Empower Physical Therapy

Rachel Miller PT, MSPT, WCS, CFMT – President

Informed Consent

I, _____ do hereby give my consent to have the
Patient/Guardian
clinical staff of Empower Physical Therapy provide therapy service(s) as prescribed by the treating physician(s). I understand that the initial physical therapy evaluation will be performed by a licensed physical therapist. I reserve the right to refuse any test or procedure that has not been explained to my satisfaction. I have the right to receive the medical records generated by Empower Physical Therapy for a reasonable copy fee.

During the course of treatment, you or the patient may experience a temporary increase in symptoms, especially after the initial evaluation. In most circumstances this is a normal part of the recovery process, especially with manual therapy. It is important for you to inform the clinical staff of any difficulties or symptoms you or the patient are having first and foremost before immediately calling the doctor. You may contact this facility at any time to discuss your or the patients status if you believe that what you or the patient are experiencing seems out of the ordinary. Please remember that your or the patients care is our top priority. We want to provide you or the patient with as much information and education that we can to help expedite your rehabilitation and recovery.

Reports generated by Empower Physical Therapy will be directed to all involved parties. Referring physicians get a copy of all your reports. The insurance company administering your benefits will also receive a copy. If your injury is being handled by Workers' Compensation or an Auto Company, a copy of your reports will be directed to an employer representative or claims adjuster and any rehabilitation specialists monitoring your case. Please inform a staff member if you would like reports sent to any other doctors involved with your treatment.

For safety and security reasons:

> **You may ask your therapist to take pictures and/or videos of you doing your exercises so you can reference at home. Any pictures or videos taken at Empower Physical Therapy are for educational purposes only and CANNOT be shared in any format (via email, phone, internet, social media…)**

Our staff is grateful for the opportunity to provide rehabilitation services to you.

Patient Name: _____
(Please Print)

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

> **This notice describes how health information about you as a patient may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.**

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your personal health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time. You may at any time access, copy, and amend your records, request confidential communications, obtain accounting of disclosures that require authorization, and place restrictions on the use of your PHI.

We may use and disclose your PHI in the following ways:

- TREATMENT: PHI may be disclosed to healthcare providers or others assisting in your care.
- PAYMENT: Our practice may use and disclose your PHI in order to bill and collect payment for the services rendered. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for treatment. PHI may also be sent to attorneys in lien or third party actions for payment.
- HEALTHCARE OPERATIONS: Our practice may use and disclose your PHI to operate our business including but not limited to the evaluation and review of the quality of care you received from us by our physical therapy provider network, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations. Finally, our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

All other disclosures of your personal health information will be made only with your written authorization and you may revoke that authorization at any time.

If you have questions about this Notice, please contact Rachel Miller PT, MS, WCS, CFMT, Owner, Empower Physical Therapy, Inc. Effective 09/20/2016

Patient Name: _____
(Please Print)

Patient/Guardian Signature: _____ **Date:** _____
I have been made aware and understand this Notice

Witness Signature: _____ Date: _____

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PAYMENT AND COLLECTION POLICY

Payment is expected at the time of service. Unpaid balances left by your insurance companies will be your responsibility. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Cash, money order, and/or HSA, HRA, MasterCard, Visa, American Express and Discover are accepted forms of payment on the account.

Please be advised that Empower Physical Therapy is not a credit grantor and therefore, failure to maintain payment arrangements may result in the placement of your account with a collection agency or attorney for collection.

*__Collection Policy__: **In the event that you fail to pay as agreed or as the terms state, you agree to pay any and all collection fees, attorney fees, court cost or recovery costs. Please avoid this by keeping up with your payments and communication with the office staff.**

- ☐ **HEALTH INSURANCE:** Primary insurance will be billed by Empower Physical Therapy as a courtesy to you. Patients are responsible for knowing their own insurance benefits for physical therapy. Payment of insurance benefits is not forthcoming on chargers older than 60 days; therefore outstanding charges regardless of insurance carrier will be due by the patient above and beyond co-pay, co-insurance, deductible, and/or primary coverage classified as “above usual and customary” upon receipt of the Explanation of Benefits.
- ☐ **MEDICARE:** Medicare will pay 80% of Medicare approved charges; therefore 20% will be collected as a co-insurance. Please check your Medicare Handbook for details about capitation and run-out benefits.
- ☐ **WORKERS COMPENSATION AND MOTOR VEHICLE ACCIDENTS:** Patients will be asked to provide the following information: Date of Injury, Claim Number, Billing Address, Medical Payment Coverage and any authorizations required for services to be rendered. We will obtain a copy of your health insurance card for submission of any balance not covered. The patient is responsible for any balance not covered.

Patient Name: _____
(Please Print)

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ Date: _____

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Attendance Policy

(Please read thoroughly)

Empower Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Failure to keep your scheduled appointments hinders our ability to provide the best care to our patients. **We expect 24 hours notice prior to re-scheduling or canceling an appointment.** This allows us the opportunity to offer that time slot to another patient (from the waiting list) and we can re-schedule your appointment so that you do not have to miss out on your visit(s). We must ask your full cooperation with the following attendance policy:

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment will be cancelled and a fee charged for missing the appointment. Two (2) cancelled or no-show visits without 24 hours notice will result in all remaining appointments being removed from the schedule and discharge from physical therapy
- Failure to give Empower Physical Therapy the necessary 24 hours notice will result in a "No Show Appointment Fee"
- THE FEE CANNOT BE BILLED TO YOUR INSURANCE COMPANY AND WILL BE DIRECTLY YOUR RESPONSIBILITY

The Physical Therapy No Show Appointment Fee is as follows: $75 fee for the Initial Evaluation and $50 fee for all other appointments.

You will only be charged if you do not provide appropriate notice for your cancellation. All phone messages are received and recorded in a timely fashion. This policy applies to all patients, including worker's compensation.

Please Read The Following Information Carefully

By signing below, you understand Empower Physical Therapy will charge you **$50** for no-show appointments with less than 24 hours notice or cancellation.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All worker's compensation patients that are absent in the above descriptions will be noted to the Workers Compensation Insurance by phone contact and progress note.

Patient/Guardian Signature_____ **Date** _____ / _____ / _____

470 John Young Way · Suite 200 · Exton, PA 19341 Phone: (610) 873-3076 · Fax: (610) 873-3078

Adolescent Scoliosis History

Name: _____ **Age**: _____ **Date of Initial Diagnosis**: _____

Guardian Name: _____ **Current Orthopedic Physician:** _____

Height: _____**feet** _____**inches** **Weight:** _____**lbs** **Grade Level**: _____

Date of most recent x-ray: _____

Rissor Score: _____

Is there pain? Yes or NO

If pain is present rate pain on a 0-1- scale with 10 being the worst: _____

Describe the pain (ex: constant, comes and goes, etc.): _____

Does your child wear a brace? Yes or NO

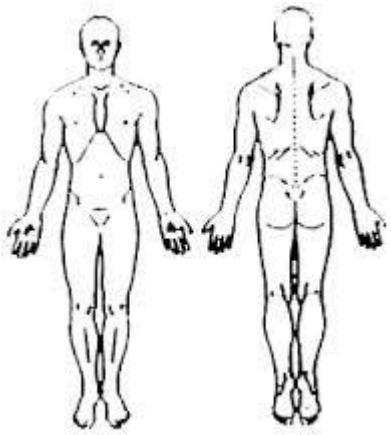
How often? _____

Is your child compliant with wearing their brace? Yes or No

Name of Brace: _____

Date of First Menstruation: _____

Please mark (X) of pain location(s) below



List the Following

Sports	Hobbies	Activities

Have you ever had any of the following conditions or diagnosis? Circle all that apply/describe:

Abuse	Headaches	Pneumonia
ADHD	Hearing Loss	Raynaud's (cold hands & feet)
Adhesive Tape Allergies	Heart Problems	Rheumatoid Arthritis
Anemia	Hepatitis	Sacroiliac/Tailbone Pain
Arthritic Condition	High Blood Pressure	Scoliosis Age of Onset
Asperger's Syndrome	HIV/AIDS	Seizures
Asthma	Infections	Spinal Cord Injury
Autism	Joint Replacement	Stress Fractures
Cancer	Kidney Disease	Stroke
Childhood Bladder Problems	Latex Sensitivity	Thyroid: Hypo/Hyper
Chronic Fatigue	Low Back Pain	TMJ/Neck Pain
Chronic Upper Respiratory Infection	Lyme Disease	Urinary Tract Infection
Depression	Lack of Menstruation	Vision Problems
Diabetes	Multiple Sclerosis (MS)	Other
Eating Disorders	Osteoporosis	Other
Head Injury	Pacemaker	Other

Empower Physical Therapy
Patient Contact/Emergency/Medication/Surgery Information

NAME: _____

Name and Numbers you wish to be contacted for your child's appointment or to leave messages:

Email address: _____ Phone #: _____

Cell #: _____Work Phone/alt: _____

Emergency Contact and who may we talk to on your child's behalf regarding your child's information (HIPPA)?

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Please give the following medications that you are currently taking
(Prescription·over the counter·herbals·vitamins·mineral/dietary/birth control):

Name of Drug	Dosage	Frequency	How Taken

Please list any operations (with date) that you have received in your lifetime:

Operations	Date	Operations	Date

X-ray/MRI	Date	X-ray/MRI	Date

****Please Bring or have sent the latest x-ray for scoliosis to our office prior to your appointment**

IF APPLICABLE, PLEASE COMPLETE THIS PAGE:

STOP-Bang Questionnaire

Yes ◯ No ◯

Snoring?

Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Yes ◯ No ◯

Tired?

Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Yes ◯ No ◯

Observed?

Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Yes ◯ No ◯

Pressure?

Do you have or are being treated for **High Blood Pressure**?

Yes ◯ No ◯

Body Mass Index more than 35 kg/m^2?

Yes ◯ No ◯

Age older than 50 year old?

Yes ◯ No ◯

Neck size large? (Measured around Adams apple)

For male, is your shirt collar 17 inches/43 cm or larger?
For female, is your shirt collar 16 inches/41 cm or larger?

Yes ◯ No ◯

Gender = Male?

Scoring Criteria: **For general population**

Low risk of OSA: Yes to 0-2 questions
Intermediate risk of OSA: Yes to 3-4 questions
High risk of OSA: Yes to 5-8 questions

or Yes to 2 or more of 4 STOP questions + male gender

or Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m^2

or Yes to 2 or more of 4 STOP questions + neck circumference

(17”/43cm in male, 16”/41cm in female)

SRS-22r† Patient Questionnaire

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____
Mo / Day / Year Years / Months

Instructions: We are carefully evaluating the condition of your back, and it is **IMPORTANT THAT YOU ANSWER EACH OF THESE QUESTIONS YOURSELF. PLEASE CIRCLE THE <u>ONE BEST ANSWER</u> TO EACH QUESTION**.

1. Which of the following best describes the amount of pain you have experienced during the past 6 months?

None __ Mild__ Moderate__ Moderate to severe __ Severe __

2. Which one of the following best describes the amount of pain you have experienced over the last month?

None __ Mild__ Moderate__ Moderate to severe __ Severe __

3. During the past 6 months, have you been a very nervous person?

None of the time __ A little of the time __ Some of the time __ Most of the time __ All of the time __

4. If you had to spend the rest of your life with your back as it is right now, how would you feel about it?

Very happy __ Somewhat happy __ Neither happy nor unhappy __ Somewhat unhappy __ Very unhappy __

5. What is your current level of activity?

Bedridden __ Primarily no activity __ Light labor, such as household chores __
Moderate manual labor and moderate sports, such as walking and biking __ Full activities without restriction __

6. How do you look in clothes?

Very good __ Good __ Fair __ Bad __ Very bad __

7. In the past 6 months, have you felt so down in the dumps that nothing could cheer you up?

Very often __ Often __ Sometimes __ Rarely __ Never __

8. Do you experience back pain when at rest?

Very often __ Often __ Sometimes __ Rarely __ Never __

9. What is your current level of work/school activity?

100% normal __ 75% normal __ 50% normal __ 25% normal __ 0% normal __

10. Which of the following best describes the appearance of your trunk, defined as the human body except for the head and extremities?

Very good __ Good __ Fair __ Poor __ Very Poor __

11. Which one of the following best describes your medication usage for your back?

None __ Non-narcotics weekly or less (e.g., aspirin, Tylenol, Ibuprofen) __
Non-narcotics daily __ Narcotics daily __ Other: Medication Usage (weekly or less or daily) __

12. Does your back limit your ability to do things around the house?

Never __ Rarely __ Sometimes __ Often __ Very often __

13. Have you felt calm and peaceful during the last six months?

All of the time __ Most of the time __ Some of the time __ A little of the time __ None of the time __

14. Do you feel that your condition affects your personal relationships?

None __ Slightly __ Mildly __ Moderately __ Severely __

15. Are you and/or your family experiencing financial difficulties because of your back?

Severely __ Moderately __ Mildly __ Slightly __ None __

16. In the past six months, have you felt down hearted and blue?

Never __ Rarely __ Sometimes __ Often __ Very Often __

17. In the past three months, have you taken any sick days from work/school due to back pain and, if so, how many?

0 ___ 1 ___ 2 ___ 3 ___ 4 or more___

18. Does your back condition limit your going out with friends/family?

Never __ Rarely __ Sometimes __ Often __ Very often__

19. Do you feel attractive with your current back condition?

Yes, very __ Yes, somewhat __ Neither attractive nor unattractive __ No, not very much __ No, not at all __

20. Have you been a happy person during the past six months?

None of the time __ A little of the time __ Some of the time __ Most of the time __ All of the time__

21. Are you satisfied with the results of your back management?

Very satisfied __ Satisfied __ Neither satisfied nor dissatisfied __ Unsatisfied __ Very unsatisfied __

22. Would you have the same management again if you had the same condition?

Definitely yes __ Probably yes __ Not sure __ Probably not __ Definitely not __