ATC
Allen Therapy Center, P.A.

PATIENT HEALTH QUESTIONNAIRE

DATE: ____________ NAME: ______________________________

DEMOGRAPHIC INFORMATION

WHERE DO YOU LIVE?

☐ PRIVATE HOME OR APT. ☐ ASSISTED LIVING OR GROUP HOME ☐ LONG-TERM CARE FACILITY
☐ OTHER ____________

WHO DO YOU LIVE WITH? (CHECK ALL THAT APPLY)

☐ ALONE ☐ SPOUSE/SIGNIFICANT OTHER ☐ CHILD/CHILDREN ☐ GROUP SETTING
☐ PERSONAL CARE ATTENDANT ☐ OTHER ______________________________

DOES YOUR OCCUPATION PRIMARILY INVOLVE?

☐ SITTING AT A COMPUTER OR PROLONGED COMPUTER USE
☐ MANUAL LABOR ☐ RETIRED
☐ HOMEMAKER ☐ OTHER
☐ HOMEMAKER WITH SMALL CHILDREN

EMPLOYMENT/WORK STATUS (CHECK ALL THAT APPLY)

☐ FULL-TIME, OUTSIDE HOME ☐ FULL-TIME, IN HOME
☐ PART-TIME, OUTSIDE HOME ☐ PART-TIME, IN HOME
☐ WORKING WITH MODIFICATION BECAUSE OF CURRENT INJURY
☐ NOT WORKING BECAUSE OF CURRENT ILLNESS/INJURY
☐ UNEMPLOYED ☐ RETIRED
☐ OTHER ____________________

WHAT ARE YOUR HOBBIES AND ARE YOU ABLE TO CURRENTLY PARTICIPATE AT THE LEVEL AND FREQUENCY YOU WOULD LIKE?

____

PAST MEDICAL HISTORY

LIST ALL HEALTH PROBLEMS, HOSPITALIZATIONS, SURGERIES AND ALLERGIES OR PROVIDE A LIST TO YOUR THERAPIST:

____

____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A LIST TO YOUR THERAPIST:

____

ARE YOU A DIABETIC? ☐ YES ☐ NO
IF YES, FOR HOW LONG? ____________________

DO YOU HAVE A PACEMAKER? ☐ YES ☐ NO

ARE YOU PREGNANT? ☐ YES ☐ NO
IF YES, HOW MANY MONTHS? ____________________

DO YOU USE A? (CHECK ALL THAT APPLY)

☐ CANE ☐ WALKER/ROLLING WALKER/ROLLATOR ☐ MANUAL WHEELCHAIR ☐ MOTORIZED WHEELCHAIR
☐ OTHER ____________

If yes to any of the above, what condition necessitates the use of assistance? ______________________

PLEASE LIST OTHER PHYSICIANS WHO ARE TREATING YOU AND FOR WHAT CONDITION
(DO NOT INCLUDE THE CONDITION YOU ARE HERE FOR)

____

HAVE YOU RECEIVED PREVIOUS PHYSICAL OR OCCUPATIONAL THERAPY? ☐ YES ☐ NO
If yes, for what condition and what did you like/dislike about the treatment?

____

DO YOU CURRENTLY HAVE A FAMILY PHYSICAL THERAPIST? ☐ YES ☐ NO

IN GENERAL, HOW WOULD YOU SAY YOUR OVERALL HEALTH IS RIGHT NOW?

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

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QUESTIONS 1-12 ARE FOR PATIENTS WHO RECENTLY HAD SURGERY AND ARE HERE FOR POST-SURGICAL REHABILITATION. IF YOU HAVE NOT HAD SURGERY PLEASE GO TO THE NEXT SECTION OF QUESTIONS

1 DATE OF SURGERY: ________ / ________ / ________

2 TYPE OF SURGERY: ______________________________

3 DESCRIBE YOUR SYMPTOMS PRIOR TO SURGERY:

____
____
____

4 HOW DID YOUR SYMPTOMS BEGIN PRIOR TO SURGERY?

____
____

5 NATURE OF SYMPTOMS:

SINCE SURGERY
- ☐ SHARP
- ☐ BURNING
- ☐ DULL ACHE
- ☐ TINGLING
- ☐ NUMB
- ☐ SHOOTING

PRIOR TO SURGERY
- ☐ SHARP
- ☐ BURNING
- ☐ DULL ACHE
- ☐ TINGLING
- ☐ NUMB
- ☐ SHOOTING

6 HOW OFTEN ARE SYMPTOMS EXPERIENCED?

SINCE SURGERY
- ☐ CONSTANTLY (76-100% OF DAY)
- ☐ FREQUENTLY (51-75% OF DAY)
- ☐ OCCASIONALLY (26-50% OF DAY)
- ☐ INTERMITTENTLY (0-25% OF DAY)

PRIOR TO SURGERY
- ☐ CONSTANTLY (76-100% OF DAY)
- ☐ FREQUENTLY (51-75% OF DAY)
- ☐ OCCASIONALLY (26-50% OF DAY)
- ☐ INTERMITTENTLY (0-25% OF DAY)

7 SINCE YOUR SURGERY WOULD YOU REPORT THAT YOUR SYMPTOMS ARE:
☐ BETTER ☐ WORSE ☐ SAME ☐ IMPROVING

8 WHAT IS YOUR AVERAGE PAIN INTENSITY?
LAST 24 HOURS/PAST WEEK/LAST 4 WEEKS (CIRCLE ONE)
None Unbearable
0 1 2 3 4 5 6 7 8 9 10

9 HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR WORK, HOBBIES OR DAILY ACTIVITIES?

SINCE SURGERY ☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

PRIOR TO SURGERY ☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

10 PRIOR TO SURGERY, WHO DID YOU SEE FOR YOUR SYMPTOMS?

☐ NO ONE ☐ CHIROPRACTOR ☐ MEDICAL DOCTOR ☐ PHYSICAL THERAPIST

☐ OTHER ______________________________

11 WHAT TREATMENT DID YOU RECEIVE PRIOR TO YOUR SURGERY AND WHEN (APPROXIMATELY)?

____

12 PRIOR TO SURGERY WHAT TESTS DID YOU HAVE?
☐ XRAYS ☐ MRI ☐ CT SCAN ☐ OTHER ______________________________

QUESTIONS 13-21 ARE FOR PATIENTS WHO ARE HERE AS A RESULT OF AN INJURY OR CONDITION

13 DESCRIBE YOUR CURRENT SYMPTOMS: ______________________________

____

____

14 DID YOUR SYMPTOMS BEGIN AS A RESULT OF A SPECIFIC INJURY OR GRADUAL ONSET?

□ INJURY □ GRADUAL ONSET EXPLAIN: ______________________________

15 HOW OFTEN ARE SYMPTOMS EXPERIENCED?

□ CONSTANTLY (76-100% OF DAY)
□ FREQUENTLY (51-75% OF DAY)
□ OCCASIONALLY (26-50% OF DAY)
□ INTERMITTENTLY (0-25% OF DAY)

16 WHAT IS YOUR AVERAGE PAIN INTENSITY?

LAST 24 HOURS/PAST WEEK/LAST 4 WEEKS (CIRCLE ONE)

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

17 HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR WORK, HOBBIES OR DAILY ACTIVITIES?

□ NOT AT ALL
□ A LITTLE BIT
□ MODERATELY
□ QUITE A BIT
□ EXTREMELY

18 HOW ARE YOUR SYPTOMS CHANGING?

□ IMPROVING
□ NOT CHANGING
□ WORSE

19 WHO HAVE YOU SEEN FOR YOUR INJURY OR SYMPTOMS?

□ NO ONE □ CHIROPRACTOR □ MEDICAL DOCTOR □ PHYSICAL THERAPIST

□ OTHER ______________________________

20 WHAT TREATMENT DID YOU RECEIVE FOR YOUR INJURY OR SYMPTOMS AND WHEN (APPROXIMATELY)?

____

____

21 WHAT TESTS HAVE YOU HAD RELATED TO YOUR INJURY OR SYMPTOMS?

□ XRAYS □ MRI □ CT SCAN □ OTHER ______________________________

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND ACCURATE

SIGNATURE: ______________________________ DATE: ______________

CONSENT FOR TREATMENT

HIPAA ACKNOWLEDGEMENT

CONSENT FOR TREATMENT AND ADMISSION:

I agree to be admitted to ATC dba PLANO THERAPY CENTER, P.A. as an outpatient, and authorize the therapy staff to evaluate and treat within the scope of physical and occupational therapy practice as ordered by the referring physician.
Initials ___________

RELEASE OF INFORMATION:

I hereby authorize ATC dba PLANO THERAPY CENTER, P.A. to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment.
Initials ___________

WORKER'S COMPENSATION PATIENTS RELEASE OF INFORMATION:

I authorize ATC dba PLANO THERAPY CENTER, P.A. to discuss/forward any relevant vocational information, as related to my rehabilitation, with my worker's compensation/group insurance carrier/external case manager.
Initials if applicable _________

ASSIGNMENT OF BENEFITS:

I hereby assign all of my right, title, and interest to ATC dba PLANO THERAPY CENTER, P.A. of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of ATC DBA PLANO THERAPY CENTER, P.A. customary charges for the services provided. Initials ___________

FINANCIAL AGREEMENT:

I assume financial responsibility for the payment of all charges at the time of service unless covered under worker's compensation, Medicare, or a specific insurance carrier. As a courtesy to you, ATC dba PLANO THERAPY CENTER, P.A. will file your claims to the insurance carrier that you have provided to us. By initialing below you agree for your insurance to be filed. All deductibles, co-insurances, and co-pays including non-covered services are your financial responsibility. Any account not paid will be referred to a third party collection agency to include all reasonable collection fees, not limited to attorney fees, investigative fees, and court costs. Initials ___________

CANCELLATION/NO-SHOW POLICY:

As a courtesy to our staff and other patients we ask that you keep your scheduled appointments. If you are unable to attend a scheduled appointment, please call and cancel at least two (2) hours prior to the appointment. Failure to cancel the appointment within the time frame will result in the assessment of a fee in the amount of $20 per incidence.
Initials ___________

HIPAA ACKNOWLEGEMENT:

I have received the Privacy Notice of ATC dba PLANO THERAPY CENTER, P.A. on today's date. Initials ___________

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient and his/her agent to execute the above and accept its terms. If patient's condition prohibits written consent, agent who is present when verbal consent is given should sign patient's name by agent's name. If patient is unable to consent or is a minor, complete the following:

If patient is a minor, how many years of age? _______________If patient is unable to give his/her consent,

why?____

____ _____________________

Patient/Relative/Authorized Agent Signature Date

____

Relationship to Patient (if signature is not the patient's)

____

Witness Signature

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. About Protected Health Information—"PHI".

In this Notice, "We," "Our" or "Us" means ATC dba Plano Therapy Center, P.A. and Our workforce of employees and volunteers. "You" and "Your" refers to each of Our patients who is entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of Your health information. For example, federal health information privacy regulations require Us to protect health information about You in the manner that We describe here. Certain types of health information may specifically identify You. Because We must protect this health information, We call this Protected Health Information--or "PHI." In this Notice, We tell You about:

- How We use Your PHI
- When We may disclose Your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or with a complaint

2. Some of the ways We use or disclose Your Protected Health Information.

We will use Your PHI to treat You. We will use Your PHI and disclose it to get paid for Your care. We are allowed to use, or disclose Your PHI for certain activities that We call "health care operations." Health care operations involve a lot of the administration, education and quality assurance activities in Our hospital. We will give You examples of each of these to help explain them, but space does not permit
a complete list of all uses or disclosures. That is one reason why You can contact Us and ask Us questions.

<u>Treatment</u>
We use and disclose Your PHI in the course of Your treatment. For example, if You need to be referred to another healthcare provider, We may send Your treatment notes to the Physician.

<u>Payment</u>
After We treat You, We will ask Your insurer to pay Us. We may type some of Your PHI into Our computers and send a claim to Your Insurer. Here, We use Your PHI to tell Your insurer what type of health problem You had and what We did to treat You. Your insurer may ask Us to give them Your membership number in Your employer's health plan, or Your insurer may want to review Your medical record to be sure that Your care was necessary. When We use and disclose Your PHI this way, it helps Us to get paid for Your care and treatment.

<u>Health Care Operations</u>
We also use and disclose Your PHI in Our health care operations. For example, Our therapists meet periodically to study medical records to monitor the quality of care in Our facility. Your medical record and PHI could be used in these quality assessments. Sometimes, We train students in Our facility and use the PHI of real patients to test them on their skills. Other operational uses or disclosures may involve business planning for Our facility, or the resolution of a complaint.

<u>Special Uses</u>
We also use or disclose Your PHI for purposes that involve Your relationship to Us as a patient. We may use or disclose Your PHI to:

- Remind You that You have an appointment with Us for treatment.
- Tell You about treatment alternatives and options.
- Tell you about Our other health benefits and services.

<u>Your Authorization May Be Required</u>
In many cases summarized here, We may use or disclose Your PHI either with Your consent or as required or permitted by law. In all other cases, We must ask for, and You must agree to give, a written authorization that has specific instructions and limits on Our use or disclosure of Your PHI. If You later change Your mind, You may revoke Your authorization.

3. Certain Uses and Disclosures of Your PHI that are Required or Permitted by Law.

Many laws and regulations apply to Us that affect Your PHI. These laws and regulations may either require Us or permit Us to use or disclose Your PHI. From the federal health information privacy regulations, here is a list describing required or permitted uses and disclosures.

- If You do not verbally object, We may share some of Your PHI with a family member or friend who is involved in Your care.
- We may use Your PHI in an emergency when You are not able to express Yourself.
- If We receive certain assurances that protect Your privacy, We may use or disclose Your PHI for research.

We may also use or disclose Your PHI:

- When required by law for example, when ordered by a Court to turn over certain types of Your PHI, we must do so.
- For public health activities such as reporting a communicable disease or reporting an adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To the government regulators or its agents to determine whether We comply with applicable rules and regulations.
- In judicial or administrative proceedings such as in response to a valid subpoena.
- When properly requested by law enforcement officials (such as reporting gun shot wounds), or for other legal requirements.

If We reasonably believe that to do so will avert a health hazard or to respond to a threat to public safety such as an imminent crime against another person.

- If You are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

4. Certain Stricter Requirements that We Follow.

Several state laws may apply to Your PHI that set a stricter standard than the protections required by the federal health privacy regulations. Stricter state law in Texas will, for example, limit Us from using or disclosing:

- PHI regarding individuals who are the subject of HIV related information, We may not use or disclose such HIV information except to You, Your doctor, Your insurer and a small number of additional persons without Your express written consent.
- Records that contain alcohol and drug abuse information without Your consent or a court order if the treatment program is funded by state or local government.
- Your records without Your consent or a court order if they contain information relating to inpatient mental health treatment or involuntary outpatient mental health treatment. There may be exceptions for certain government officials.

5. Your Privacy Rights and How to Exercise Them.

You have specific rights under Our federally required privacy program. Each of them is summarized here.

Your Right to Request Limited Use or Disclosure
You have the right to request that We do not use or disclose Your PHI in a particular way. However, We are not required to abide by Your request. If We do agree to Your request, We must abide by the agreement.

Your Right to Confidential Communication
You have the right to receive confidential communications from Us at a location that You provide. We require that You make Your request in writing, provide us with the other address, and explain to Us if the request will interfere with Your method of payment for Your care.

Your Right to Revoke Your Consent or Authorization
If You have granted Us Your consent or authorization to use or disclose Your PHI, You may revoke the consent or authorization in writing. However, if We have relied on Your consent or authorization, we may use or disclose Your PHI to that extent.

Your Right to Inspect and Copy
You have the right to inspect and copy Your PHI. We may refuse to give You access to Your PHI if We think it may cause You harm but We have to explain why and give You someone to contact about Our decision who will how and when to get a review of Our refusal.

Your Rights to Amend Your PHI
If You disagree with what Your PHI in Our records says about You, You have the right to request in writing that We amend Your PHI when it is in a record that We create or have maintained for Us. We are not required to respond to Your request if the records You are asking about are not Our records. We may refuse to make Your requested amendment. Then, You will have a right to submit a written statement about why You disagree. If We still disagree, We may prepare a counter-statement. Your statement and Our counter-statement must be made part of Our record about You.

Your Right to Know Who Else Sees Your PHI
You have the right to request an accounting of certain disclosures that We have made of Your PHI over the past six years. You cannot ask for disclosures before April 14,2003. We do not have to account for all disclosures, including those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting but there may be for additional accountings. We will tell You if there is a charge for Your accounting and You will have the right to withdraw Your request, or to pay to proceed.

Your Rights to Complain
If you believe that Your privacy rights have been violated, You have the right to make a complaint to Us, or to the Secretary of Health and Human Services. We will not retaliate against You if You file a complaint about Us. To file a complaint, You should submit it in writing to the contact person identified in this Notice (7, below). Your complaint should provide a reasonable amount of specific detail to enable Us to investigate a potential problem.

6. Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require Us to protect Your PHI. Those rules also require Us to give You Notice of Our privacy practices. This document is Our Notice. If You did not get a paper copy of this Notice, You may have one. We will abide by the privacy practices set forth in this Notice. However, We reserve the right to change this Notice and Our privacy practices when permitted or as required by law.

If We change Our Notice of privacy practices, We will provide Our revised Notice to You when You next seek treatment from us. You may also obtain Our most recent Notice from Our web site.

7. Contact Information

If You have questions about this Notice, or if You have a complaint, please contact:

Name: Teresa Mogan
Title: Director of HR
Address: 5228 W. Plano Parkway
Plano, TX 75093
Phone: 972.250.5700

8. Effective Date

This Notice takes effect on December 15, 2003.

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Allan Sutker, MD; Alan Barber, MD; Purcell Smith, MD; Earl Lund, MD; Randal Troop, MD; Stephen Courtney, MD; John Crates, MD; Kenneth Dauber, MD; Cameron Carmody, MD; Solomon Chaim, MD are the owners of ATC dba Plano Therapy Center, P.A.

2. You have the right to choose the provider of your physical therapy services. Therefore, you have the option to use a health care facility other than ATC dba Plano Therapy Center, P.A.

3. You will not be treated differently by your physician if you choose to obtain physical therapy services at a facility other than ATC dba Plano Therapy Center, P.A.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of ATC dba Plano Therapy Center, P.A. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in ATC dba Plano Therapy Center, P.A.

______________________________ Signature of Patient	______________________________ Signature of Parent or Guardian (If applicable)
______________________________ Type or Print Name of Patient	______________________________ Type or Print Name of Parent or Guardian (If applicable)

Dated:_________________________

CANCELLATION AND NO-SHOW POLICY

As a courtesy to our staff and patients, we ask that you keep your scheduled appointments.

In the event that you are unable to attend a scheduled appointment, please call and cancel at least two (2) hours prior to the appointment. Failure to cancel within this time period will result in the assessment of a no-show fee in the amount of **$20** per incidence which is due at your next scheduled visit.

Cancellations of your appointments should be called during regular business hours but can be left on the voicemail during weekends and holidays or other times of closure. We realize that occasionally unforeseen and emergency situations do occur and will take into consideration extraordinary circumstances on an individual basis.

Thank you for choosing ATC dba Plano Therapy Center, P.A. for your physical and occupational therapy needs, we look forward to serving you.