ADVANCED PHYSICAL THERAPY SPECIALISTS
THE ART OF PHYSICAL THERAPY

Medical Screening Questionnaire

Name:_____

Do you smoke? __Yes __No

Do you have a pacemaker? __Yes __No

Are you currently pregnant or do you think you might be pregnant? __Yes __No __NA

Have you been or are you on long term steroid use? __Yes __ No / Height ____ weight ____

Do you or have you had any facial / jaw pain? __Yes __No

Have you recently noticed any of the following?

__Fatigue
__Numbness/tingling
__Constipation
__Fever/Chills/Sweats
__Muscle Weakness
__Diarrhea
__Nausea/Vomiting
__Dizziness/Light Headedness
__Shortness of Breath
__Blurred Vision
__Weight Loss/Gain
__Heartburn/Indigestion
__Fainting
__Balance Issues
__Difficulty Swallowing
__Cough
__Falls
__Changes in Bowel/Bladder Function
__Headaches
__Night Pain
__Difficulties Sleeping
__Unexplained Weightloss

Have you EVER been diagnosed with any of the following conditions?

__Skin Cancer
__Cancer
__Depression
__Thyroid Problems
__Heart Problems
__Lung Problems
__Diabetes
__Chest Pain/Angina
__Tuberculosis
__Osteoporosis
__Asthma
__Multiple Sclerosis
__Circulation Problems
__Rheumatoid Arthritis
__Epilepsy
__Blood Clots
__Other Arthritic Conditions
__Ulcers
__Stroke
__Bladder/Urinary Tract Infection
__Anemia
__Kidney Problem/Infection
__Hepatitis
__Bone or joint infection
__Sexually Transmitted Disease/HIV
__Pneumonia
__Chemical Dependency
__Pelvic Inflammatory Disease
__High Blood Pressure
__Liver Problems

Has anyone in your immediate family EVER been diagnosed with any of the following conditions?

__Cancer
__Diabetes
__Tuberculosis
__Gout
__Heart Problems
__Stroke
__Thyroid Problems
__High Blood Pressure
__Depression
__Blood Clots

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches)

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

WELCOME TO Advanced Physical Therapy Specialists!

PATIENT INFORMATION

NAME_____ M / F

PHONE (H)_____

(W) _____ (C)_____

ADDRESS_____

CITY_____STATE_____ZIP_____

BIRTHDATE _____ /_____/_____

SOCIAL SECURITY#_____/_____/_____

EMAIL ADDRESS_____

___

REFERRING PHYSICIAN_____

FAMILY PHYSICIAN_____

DIAGNOSIS_____

DATE OF INJURY_____

IS YOUR CASE IN LITIGATION? YES/NO

HOW DID YOU HEAR ABOUT OUR CLINIC?

_____

Advanced Physical Therapy Specialists

OFFICE POLICIES & PROCEDURES

Welcome and thank you for choosing Advanced Physical Therapy Specialists for your Physical Therapy needs.

As a courtesy to others and our Therapists and to other patients trying to get scheduled, we require a 24-hour (or greater) notice for cancellations. This allows others on waiting lists to be seen. Only weather, emergencies, or illnesses are excusable. A $60 fee will be billed upon violation of this policy.

PRIVACY POLICY

I understand that Advanced Physical Therapy Specialists, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

CONSENT TO TREATMENT

Advanced Physical Therapy Specialists is a hands-on Physical Therapy clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of electrical stimulation, traction, deep tissue massage, therapeutic exercise programs, gait training, neuromuscular re-education, craniosacral therapy, trigger point dry needling, myofascial release, bone and soft tissue manipulation, as well as other treatment modalities may be used. Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern; however, please ask if you have any concerns or questions. The number of treatments needed and recovery time can vary due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Advanced Physical Therapy Specialists, LLC. I authorize Jeremy Wehking PT and the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

I have read and completely understand the above written statements.

X_____Date_____ Signature of patient/legal guardian

NOTICE OF PRIVACY PRACTICES (MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us 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", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.
We may use and disclosed 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 obtained 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 aspects of running our practice, 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 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 only with your written authorization. You may revoke such authorization in writing and we are 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 communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 14th, 2003** and we are 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 and to make the new notice provisions effective for all protected health information that we maintain. We 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 written complaint with our office, or with 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. We will not retaliate against you for filing a complaint.

Please contact us for more information.
Advanced Physical Therapy Specialists
5901 SW 74th Street Suite 201
South Miami, FL 33143
305-433-1172

For more information about HIPAA or to file a complaint:
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

_____
Patient's Signature

_____
Patient's Full Name

_____
Date