HIPAA toolkit form E
Notice and Acknowledgement

I acknowledge that I have been offered/received the attached Notice of Privacy Practices.

⇨ _____ _____ ⇦
Patient or Personal Representative Signature Date

If a Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

HIPAA Form F
Documentation of Good Faith Efforts

_____ _____
Patient Name Date

The patient presented for treatment on this date and provided with a copy of the practice's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained because:

____ Patient refused to sign. ___ Patient was unable to sign because _____

___ There was a medical emergency (the practice will attempt to obtain acknowledgement at the next available opportunity)
___ Other reason _____

Signature of Employee completing form: _____

HIPAA WAIVER

Diversified Physical Therapy and/or its staff are hereby authorized to leave messages and information regarding my account, my medical condition, test results, appointment times and/or schedule changes on my answering machine or with the following persons indicated below.

This written consent will allow use and disclosure of Protected Health Information about you to "family and friends" whose names you have provided below. You may revoke this consent, in writing at any time except to the extent that we have already taken action in reliance on the consent. If you revoke you consent, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

⇨ _____ _____ ⇦
Patient's Signature Date

_____ _____
Name of "Family or Friends" Relationship

_____ _____
Name of "Family or Friends" Relationship

PATIENT INTAKE
DPTS, INC.

NAME: _____ DATE OF BIRTH: __/__/____
LAST FIRST MIDDLE AGE: _____ SEX: M F

ADDRESS: _____ HOME PHONE: _____
STREET CELL: _____

_____ FAMILY PHYSICIAN: _____
CITY STATE ZIP PHONE: _____

MARITAL STATUS: M S W D SS#: _____

EMPLOYER: _____ WORK PHONE: _____

WORK ADDRESS: _____ HOSPITAL PREFERENCE: _____

ENVIRONMENTAL/SUPPORT SYSTEM/ EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____ PHONE: _____

ADDRESS: _____

ARE YOU CURRENTLY RECEIVING HOME CARE SERVICES? YES _____ NO _____
HAVE YOU HAD PHYSICAL THERAPY ANY WHERE ELSE THIS YEAR?

NO _____ YES _____ WHERE: HOME _____ OUTPATIENT _____

INSURANCE INFORMATION

PRIMARY INS: _____ SECONDARY INS: _____ CARDHOLDER'S DOB: __/__/____

IS THIS CONDITION THE RESULT OF AN **AUTOMOBILE ACCIDENT** OR **WORK RELATED** INJURY?
CIRCLE ONE IF APPLICABLE AND PROVIDE THE FOLLOWING INFORMATION

AUTO OR WORK: INSURANCE CARRIER: _____ DATE OF INJURY: __/__/____

CLAIM ADJUSTER'S NAME: _____ CLAIM/POLICY #: _____

HOW DID YOU HEAR ABOUT US? PHONE BOOK: _____ FRIEND: _____

PHYSICIAN: _____ ADVERTISEMENT: _____ OTHER: _____

EMAIL: _____

Diversified Physical Therapy Specialists

PATIENT RIGHTS

As a patient you have the right to the following:

1. Treatment and care without discrimination based on race, religion, or ethnic origin.
2. The right to an explanation of the information that is contained in your evaluation, progress, and discharge reports.
3. The right to refuse any treatment that you feel would be unsafe or detrimental to your condition.
4. The right to be an integral part of the decision making process regarding your care.

Consent for Treatment

Knowing that I require diagnostic evaluation and/or treatment at DPTS Inc., I do hereby voluntarily consent to such evaluation and treatment by the personnel as deemed necessary in their judgement. I further understand my responsibility to provide DPTS Inc., with complete and accurate information and to participate fully in my evaluation and treatment.

Release of Information in Case of Disaster

I authorize DPTS Inc., to release information in my patient records to the hospital in case of a disaster emergency. I understand that tis authorization may be withdrawn by me at any time. Revocation of the authorization will not affect any information already released.

Financial Policy

I authorize the release of any medical or other information necessary to process this claim. I hereby authorize my payment direct to DPTS Inc., of any insurance benefits otherwise payable to me. DPTS Inc., routinely bills your insurance company for payment of services. *It is possible that we will be denied reimbursement by your insurance company.* In the event that appropriately billed service charges are not paid in full by your insurance company, it is understood that you may be billed by DPTS Inc., ***and that you are responsible for the balance of your account***. DPTS Ins., is not responsible for loss of valuable, money, clothing, glasses, and/or personal items.

Nondiscrimination in Service

It is the policy if DPTS Inc., to provide service to all persons without regard to race, color, national origin, substance addiction, impaired vision, impaired hearing, handicap or age in compliance with 45 CFR parts 80, 84, and 91, respectively. The same requirements are applied to all, and there is no distinction in eligibility for, or in the manner of providing services. All services are available without distinction to all program participants regardless of race, color, national origin, substance addiction, impaired vision, impaired hearing, handicap or age. All persons and organizations having occasion either to refer persons for services or to recommend our services are advised to do so without regard to the person's race, color, national origin, substance addiction, impaired vision, impaired hearing, handicap or age.

Cancellation Policy

In order to provide the best treatment at DPTS Inc., the following guidelines have been implemented:

2 Cancellations/No Shows — **a verbal reminder of your commitment to your health**

4 Cancellations/No Shows — **you are eligible for discharge due to lack of compliance**

_____ _____ ****** Charges for a late cancellation or no show will be a $20 fee**

Initial **Date**

We make every effort to accommodate work, school, and family schedules. In order to achieve the best results from physical therapy, you need to make effort to keep your appointments.

The person designated to coordinate compliance with section 504 of the Rehabilitation Act of 1973 (nondiscrimination against the handicapped) is Lisa Rau, MSPT who can be reached at 989-652-4040.

I HAVE READ THROUGH THE ABOVE ISSUES AND I AGREE THAT I UNDERSTAND THEM.

_____ _____ _____

Patient/Guardian Signature Date Witness

LAST NAME: _____ DATE: _____

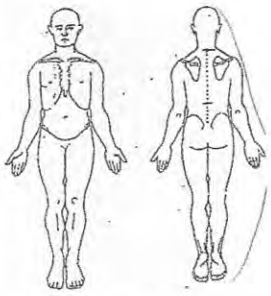
DATE OF INJURY: _____ HOW DID IT OCCUR: _____

ON SCALE OF 1 TO 10, PLEASE RATE YOUR PAIN

0----------5----------10

DESCIBE YOUR PAIN: _____

Where is your pain? Please mark the drawings where you feel your pain.



DO YOU HAVE ANY ALLERGIES? YES / NO IF YES, PLEASE LIST: _____

PLEASE LIST YOUR MEDICATIONS (dosage, times per day, and time of day):

_____

_____

_____

_____

DO YOU SMOKE? YES/ NO IF YES, HOW LONG? _____

DO YOU DRINK? YES/ NO WHO DO YOU LIVE WITH? _____

HAVE YOU EVER HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

_____ TURBERCULOSIS	_____ DIABETES	_____ ARTHERITIS
_____ EPILEPSY/SEIZURES	_____ HIGH BLOOD PRESSURE	_____ ASTHMA
_____ CANCER/ LEUKEMIA	_____ HEART CONDITION	_____ PACE MAKER
_____ METAL IMPLANTS	_____ BIRTH DEFECTS	_____ STORKE

SURGERIES:

_____

_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

_____ PAIN	_____ HEADACHES	_____ DIFFICULTY SLEEPING
_____ WEAKNESS	_____ SKIN RASH	_____ DIFFICULTY WALKING
_____ NUMBNESS	_____ CHEST PAINS	_____ DIFFICULTY SPEAKING
_____ TINGLING	_____ MEMORY LOSS	_____ DIFFICULTY SWALLOWING
_____ DIZZINESS	_____ SHORT OF BREATH	_____ DIFFICULTY WITH BALANCE
_____ STIFFNESS	_____ DEPRESSION	_____ POOS EXERCISE TOLERANCE

IS THERE ANY POSSIBILITY THAT YOU MAY BE PREGNANT?	YES	NO
ARE YOU HAVE FINANCIAL DIFFICULTY SINCE THE ACCIDENT/ INJURY?	YES	NO
DO YOU HAVE ANY NEED OR DESIRE TO SEE A SOCIAL WORKER?	YES	NO

I CERTIFY THAT ALL ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____