 = Moderate 10 = Extreme)*

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Do you smoke? ☐ Yes ☐ No # of packs/day ______

Are you pregnant? ☐ Yes ☐ No Due Date: ______

Latex Allergies? ☐ Yes ☐ No

My symptoms are currently: ☐ Getting Better ☐ About the Same ☐ Getting Worse

Is your pain affecting your sleep? ☐ Yes ☐ No

What treatments have you received for this issue so far? ______________________

Have you had an X-Ray, MRI or other test for this issue? ______________________

What makes your symptoms better? ______________________

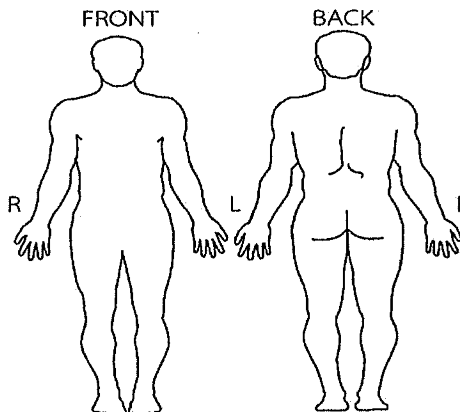
What makes your symptoms worse? ______________________

Is there anything else we should know about your symptoms or medical history? ______________________

____

On Body Diagram: Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not include areas of pain which are not related to your present problem.

///////	XXXXXXX	0000000	======
Stabbing	Burning	Pins & Needles	Numb



Pain Frequency: ☐ Less than daily ☐ Daily ☐ Increases throughout day ☐ Constant ☐ Night
☐ Other: ______________________

Past Medical History: ***Check any conditions that you currently have or have had in the past.***

☐ Cancer
☐ High Blood Pressure
☐ Osteoporosis
☐ Allergies/Asthma
☐ Diabetes
☐ Heart Problems
☐ Arthritis
☐ Seizures/Epilepsy
☐ Fever, Chills, Sweating
☐ Unexplained Weight Loss
☐ Infectious Disease
☐ Thyroid Problems
☐ Skin Disease
☐ Ulcers/Stomach Issues
☐ Stroke
☐ Depression
☐ Fibromyalgia
☐ Other______________
☐ Kidney Problems
☐ Change in Bowel/Bladder Function
☐ Broken Bones/Fracture
☐ Liver Disease
☐ Head Injury
☐ Dizziness
☐ Shortness of Breath
☐ Pace Maker

Past Surgical History: ____

____

Current Medications:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Home Layout:
☐ 1 – Story ☐ 2 – Story ☐ Condo / Apartment ☐ Stairs / Steps ☐ Shower Stall ☐ Combo Bathtub Shower ☐ W/C Accessible

Durable Medical Equipment:
☐ None ☐ Tub Bench ☐ Shower Chair ☐ Bedside Commode ☐ Raised Toilet Seat ☐ Standard Walker ☐ Rolling Walker
☐ Hemi Walker ☐ Quad Cane ☐ Straight Cane ☐ Wheelchair

Identify 3 goals that you personally would like to achieve as a result of your therapy:

1. ______________________________________
2. ______________________________________
3. ______________________________________

* Are you currently under the care of a Home Health Agency? ☐ Yes ☐ No
* Have you had any other physical, occupational or speech therapy in this calendar year? ☐ Yes ☐ No

Name: ______________________________ Date: ______________

Therapist's Signature: ______________________________ Date: ______________

To be completed by the patient, if of age, or by legal guardian.

Acknowledgement of Receipt of Notice of Privacy

I, ______________________ (print name), acknowledge that I have received the Notice of Privacy and Practices from Vermont Sports Medicine Center. I understand that Vermont Sports Medicine Center will need to use and disclose confidential information including financial and health information to provide treatment and deliver services offered by or through Vermont Sports Medicine Center, obtain and reconcile payment of such services and manage its health care operations. Please be advised that when being emailed that Vermont Sports Medicine email is not encrypted. **(Patient / Guardian Initials)** _______

I authorize Vermont Sports Medicine Center to treat my child under 18 per Physical Therapist plan of care.

(Patient / Guardian Initials) _______

I, ______________________ (print name), hereby authorize Vermont Sports Medicine Center and understand that copies of my (the patient's) medical records will be sent to the referring and primary care physicians in the chart.
(Patient / Guardian Initials) _______

I, ______________________(print name), hereby authorize Vermont Sports Medicine Center to release any medical information necessary to the appropriate insurance agency, physician, and employer (for Workers' Compensation only,) provided at the first visit, to process this claim. I authorize direct payment of medical benefits to Vermont Sports Medicine Center. It is understood that in the case of a denial from a worker's compensation or auto claim (the patient's) primary insurance information will be kept on file and be billed. **(Patient / Guardian Initials)** _______

Please check how you would like us to send your confidential healthcare information. Check ALL that apply.

☐ You may email* me at (email address): ______________________

*(*Please note that the confidentiality of electronic communications cannot be guaranteed.)*

☐ You may phone me at (daytime phone #): ______________________

☐ You may leave a phone message:

- ☐ On my answering machine at: ______________________
- ☐ With another person at: ______________ Name: ______________

I give Vermont Sports Medicine Center the right to disclose my protected health information and other personal information to the following additional persons:

Name: ______________ Relationship: __________ Phone # __________

Name: ______________ Relationship: __________ Phone # __________

Continued on next page:

Practices, Consent & Medical Release

Patient Responsibility:

I acknowledge that it is my responsibility to understand the coverage and limits of my insurance policy. I understand that I am responsible for co-payments, deductibles, and/or patient balances as directed by my insurance policy. In the event that my insurance denies payment I understand that I am responsible for my bill. If you are currently receiving home health care you cannot be seen by VSMC at the same time. In the case this happens, and the insurance denies, you will be responsible for the bill. I understand that if I have questions about my bill, I may speak with Vermont Sports Medicine Center's billing representative. My therapist is not responsible for knowing, giving advice about or reviewing my coverage.

(Patient/Guardian Initials) ______

Cancellations/No Shows:

I understand that I must notify Vermont Sports Medicine Center 24 hours before my scheduled appointment when canceling an appointment. Failure to provide a 24-hour notice of cancellation will result in a **$50.00** No Show Charge billed directly to me for each appointment missed.

(Patient/Guardian Initials) ______

Patient / Guardian Signature: ________________________ **Date:** ____________

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.