PATIENT INFORMATION: ***(PLEASE PRINT)*** **Potena Physical Therapy, Inc**

Last Name: First: MI

Address: City: State Zip -

Home Phone: Work: Cell:

Date of Birth: Age: Marital Status: M S W D Sex: M F

Social Security # Occupation:

Employer: Are you working now? If No, Last Date Worked:

Family Physician: Referring Physician:

Next Doctor Visit:

Reason for Referral: Date Symptoms Started:

Policy Holder Information: (spouse or guardian if insurance is not in your name)

Policy Holder: Employer: Occupation:

Work Phone: Cell Phone:

Policy holder's address:

Social Security#: Date of Birth:

Minors (under 18) or college students under parent's insurance please complete:

Father's Name: Work Phone: Cell Phone:

Mother's Name: Work Phone: Cell Phone:

PRIMARY INSURANCE:

Have you received **PT** or **Chiropractic** care this year from any other facility? **YES NO How Many**

Insurance: ID# Group#

Worker's Comp Claim #: *Auto Claim #:*

SECONDARY:

Insurance: ID# Group#

Insured's Name: Relationship to Patient: Self Spouse Dependent

Insured's Employer: Phone#

Insured's Social Security#: Insured's Date of Birth:

Emergency Contact: ***Phone#***

PATIENT SIGNATURE **DATE**

GUARDIAN'S SIGNATURE **DATE**

I hereby assign Potena Physical Therapy Inc. my rights & interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits/obtain payment.This authorization shall remain valid until written notice is given by me of revocation. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Reason for Referral: **Date symptoms started:**

Current Condition: Height: Weight: Pregnant? Y N

Do you drink alcoholic beverages? Y N Per Day: Per week:

Do you smoke cigarettes? Y N Packs per Day:

List Medications:

List Allergies:

Have you had other types of treatment: Chiropractic Injections Reflexology Other_____

Describe your general health: (circle one)
Excellent Good Fair Poor

Cardiovascular Fitness: (circle one)
Very Active Active Sedentary

History:
Have you ever had any of the following? (choose all that apply)

____ Anemia	____ Fractures	____ HIV	
____ Asthma	____ Headaches	____ Insomnia	____ Pacemaker
____ Cancer	____ Heart Attack	____ Kidney Problems	____ Rheumatoid Arthritis
____ Chest Pain	____ Heart Disease	____ Low Back Pain	____ Seizures
____ Diabetes	____ Heart Palpitations	____ Low Blood Pressure	____ Shortness of Breath
____ Dizziness/fainting	____ Hepatitis	____ Metal Implants	____ Stroke
____ Emphysema	____ Hernia	____ Osteoarthritis	____ Swollen Ankles
____ Fibromyalgia	____ High Blood Pressure		List Other:_____

LIST ANY RELEVANT SURGERIES WITH DATES:

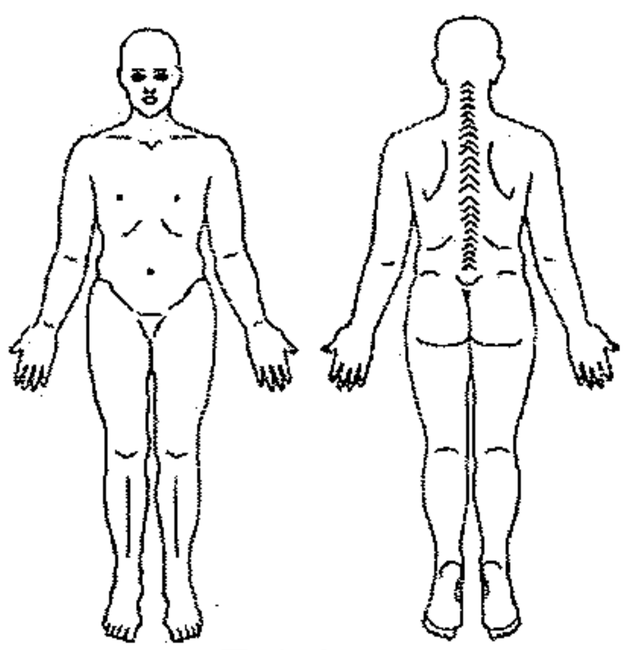
Do you use any assistive devices? (circle all that apply)
Crutches Cane Walker Wheelchair

Pain Description: (circle all that apply)
Aching Burning Deep Dull Sharp Stiff Stabbing

ON A SCALE OF 1-10: 0 = No pain 10 = Worst pain

Average pain overall throughout the day? 0 1 2 3 4 5 6 7 8 9 10
What is your pain at best? 0 1 2 3 4 5 6 7 8 9 10
What is your pain at worst? 0 1 2 3 4 5 6 7 8 9 10

Please mark picture... ***Where is your pain?***



Activities that Increase Symptoms: (choose all that apply)

____ Walking	____ Sitting	____ Exercise	____ Twisting
____ Stairs	____ Sit to stand	____ Outdoor work	____ Grasping
____ Running	____ Standing	____ Housework	____ Work
____ Bending	____ Lifting	____ Driving	____ Look up
____ Reaching	____ Cold	____ Sidelying	____ Look down
____ AM or PM	____ Evening	Other:	

Functional Limitations: (choose all that apply)

____ Walking	____ Sitting	____ Exercise	____ Writing
____ Stairs	____ Sit to stand	____ Outdoor work	____ Grasping
____ Running	____ Standing	____ Housework	____ Work
____ Bending	____ Lifting	____ Driving	____ Sports
____ Reaching	____ Sleeping	____ Shopping	____ Daily Activities

Personal Goals for Therapy: (choose all that apply)

____ Decrease pain	____ Increase Strength	____ Resume / Improve function (dressing, fix hair)
____ Improve sleep	____ Return to work	____ Increase sitting tolerance
____ Return to sports	____ Improve posture	____ Increase standing tolerance
____ Reduce swelling	____ Reduce headaches	____ Improve mobility in home & community
____ Negotiate Stairs		____ Learn self-care techniques
____ Resume / improve household chores		____ Improve body mechanics
____ Improve balance and strength		____ Regain mobility and increase flexibility

PF-1000 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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of physical therapy tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Potena Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

. the right to request restrictions on the use and disclosure of your protected health information
. the right to receive confidential communications concerning your medical condition and treatment
. the right to inspect and copy your protected health information
. the right to amend or submit corrections to your protected health information
. the right to receive an accounting of how and to whom your protected health information has been disclosed
.the right to receive a printed copy of this notice

Potena Physical Therapy, Inc. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

David P. Potena, PT
Potena Physical Therapy, Inc.
32 West Penn Avenue
Cleona, PA 17042

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

David P. Potena, PT
Potena Physical Therapy, Inc.
32 West Penn Avenue
Cleona, PA 17042
717.270.6078

Effective Date
This Notice is effective on or after October 1, 2002.

Please provide the name of person(s) to whom Potena Physical Therapy, Inc. may disclose health information and billing information:

Name of Personal Representative	Relationship to Patient	Date of Birth
_____	_____	_____
_____	_____	_____

Patient's Signature _____ Date _____