ACTION POTENTIAL Today's Date: _____

ATTENTION MEDICARE PATIENTS: Are you currently receiving home health care? Yes No
HAVE YOU BEEN SEEN IN ANY OF OUR CLINICS BEFORE __ NO __YES When: _____ _

(Mr/Mrs/Ms) Full Legal Name: _____

Address: _____
Street City State Zip

Social Security Number: _____ Phone: _____

_ Married _Single _ Other Date of Birth: _____ Age: _____ __ Male __Female

Responsible Party: _____ Relationship: _____

Emergency Contact Person: _____ Phone: _____

Employer: _____ Phone: _____

Address: _____
Street City State Zip

Employer Contact Name (if applicable) _____

Please Circle One: WORKCOMP AUTO PRIVATE HEALTH

Primary Insurance Company: _____ Phone: _____

Address: _____
Street City State Zip

Case Manager **/** Adjuster: _____ _ Phone Ext _____

ID or Claim Number: _____

Group Name: _____ _ Group Number: _____
Insured's
Name/Relationship: _____ Date of Birth: _____

Secondary Insurance Company: _____ Phone: _____

Insured's **ID** Number: _____ Date of Injury: _____

Group Name: _____ _ Group Number: _____
Insured's
Name/Relationship: _____ Date of Birth: _____

Attorney: _____ Phone: _____

Address: _____
Street City State Zip
Physician **/** Referral Source: _____

ACTION POTENTIAL
Physical Therapy

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke? ☐ Yes ☐ No**
Sex: ☐ Male ☐ Female If female, are you currently pregnant? **☐ No ☐ Yes If yes,** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester				

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Other:_____

Who referred you to physical therapy? _____

Primary Physician _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): _____

Recent flare-up? ☐ No ☐ Yes If yes, when _____

What activities are limited by this condition? (e.g. lift, reach):_____

How did your injury/symptoms occur? _____

_____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?

☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind?_____

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

☐ Physical therapy If yes, when? ___/___/___to ___/___/__

What was done?_____

☐ Chiropractor If yes, when? ___/___/___to ___/___/___

What was done? _____

☐ Medications: _____

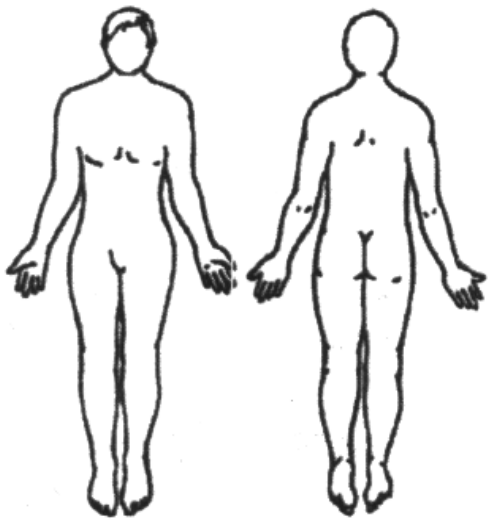
☐ X-ray _____ ☐ MRI _____

☐ CT scan _____ ☐ Other: _____

☐ Exercises: What kind? _____

Indicate on body diagrams **where** your symptoms are located

■ = Pain ***III*** = Numbness



Front Back

Comments: _____

_____

_____

Work Information

Who is your employer? _____

What is your job title/responsibilities? _____

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week _____

☐ Full Duty ☐ Restricted Duty

How many total work days have you missed? _____ Do you have a case manager/QRC? ☐ No ☐ Yes

Your Therapist Will Complete This Section

Critical work, ADL, or leisure activities affected: _____

- Lift/carry:☐ ≤ 20 lbs. rarely to occasionally (**low demand**)
  ☐ > 20 lbs., or > 1lb. constantly or > 10 lb. frequently (**mod-high demand**)

  Where to where _____ to _____.

- Repetitive motions related to condition: ☐ Occasional 1-33% (**low demand**)
  ☐ Frequent to Constant 34-100% (**mod-high demand**)

- Static positions related to condition (**mod-high**): ☐ Sit ☐ Stand ☐ Crouch
  ☐ Kneel ☐ Overhead work ☐ _____

- Leisure Activities: ☐ None/minimally impact condition **(low demand)**
  ☐ Moderate-high intensity, competitive **(mod-high demand)**

Overall functional demand (work/ADL/leisure) ☐ Low Demand ☐ Moderate-High Demand

Comments: _____

Additional Comments: _____

ACTION POTENTIAL
Physical Therapy

Indicate either "Yes" or " No" as to whether each of the following activities is difficult.

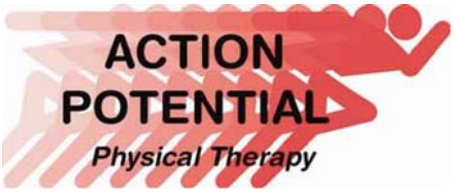
Drinking or Eating	_Yes _No	Balancing on both feet	_Yes _No
Sleeping Through the Night	_Yes _No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	_Yes _No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	_Yes _No	Lifting	_Yes _No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	_Yes _No	Carrying	_Yes _No
Getting in/out of: chairs, bed, car or bath/shower	_Yes _No	Bending, Kneeling Squatting	_Yes _No
Reaching: overhead, behind back, downward for forward	_Yes _No	Driving a vehicle or ability to use gas/brake pedals	_Yes _No
Gripping, Holding tools or Opening Jars	_Yes _No	Caring for child or adult	_Yes _No
Picking up Small Objects	_Yes _No	Housework / Yard work	_Yes _No
Sitting	_Yes _No	Recreational Activities	_Yes _No
Standing	_Yes _No	Have you fallen more than 1 time in the past year	_Yes _No
Job Related Activities	_Yes _No	Have you fallen and hurt yourself in the past year	_Yes _No

Other:

ACTION POTENTIAL
CURRENT MEDICATIONS LIST REPORT

PATIENT NAME: **DATE:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)
LIST ALL OVER-THE -COUNTER MEDICATIONS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)
LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)



POLICIES REGARDING CARE, FEES AND BILLS

We are pleased you have allowed us the opportunity to provide the specialty treatment that your physician has requested.

CARE: Our fee schedule is well within the MEDICARE guidelines for reasonable and customary charges for our region. A normal therapy session could average around $180.00 per visit. The charge per visit could be lower or higher depending on the length of the session and the type of treatment provided.

BILLS: At your initial visit we will ask you to provide us with the pertinent personal and financial information needed to process your bills. As a courtesy to you we will contact your insurance to determine your level of benefits and to obtain pre-authorizations when required. However, this is not a guarantee of payment. If you think your insurance company has not processed your claim correctly you should contact them directly. If your insurance company requires a co-pay, you will be expected to pay at each visit. Should your insurance require a deductible and/or co-insurance, we ask that you wait until you receive our statement indicating the amount your insurance requires you to pay. Further, you will be expected to pay the balance in full by cash, check or credit card within 30 days of each statement.

FINANCIAL RESPONSIBILITY: You are ultimately responsible for the financial resolution of your bill. You are financially responsible for any and all charges you incur that are not covered by your insurance or Workers' Compensation.

*In the case that your Workers' Compensation claim is not accepted by your Work Comp carrier, and they refuse to pay, you will be responsible for payment in full.

*It is especially important to know that in a liability situation, including but not limited to auto accidents, it is your responsibility to make sure we are paid for the treatment you receive. If a settlement is expected at the end of your treatment, and you have no other insurance, we will expect a minimum monthly good faith payment. We will also expect you to sign a notice of financial agreement.

Should Action Potential be required to employ an attorney to enforce payment for treatment rendered, you will be expected to pay reasonable attorney fees, court costs and interest for such enforcement. If you have questions regarding this agreement, please contact our Billing Department at 877-325-2772.

Signature: _____ Date: _____ _

104 Pro Rodeo Drive • Suite 110 • Colorado Springs, Colorado • 80919 • 719-592-1788 • Fax 719-592-1790
2233 Academy Place • Suite 50 • Colorado Springs, Colorado • 80909 • 719-475-0808 • Fax 719-475-8822
1604 East Pikes Peak Avenue • Colorado Springs, Colorado • 80909 • 719-630-3193 • Fax 719-630-3195
2435 Research Parkway • Suite 255 • Colorado Springs, Colorado • 80920 • 719-260-8400 • Fax 719-260-8405
2955 Professional Place. Suite 200 • Colorado Springs, Colorado • 80904 • 719-227-7079 • Fax 719-227-7061
328 Main Street. Colorado Springs, Colorado • 80911 • 719-392-7777 • 719-392-7783

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by Action Potential in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by **HIPAA, Action Potential** has prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Action Potential may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

* Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
* Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
* Health care operations include the business aspect of running **Action Potential,** such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may also conduct fundraising for our benefit.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made with your written authorization. You may revoke such authorization in writing and **Action Potential** is required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

* The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

* The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.

* The right to inspect and copy your protected health information.

NOTICE OF PRIVACY PRACTICES

* The right to amend your protected health information.

* The right to receive an accounting of disclosures of protected health information.

* The right to obtain, and **Action Potential** has the obligation, to provide to you a paper copy of this notice at your first service delivery date.

* The right to provide, and **Action Potential** has the obligation to receive, a written acknowledgement that you have received a copy of the Notice of Privacy Practices.

Action Potential is required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____and **Action Potential** is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices to make the new notice provisions effective for all protected health information that we maintain. **Action Potential** will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with **Action Potential,** or the Department of Health & Human Services, office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office, **Action Potential** will not retaliate against you for filing a complaint. You may contact **Action Potential** at any time during regular business hours for more information.

For further information regarding **HIP** AA contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

* Obtain payment from third-party payers.

* Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received **Action Potential's** *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that **Action Potential** has the right to change its *Notice of Privacy Practices* from time to time and that I may contact any of their locations at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that **Action Potential** restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand **Action Potential** is not required to agree to my requested restrictions, but if **Action Potential** does agree, then they are bound to abide by such restrictions.

_____ _____

Print Patient Name Date

_____ _____

Patient / Guardian Signature Print Guardian Name and Relationship to the Patient

OFFICIAL USE ONLY	
I attempted to obtain the patient's signature in acknowledgement to this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.	
Date:	Initials:
Reason:	

104 Pro Rodeo Drive • Suite 110 • Colorado Springs, Colorado • 80919 • 719-592-1788 • Fax 719-592-1790
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328 Main Street. Colorado Springs, Colorado • 80911 • 719-392-7777 • 719-392-7783

RELEASE OF INFORMATION, CONSENT TO TREAT, INSURANCE VERIFICATION, AND FINANCIAL RESPONSIBILITIES

PATIENT NAME: _____

We are glad you and your physician have chosen Action Potential to provide you physical therapy care. We view physical therapy as a joint effort involving both the therapist and you. The goals of the therapist are to reduce your assessed problems and symptoms as quickly and pleasantly as possible. Your goals as a patient are to follow through with instructions that your physical therapist recommends and to attend all of your scheduled appointments on time.

Please understand that we will be as flexible as possible with you and your schedule. With enough notice, we can rearrange appointments as needed. We require 24-hour notice of cancellations. Other patients need to fit their appointments into our schedule so please be considerate of others by keeping the appointments that you make with us. ACTION POTENTIAL reserves the right to charge a $30 fee for patients who do not show up to a scheduled appointment or cancel less than 24 hours in advance.

RELEASE OF INFORMATION AND CONSENT TO TREATMENT:

1. I consent to be treated by Action Potential.
2. I authorize Action Potential to request any information regarding illness, injury, medical history, treatment, or copies of medical records from other health care providers.
3. I authorize Action Potential to release any information requested by my insurance company or other health care providers, regarding my medical history, treatment, evaluation, or any other subjective history.

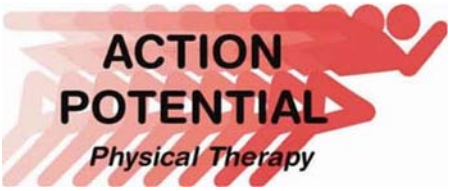
PATIENT SIGNATURE: _____ DATE: _____

ASSIGNMENT OF MEDICAL BENEFITS

1. In order to accommodate you, (our patient), we will do our best to verify insurance benefits in a timely manner. Physical Therapy benefits will vary with each insurance company. WE SUGGEST THAT YOU ALSO VERIFY YOUR INSURANCE BENEFITS TO FULLY UNDERSTAND WHAT IS AND WHAT IS NOT COVERED.
2. As a courtesy to you, (our patient), Health Insurance Claims, Auto Insurance Claims, and Workers' Compensation Claims are filed by Action Potential.

I authorize and instruct my insurance company to make checks payable to Action Potential, and mail directly to Action Potential, 2233 Academy Place, Suite 50, Colorado Springs, CO 80909.

PATIENT SIGNATURE: _____ DATE: _____



PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner (check all that apply):

__ Home Telephone _____

Leave message with detailed information

Leave message with call-back number only

__ Written Communication

__ Mail to my home address

__ Mail to my work address

__Fax to this number _____

__ Work Telephone _____

__Leave message with detailed information

__ Leave message with call-back number only

Other: _____

_____ _____

Patient Signature Date

_____ _____

Print Name Birth Date

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use of disclosure of, and requests for, PHI to be minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Health care entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency.