The Physical Therapy Experience

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.

Background: In 1996, congress recognized the need for national patient privacy standards as part of that Health Insurance Portability and Accountability Act, abbreviated as HIPPA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information.

1) Uses and Disclosures Required by Law:

- By the law, consent if not required to disclose health information to other providers who have referred you for services or are involved in your care.
- Additionally, none is needed to disclose health information to your insurance company, including Medicare, so payment can be obtained for services rendered.
- We may share some of you personal health information with a family member or friend involved in your care if you do not object.
- We may use your personal health information in an emergency situation when you may not be able to express yourself.
- We may use or disclose your personal health information for research purposes if we are provided with specific assurances that your privacy will be protected.
- We may also disclose your personal health information when we are required to do so by law, for example by court order or subpoena.
- Disclosures to health oversight agencies are sometime required by law to report certain diseases or adverse drug reactions.
- We may use and disclose health information about you to advert 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 personal health information may be used or disclosed by us for other purposes.

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2) Your Privacy Rights:

- You have the right to request how your personal health information is used; however we are not required to agree with your request. If we do agree, we must abide by your request.
- 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.
- You have the right to request an amendment be made to your personal health information, if you disagree with what is 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.
- 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 personal health information. 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 next seek treatment from us.

Privacy Contact

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

Office for civil rights
U.S Department of Health & Human Services
26 Federal Plaza- Suite 3313
New York, New York 10278
Tel: (212) 264-3313
TDD: (212) 264-2355
Fax: (212) 264-3039

This office has always recognized the importance of privacy.
This new federal law formulizes practices that have been followed routinely.

I HAVE READ AND UNDERSTOOD THE INFORMATION STATED ABOVE.

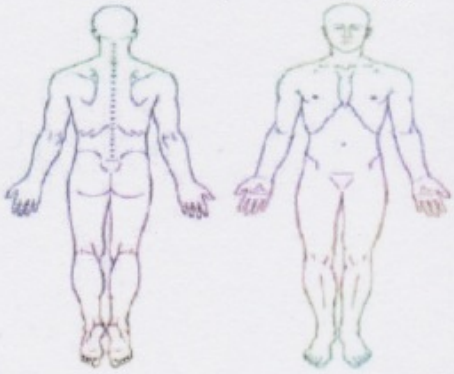
SIGNATURE:_____ DATE:_____

Patient Health Questionnaire-PHQ

Patient Name:_____ Date:_____

1. Describe your symptoms:_____
   _____
   a. When did your symptoms start?_____
   b. How did your symptoms begin?_____
2. How often do you experience your symptoms?
   a. Constantly (76%-100%)
   b. Frequently (51%-75%)
   c. Occasionally (26%-50%)
   d. Intermittently (0%-25%)
3. What describes the nature of your symptoms?
   a. Sharp
   b. Dull ache
   c. Numb
   d. Shooting
   e. Burning
   f. Tingling
4. How are your symptoms changing?
   a. Getting better
   b. Not changing
   c. Getting worse

Indicate where you have pain or other symptoms:



5. During the past 4 weeks:
   a. Indicate the average intensity of your symptoms: None: 1 2 3 4 5 6 7 8 9 10 :Unbearable
   b. How much has pain interfered with your normal work (including both outside the home and house work)
      1.Not at all 2. A little bit 3. Moderately 4.Quite a bit 5.Extremely
6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting friends, relatives, etc)
   1.All the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time
7. In general would you say your overall health right now is...
   1.Excellent 2. Very good 3. Good 4. Fair 5. Poor
8. Who have you seen for your symptoms?
   a. No one
   b. Chiropractor
   c. Medical Doctor
   d. Physical Therapist
   e. Other

   1.What treatment did you receive and when?_____
   2.What tests have you had for your symptoms and when were they performed?
   a. Xrays, date:_____
   b. MRI, date:_____
   c. CT Scan, date:_____
   d. Other, date: _____.
9. Have you had similar symptoms in the past? (PLEASE CIRCLE ONE) **YES** **NO**
   a. If you have received treatment in the past for the same of similar symptoms, who did you see?
      1.This office
      2.Chiropractor
      3.Medical Doctor
      4.Physical Therapist
      5.Other_____
10. What is your occupation?_____
11. Are you currently working? _____

SIGNATURE:_____ DATE:_____

The Physical Therapy Experience

Patient Information

Name:_____ Date of Birth:_____Sex:_____

Address:_____City:_____ State/Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Social Security: _____

E-Mail Address:_____

Employer's Name:_____

Employer's Address:_____

****Referring Doctor**:_____

Whom may we thank for this referral?_____

Insurance Information (PLEASE FILL OUT **A** OR **B**)

A. Private Insurance

Insurance Name:_____ ID Number:_____

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

Secondary Insurance (If applicable):_____ ID Number:_____

B. Worker's Compensation/No-Fault (PLEASE CIRCLE ONE)

Insurance Name:_____

Insurance Address:_____

Date of Accident:_____Policy Number:_____

Claim Number:_____Case Manager: _____

Carrier Case Number:_____ (if have one)

Phone Number & EXT:_____Fax Number:_____

*I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORAMTION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE:_____ DATE:_____

**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PT EXPERIENCE, PLLC. FOR PROFESSIONAL SERVICES DESCRIBED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE:_____ DATE:_____

OUR GREATEST APPRECIATION IS YOUR REFERRAL TO OTHERS. THANK YOU!

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

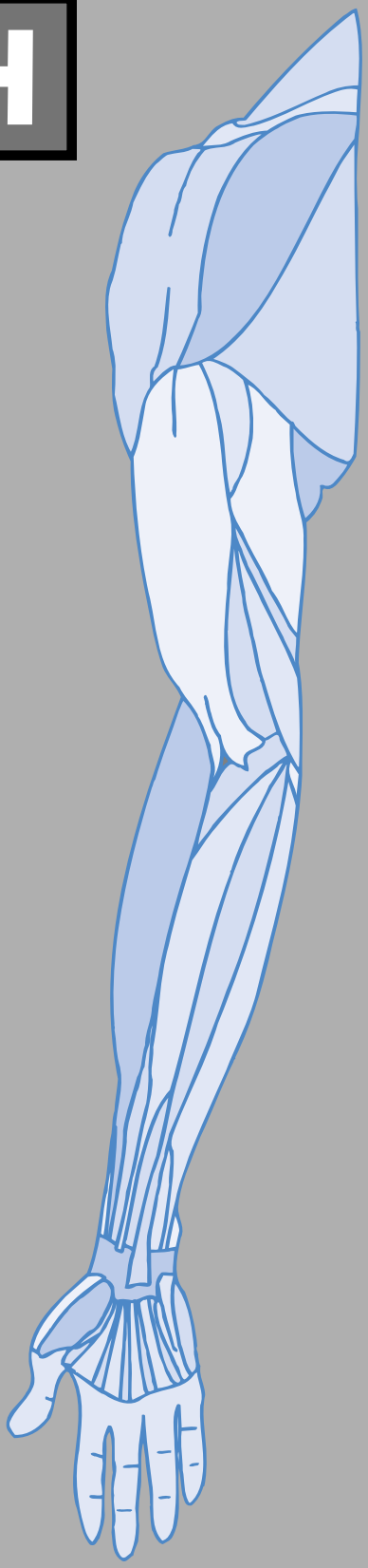
	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1.	using your usual technique for your work?	1	2	3	4	5
2.	doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3.	doing your work as well as you would like?	1	2	3	4	5
4.	spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1.	using your usual technique for playing your instrument or sport?	1	2	3	4	5
2.	playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3.	playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4.	spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

INSTITUTE FOR WORK & HEALTH
INSTITUT DE RECHERCHE SUR LE TRAVAIL ET LA SANTÉ

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