FULTZ
PHYSICAL THERAPY & JOINT REHAB

(Please Print Clearly)

Patient's First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ____ / ____ / ____ Patient's SS#: _____ / _____ / _____ DL #: _____ Gender: ☐ Male ☐ Female

Hm. Ph#: (____) _____ Cell #: (____) _____ Email: _____

Patient's Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other Student: ☐ Full-time ☐ Part-time

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled

Place of Employment: _____ Occupation: _____

Wk.#: (____)_____ Address: _____ City:_____ St:_____ Zip:_____

Spouse's Name: _____ Spouse's DOB: ____ / ____ / ____ Spouse's SS#: ____ / ____ / ____

Spouse's Place of Employment: _____ WK#: (____) _____

Responsible Party/Guardian: (If not the patient; or If patient is a minor (under the age of 18):

First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ____ / ____ / ____ SS#: _____ / _____ / _____ DL #: _____ Hm. Ph#: (____) _____

Cell #: (____) _____

Place of Employment_____ Wk.#: (____)_____

Address: _____ City: _____ St: _____ Zip: _____

Emergency Contact: _____#(____)_____ Relationship: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize the release of any and all medical information necessary to process my claim for services provided by Fultz Physical Therapy and Joint Rehab, and request payment of benefits to Fultz Physical Therapy and Joint Rehab, LLC.

I hereby consent to the release and disclosure of my personal health information to Fultz Physical Therapy and Joint Rehab, LLC. This release authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of deciding plan of treatment.

Patient's/Responsible Party's Signature: _____ Date: _____

Patient's Name: _____ DOB: ____/____/____ Date completed:_____

Referring Physician:_____ Return Date to Physician:_____

What caused you to seek physical therapy/medical attention? _____

Your condition is related to: Employment Auto Accident Home Other

Date of condition/accident: _____/_____/_____ State Accident Occurred: _____

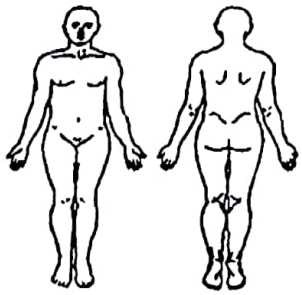
What is your major compliant? Please be as detailed as possible_____

_____

Have you had this problem before? ___ Yes ___ No

Mark the location of your pain with an "X":

FRONT BACK



If you have pain, what is your pain level? (0= No Pain, 10 = Extreme Pain – Circle)

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

What make your pain better? _____

What make your pain worse? _____

Is this pain getting: ____ Better _____ Worse _____ Not Changing

What type of treatments have you received for this condition? ____ X-Rays ____Surgery ____Chiropractic ___MRI

____ Medications _____Injection _____Bone Scan _____CT/CAT Scan ____Physical Therapy ____Home Health

Please describe (agency, etc.)_____

Have you fallen in the last 12 months? Yes No If yes, how many times? _____

Did your fall result in any injury? Yes No _____

PLEASE CHECK ALL PROBLEMS DIAGNOSED BY A DOCTOR. CIRCLE IF YOU ARE CURRENTLY BEING TREATED.

___Bronchitis/Emphysema/Lung Disease ___ Sciatica ___Gout ___Heart Disease

___Pneumonia ___Fibromyalgia ___Implants ___ Lupus

___Abnormal Chest X-Ray ___Bursitis ___High/Low Blood Pressure ___Tuberculosis

___Chronic Fatigue Syndrome ___TMJ Dysfunction ___Dizziness/Fainting Spells ___Epilepsy

___Thrombosis/Phlebitis ___Muscular Dystrophy ___Pregnant – due date_____ ____Diabetes

___Carpal Tunnel Syndrome ___ Blood-Borne Pathologies: HIV AIDS Hepatitis A Hepatitis B Hepatitis C

___Tumors/ Cancer—Year_____ Type_____ Remission: Yes No ___Pace Maker—If Yes, date rec'd _____

___Sprains/ Dislocations/Broken Bones—Please List:_____

Please list all medications you are currently taking and what they are for [Specific name of medication, dosage, frequency & Route (Example: by mouth), please include over the counter, prescriptions, herbals & vitamins]: _____

_____

_____

Please list any previous surgeries: _____

_____

Height:_____ Weight:_____

Fultz Physical Therapy and Joint Rehab, LLC
5795 N. Market St., Suite 8
Shreveport, LA 71107
(318) 489-4298
(318) 489-4299

HIPAA-ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date:_____

We at Fultz Physical Therapy are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____
Printed name of patient or patient's representative/parent

_____
Relationship to patient

HIPAA Notice of Privacy Practices

Fultz Physical Therapy and Joint Rehab, LLC
5795 N. Market St., Suite 8
Shreveport, LA 71107

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information.
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other reuse required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of you physician's practices. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your projected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law: Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164,500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or preceding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
Disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Service if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____