Smith
THERAPY PARTNERS

PATIENT DEMOGRAPHICS

_____ (_____)_____

PATIENT NAME (FIRST) (LAST) (M.I) PHONE

_____/_____/_____ _____ _____ _____-_____-_____

DATE OF BIRTH GENDER MARITAL STATUS SOCIAL SECURITY #

_____

PATIENT ADDRESS CITY STATE ZIP CODE

_____

MAILING ADDRESS (if different than above) CITY STATE ZIP CODE

_____

EMAIL ADDRESS

GUARANTOR OF MINOR

_____ _____/_____/_____

NAME (FIRST) (LAST) (M.I) DATE OF BIRTH

_____

MAILING ADDRESS CITY STATE ZIPCODE

(_____)_____ (_____)_____ _____-_____-_____

CELL PHONE HOME PHONE SOCIAL SECURITY #

PATIENT EMPLOYER

_____ _____

PATIENT'S EMPLOYER OCCUPATION

_____ (_____) _____

EMPLOYER'S ADDRESS WORK PHONE #

EMERGENCY CONTACT

_____ _____ (_____)_____

WHO WE SHOULD NOTIFY IN CASE OF EMERGENCY? RELATIONSHIP PHONE #

MEDICAL INFORMATION

_____ _____

BODY PART/ TYPE OF INJURY DATE OF INJURY

TYPE OF INJURY: AUTO RELATED_____ WORK RELATED_____ PAST INJURY_____ OTHER_____

HAVE YOU RECEIVED ANY PHYSICAL THERAPY THIS YEAR? _____ IF YES, WHERE_____

_____ (_____)_____ (_____)_____

REFERRING DOCTOR PHONE # FAX#

Smith
THERAPY PARTNERS

INSURANCE INFORMATION

_____ _____ (_____)_____
PRIMARY INSURANCE MEMBER ID# PHONE #

_____
INSURANCE ADDRESS CITY STATE ZIPCODE

_____ _____ _____/_____/_____
POLICY HOLDERS NAME RELATIONSHIP TO PATIENT DATE OF BIRTH

_____ _____ (_____)_____
SECONDARY INSURANCE MEMBER ID# PHONE #

_____
INSURANCE ADDRESS CITY STATE ZIPCODE

_____ _____ _____/_____/_____
POLICY HOLDERS NAME RELATIONSHIP TO PATIENT DATE OF BIRTH

_____ _____ (_____)_____
TERTIARY INSURANCE MEMBER ID# PHONE #

_____
INSURANCE ADDRESS CITY STATE ZIPCODE

_____ _____ _____/_____/_____
POLICY HOLDERS NAME RELATIONSHIP TO PATIENT DATE OF BIRTH

CONSENT FOR CARE & TREATMENT

I seek the services of Smith Therapy Partners (STP) and its employees and do here by give consent and authorize STP to perform physical therapy evaluation, physical therapy treatment, strength therapy exercise and related services as ordered by my physician. I understand that services and treatments offered by STP are intended to help me recover and enhance my ability to live an active independent lifestyle. I understand that the services I receive from STP may cause discomfort, increased pain, increased swelling, or may aggravate a previously existing condition.

I understand that STP makes no representation, claims, or guarantees that my medical or health problems or conditions will be helped by undergoing treatment or services with STP. I understand that my failure to comply with treatment recommendations and/or home exercise programs may impede results.

I certify that I have read, understand, and give the Consent for Care & Treatment.

Patient Signature: _____ Date: _____

FINANCIAL POLICY

STP has the following financial policies that must be accepted by our patients for services to be provided.

1. INSURANCE: As a courtesy to our patients we will bill the insurance carrier. All payments received will be applied to the patient's account balance. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If the insurance carrier fails to pay the bill, STP will expect the patient to pay. I understand that it is my responsibility to know my benefits and I will not hold STP responsible for any misinterpretation of insurance benefits and coverage for physical therapy.

2. PATIENT RESPONSIBILITY: I agree to pay for all services provided. It is STP policy to collect all patient co-payments at time of service and all ***estimated*** co-insurances and deductibles will be collected at time of service, as well as by monthly mailed statements. If payments due are not received within 90 days and collection services are needed, I understand that all collections fees, court fees, and attorney fees associated with collections will be added to my balance due and my responsibility to pay.

3. LIENS: STP accepts Personal Injury Liens. Please notify us if this treatment is part of a personal injury case additional paperwork will be required.

4. NO CANCELLATION & NO SHOW: Please be aware that we require a 24-hour notice for cancelling an appointment. The charge for cancellation without proper notice is $50.00 for a physical therapy visit. This charge will not be covered by your insurance but will have to be paid by you personally prior to receiving additional treatment.

5. PAYMENT TYPES ACCEPTED: STP accept Debt, Visa and Mastercard for payment of copays, co-insurance and deductible due. Your form of payment will be captured by an encryption scanner and kept securely on file for all future payments you authorize. We DO NOT accept cash or check payments at time of service.

6. HARDSHIPS: STP understands that hardships my occur and as a result it may be necessary to set up a payment plan for a patient requiring treatment. Please notify us as soon as possible if a hardship has occurred so that we may work to help you.

PATIENT RESPONSIBILITY

I have read and understand the financial policy set by Smith Therapy Partners (STP). I understand my responsibility for payment of my account and by signing this form I agree to the terms. I hereby accept financial responsibility for all charges for my treatment and authorize STP to share with my insurance company any medical information needed to determine medical necessity and payment.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Guarantor for Minor Signature	Printed Name	Date

**If the patient is a minor and under the age of 18, a Parent or Guardian must sign agreement of the terms.

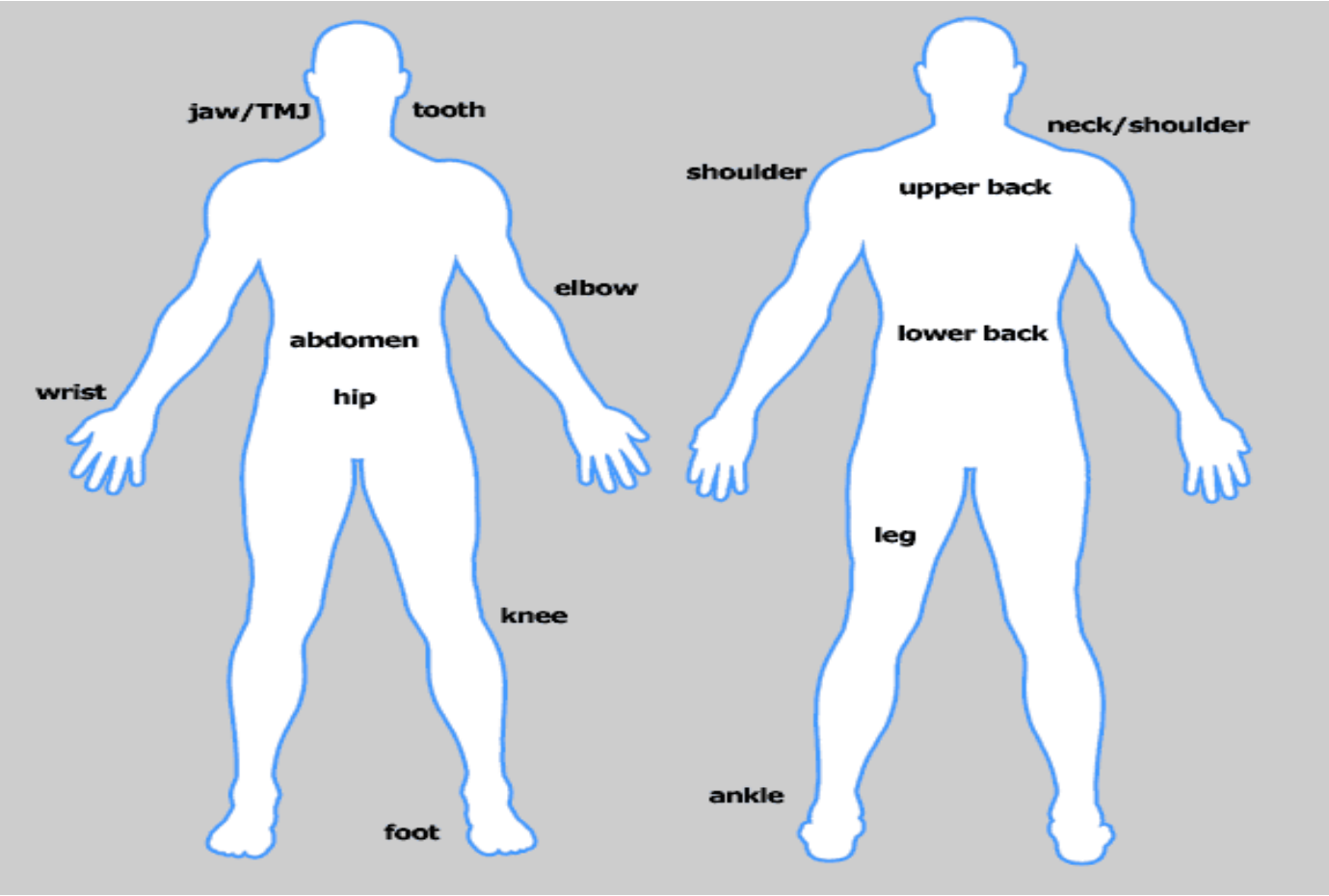
Medical History Questionnaire

Today's Date:_____ **Patient Name**: _____

Date of Birth: _____ Age: _____

Current Episode of Care

1. What is your main goal for Physical or Occupational Therapy? _____
2. Have you had these symptoms previously? _____
3. Date of injury/symptoms onset: _____/_____/_____
4. Have you received Physical / Occupational Therapy previously for this condition? YES NO
    a. If yes, When and Where _____
5. Please mark the areas on the diagram below where you are experiencing the symptoms:



6. Please use the key below to describe the pain:
    a. /// Sharp pain b. ooo Dull pain c. ## Numbness d. >>> Tingling
7. Are your symptoms: (Circle all that apply)
    a. Constant b. Intermittent c. Activity related
8. When do you feel the best? (Least symptoms) (Circle time)
    a. Morning b. Afternoon c. Evening/Night d. After exercise
9. When do you feel the worst?
    a. Morning b. Afternoon c. Evening/Night d. After exercise
10. How do the pain/symptoms effect your sleep?
    a. No problem b. Difficult falling asleep c. pain wakes me up d. only sleep with meds
11. What position/activity makes the symptoms better? _____

12. What position/activity makes the symptoms worse? _____
13. Does coughing, sneezing or taking a deep breath make your pain worse? YES NO
14. Do activities like bending, sitting, lifting, twisting and/or turning in bed make your pain worse? YES NO
15. Do you have pain or difficulty with bowel, bladder or sexually related activity/function? YES NO
16. On a scale from 0 to 10 with "0" being no pain and "10" being worst pain imaginable please rate: **(Circle)**

    a. **Current pain**: 1 2 3 4 5 6 7 8 9 10
    b. **Best your pain has been in past 24 hours**: 1 2 3 4 5 6 7 8 9 10
    c. **Worst your pain has been in past 24 hours**: 1 2 3 4 5 6 7 8 9 10

17. Medication: Please list physician prescribed medication you are currently taking, also include any over the counter medication or Herbal Remedies

Medication	Dosage	Method

18. Please describe any significant injuries or surgeries for which you have been treated (fractures, dislocations, sprains) and approximate date

_____ _____ _____ _____
DATE INJURY DATE INJURY

_____ _____ _____ _____
DATE INJURY DATE INJURY

Past Medical History

1. Is this injury related to? **(Circle)** Work Car Accident Other liability/Potential lawsuit Not applicable
2. Do you have a primary care physician? YES NO
    a. If yes, when was the last visit? _____/_____/_____
3. Race/Ethnicity: **(Circle)**
    a. Caucasian (White) Hispanic/Latino African American Asian
    b. Native American Other Decline
4. During the past month have you been feeling down, depressed or hopeless? YES NO
5. During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
6. Do you ever feel unsafe at home or has anyone hit you or tried to injury you in any way? YES NO
7. Please complete the following medical history check list:

Please Mark Each box	**No**	**Yes**	**N/A**	**Please Mark each box**	**No**	**Yes**	**N/A**
Smoking/ including smokeless				Sexual Dysfunction			
Diabetes				Bowl/Bladder problems			
Heart Condition				Groin Numbness			
High blood pressure				Arthritis			
Chest pain				Osteoporosis			
Stroke				Psychological Condition			
Kidney condition				Seizures			
Blood Clot/DVT				Dizziness/Faintness			
Breathing difficulty				Ringing in ears			
Cancer				Allergy to latex (gloves)			
Difficulty swallowing				Head Injury			
Circulation/Vascular problem				Obesity			
Unexplained Weight loss				Chronic pain/Fibro/HA's			
Double vision				fractures			
Night Sweats/Night pain				Infection			
Metal implants				Fever/Nausea			
Pacemaker				Asthma			
History of Cancer/Type				Stomach Ulcers			
Thyroid problems				Are you pregnant?			

Please Mark Each Box	**No**	**Yes**	**If yes, please specify**
Infection/Disease (Hepatitis, Tuberculosis, HIV)			
Neurologic Condition (MS/ Parkinson's)			
Spinal Cord injury			
Degenerative Joint Disease			Location:

Therapist Initials:_____ Patient Signature_____ Date:_____/_____/_____

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.

Effective Date: 10/1/2020

Please Review Carefully

This Notice describes the privacy practices of Smith Therapy Partners LLC ("SPT") and members of its workforce. This Notice applies to services furnished to you at all SPT facilities which involve the use or disclosure of your health information.

PRIVACY OBLIGATION

SPT is required by law to maintain the privacy of your health information ("protected health information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your PHI. SPT uses computerized systems that may electronically disclose your PHI for purposes of treatment, payment and/or health care operations as described below. When SPT uses or discloses your PHI, SPT is required to abide by the terms of this Notice or other notice in effect at the time of the use or disclosure.

NOTIFICATIONS

SPT is required by law to protect the privacy of your health information, distribute this Notice of Privacy Practices to you, and follow the terms of this Notice. SPT is also required to notify you if there is a breach of your PHI.

PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

In certain situations, your written authorization must be obtained in order to use and/or disclose your PHI. However, an authorization is not required for the following uses and disclosures:

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We will use your health information for treatment:

For example: We may disclose your protected health information to other physicians who may be treating you or consulting with us regarding your care. We may disclose your protected health information to those who may be involved in your care after you leave here, such as family members or your personal representative.

We will use your health information for payment:

For example: We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, or to demonstrate medical necessity.

We will use your health information for regular health care operations:

For example: We may use your PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may use or disclose your PHI in the course of maintenance and management of our electronic health information systems.

We will use and disclose your health information as otherwise permitted or required by law. Examples of those uses and disclosures are as follows:

- ***Business Associates**:* There are some services provided in our organization through agreements with business associates. For example, our electronic medical record vendor. To protect your health information, we require business associates to appropriately safeguard your information.
- ***Relatives, Close Friends and Other Caregivers:*** Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practically be provided because of your incapacity or an emergency circumstance, SPT may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, SPT would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.
- ***Public Health Activities.*** Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (3) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
- ***Victims of Abuse, Neglect or Domestic Violence.*** Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.
- ***Health Oversight Activities.*** Your PHI may be disclosed to a health oversight agency that oversees SPT and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.
- ***Judicial and Administrative Proceedings.*** Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
- ***Law Enforcement Officials.*** Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.
- ***Correctional Institution.*** You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.
- ***Organ and Tissue Procurement.*** Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation to facilitate such donation or transplantation.

- ***Research.*** Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.
- ***Health or Safety.*** Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
- ***U.S. Military.*** Your PHI may be use or disclosed to U. S. Military Commanders for assuring proper execution of the military mission. Military command authorities receiving protected health information are not covered entities subject to the HIPAA Privacy Rule.
- ***Other Specialized Government Functions.*** Your PHI may be disclosed to units of the government with special functions, such as the U.S. Department of State under certain circumstances or to the Secret Service or National Security Agency to protect the country or the President.
- ***Workers' Compensation.*** Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.
- ***Appointment Reminders.*** Your PHI may be used to tell or remind you about appointments.
- ***As Required by Law.*** Your PHI may be used and disclosed when required to do so by any other law.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Uses or Disclosures with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form. For instance, you will need to execute an authorization form before your PHI can be sent to an attorney representing you or the other party.

Except to the extent that SPT has taken action in reliance upon it, you may revoke any written authorization obtained in connection with your PHI by delivering a written revocation statement to SPT.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of SPT the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your PHI for treatment, payment, health care operations as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on disclosures to your health insurer regarding health care items or services for which you have paid out-of-pocket and in-full.
- Obtain a paper copy of this notice of privacy practices.
- Inspect and/or receive a copy of your health record, as provided by law.

- Request that we amend your health record, as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of disclosures of your health information, as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Privacy Officer at the contact listed below.

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that SPT maintains, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas at all SPT clinics and on our Internet site at https://smiththerapypartners.com/ You also may obtain any new notice by contacting the Privacy Officer.

For Additional Information or to File a Complaint: If you have questions regarding this Notice or have a concern that your privacy rights may have been violated, you may contact us using the information below.

Smith Therapy Partners LLC CONTACT INFORMATION:

Privacy Officer Smith Therapy Partners 10785 West Twain Avenue, Las Vegas, Nevada 89135 Office: 725-726-7847	You may also file a complaint with the **U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint. We will not retaliate against you for filing a complaint.

I hereby acknowledge that a copy of the Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Smith Therapy Partners practices or my rights with regard to my personal health information, I may contact the Privacy Officer listed above for further information as set in this notice.

Patient Name: _____

Patient Signature: _____ Date: _____

This signed acknowledgement will be kept in your patient medical record.