



## **Notice of Patient Information Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **Probility Physical Therapy LEGAL DUTY**

Probility Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

Probility Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, information about your account status, or information about treatment alternatives or other health related benefits that could be of interest to you.

Probility Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies (information will not include patient names or social security numbers). We also provide information when required by law.

In any other situation, Probility Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop future disclosures at any time.

Probility Physical Therapy may change its policy at any time. When changes are made a new Notice of Information Practices will be posted in a common area of our office. You may also request an updated copy of our Notice of Information Practices at any time.

### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reason other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Probility Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

### **CONCERNS AND COMPLAINTS**

If you are concerned that Probility Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our office at the address above. You may also send a written complaint to the U.S. Department of Health and Human Services.

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**I have read and understand the Notice of Patient Information Practices.**

\_\_\_\_\_

\_\_\_\_\_

**Signature**

**Date**

*Enjoy Your Life Again!*

April 11, 2012

Dear Patients:

**Our no-show/cancellation policy is as follows:**

A cancellation or no-show is documented when the following occurs:

- 1) The patient cancels or does not show up for their appointment **without giving 24 hours notice of their scheduled appointment** and
- 2) The patient does not reschedule their appointment within the same week.

Patients will be given the chance to reschedule one appointment (when they give less than 24 hours notice) each week. Any more than that in a given week will be classified as a cancellation or no-show.

**In the event of three (3) cancellations or no-shows within thirty (30) days, the patient will be charged a fee of \$25.00.** The patient will additionally be charged for each cancellation or no-show thereafter. After a repeated record of canceling/no-showing occurs, (4 cancellations or no-shows within 30 days, or 6 within sixty days), patients will no longer be able to schedule appointments ahead of time. A patient may, however, call on a given day and schedule an appointment at that time for that day. In some cases, patients will be discharged if they have a record of too many cancellations or no-shows.

We truly value our patients' time just as we hope that you value ours. Having said that, whenever a patient does not appear for scheduled appointments, everyone is affected – you do not get the treatment that was needed and we lose a spot that another patient could have filled.

**Please make every effort to provide at least 24 hours notice if an appointment must be missed.** We understand unexpected conflicts can occur and that your lives are as busy as ours. We strive to work together with you to fit your schedules.

**Thank you in advance for your understanding and cooperation,**

Patrick Hoban, PT, MS, ATC, FF-CIMT  
Owner  
Probility Physical Therapy

Agreed to and Acknowledged by:

Patient Name

Patient Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Enjoy Your Life Again!*



**PATIENT INFORMATION**

LAST NAME	FIRST NAME	MI	DOB	SOCIAL SECURITY #	SEX
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HOME ADDRESS	CITY, STATE	ZIP CODE	HOME # ( )	CELL # ( )
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MARITAL STATUS	HAVE YOU EVER BEEN TREATED AT THIS CLINIC BEFORE?	IF YES, WHEN?
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EMPLOYMENT STATUS EMPLOYED ( ) STUDENT ( ) N/A ( )	EMPLOYER NAME / SCHOOL NAME	TITLE / POSITION
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WORK ADDRESS	CITY	ZIP	WORK # ( )
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E-MAIL ADDRESS (OPTIONAL)

**GUARANTOR: If this patient is a minor**, please state the name, phone number and address of the person(s) financially responsible for all balances relating to this treatment.

LAST NAME	FIRST NAME	RELATIONSHIP
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ADDRESS	CITY, STATE	ZIP
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HOME # ( )	WORK # ( )
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**IN CASE OF EMERGENCY CALL**

LAST NAME	FIRST NAME	RELATIONSHIP
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ADDRESS	CITY, STATE	ZIP
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HOME # ( )	WORK # ( )
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**ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREAT**

I HEREBY ASSIGN ALL MEDCAL BENEFITS TO WHICH I AM ENTITLED TO PROBILITY PHYSICAL THERAPY IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONEL OF PROBILITY PHYSICAL THERAPY AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE. I CONSENT TO BEING KNOWINGLY PHOTOGRAPHED OR VIDEOTAPED BY AUTHORIZED PERSONEL OF PROBILITY PHYSICAL THERAPY FOR MEDICAL REASONS SUCH AS POSTURAL CORRECTION, GAIT/MOVEMENT ANALYSIS OR EDUCATIONAL PURPOSES.

<b>AUTHORIZED SIGNATURE</b>	<b>TODAY'S DATE</b>
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# PATIENT INITIAL QUESTIONNAIRE

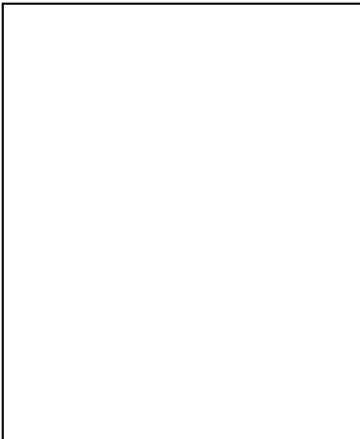
Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. What are your symptoms? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Which of the following best describes how your injury occurred? (Check only one)  
 Lifting                       Trauma                       Unknown  
 Car accident               Degenerative process       Other: \_\_\_\_\_  
 A fall                       During recreation/sports       Cumulative trauma / overuse  
 Running

3. Where did your injury occur?     at work               auto  
 personal home     other premise \_\_\_\_\_     unsure



4. Date of injury / onset of symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Nature of symptoms (check all that apply):  sharp     dull     aching     tingling  
 occasional     constant     throbbing     other \_\_\_\_\_

6. Please state your pain level on a scale of 0 – 10: \_\_\_/10  
(Zero = no pain, 10 = hospitalized by pain)

7. Prior to this onset, were you free of these symptoms? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain \_\_\_\_\_

8. Have you had any operations on the body region associated with your present symptoms?  
 No                       Yes, date \_\_\_\_\_  
\_\_\_\_\_

9. Does the pain wake you at night?  
 Yes \_\_\_x/night               No

10. Are your symptoms worse in the:  Morning     Afternoon     Evening?  
11. Are your symptoms worse in:  Sitting    or     Standing?

12. What makes your symptoms worse? (check all that apply)
- Sitting \_\_\_\_\_
  - Standing \_\_\_\_\_
  - Walking \_\_\_\_\_
  - Squatting
  - Lying down
  - Stress
  - Vacuuming
  - Sports/recreation activities such as \_\_\_\_\_
  - Going to/from sitting
  - Reaching out/overhead
  - Reaching behind back
  - Looking up overhead
  - Swallowing
  - Up/down stairs
  - Doing dishes
  - Coughing/sneezing
  - Taking a deep breath
  - Sleeping
  - Sustained bending
  - Chewing
  - Up/down an incline
  - Making the bed
  - Other \_\_\_\_\_

13. What relieves / lessens your symptoms?
- Sitting
  - Changing positions
  - Exercise
  - Nothing
  - Other: \_\_\_\_\_
  - Standing
  - Rest
  - Heat
  - Stretching
  - Lying down
  - Alcohol
  - Cold
  - Massage

14. What previous treatment have you had?
- None
  - Medication
  - Traction
  - Manipulation/adjustment by a Osteopath or Chiropractor
  - Physical Therapy
  - Injections
  - TENS unit
  - Bracing/taping
  - Exercise
  - Massage therapy
  - Other \_\_\_\_\_

15. Have you had any of the following?
- X-rays
  - Arthrogram
  - MRI
  - Other: \_\_\_\_\_
  - CT Scan

16. Are you currently working?  Yes  No  Part-time  Full-time  Restricted duty  
Occupation (specific) \_\_\_\_\_

17. What positions are you in while working?  
 Standing  Sitting  Walking  Bending  Lifting lbs \_\_\_\_\_ Frequency \_\_\_\_\_

18. Please list any activities that you can't do now because of your injury / symptoms:  
\_\_\_\_\_

19. What goals would you like to achieve from therapy? \_\_\_\_\_

20. Have you had, or do you currently have, any of the following medical conditions?
- Cancer
  - High Blood Pressure
  - Pregnant – current
  - Joint Replacement
  - Medications (Please list) \_\_\_\_\_
  - Heart Disease
  - Diabetes
  - Bone and joint disorders
  - History of seizures
  - Pacemaker
  - Breathing difficulties
  - Recent surgery (this year)

21. Past Medical History:  
\_\_\_\_\_

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THERAPIST SECTION

22. How did the patient hear about us? \_\_\_\_\_
23. Patient has been made aware of diagnosis and prognosis.  Yes  No **Functional Score** \_\_\_\_\_
24. Discussed goals with patient.  Yes  No

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Dear Patient,

At Probility Physical Therapy, we try to be clear in every part of your care, including the billing aspect. We work hard to be comprehensive in our treatment of your condition and this is what we are known for and why your doctor has referred you to us. You can expect that treatments will last 45-60 minutes on average and that you will have one on one time with your therapist every visit. Most treatments will include hands on techniques called Manual Therapy, exercises for strengthening and stretching called Therapeutic Exercise, and certain modalities such as Electrical Stimulation, Ultrasound or Traction. The charges you will see on your Explanation of Benefits may vary at times, based on the amount of time you spend in the clinic and the types of treatments that are done with you.

Our Billing Department bills your visits (claims) the day after you receive treatment. It can take approximately 14 to 60 days for your claims to get processed by your insurance company. Once your claims are processed, your insurance company will send both you and Probility Physical Therapy their determination. If there is a patient responsibility listed on your Explanation of Benefits this amount will be billed to you by Probility Physical Therapy. Our statements are mailed out monthly once a balance has been accrued. You have 30 days to pay your balance in full.

If you have any questions regarding the billing of your claims please feel free to call our Billing Department at (734) 528-9760. They are available on Mondays, Wednesdays and Thursdays.

Sincerely,

Probility Physical Therapy

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date