

HRUSKA CLINIC INC.

Restorative Physical Therapy Services
5241 R Street, Lincoln, NE 68504
Phone 402.467.4545; Fax 402.467.4580

PATIENT INFORMATION FORM

TODAY'S DATE _____

Name _____ Age _____

Employer _____

Date of Injury / Onset of Pain _____

Referring Physician _____

Next Appointment with Referring Physician _____

CHIEF COMPLAINT: What is the nature of your pain or problem?

List the names of all the health professionals you have seen for treatment for this condition: _____

Injury work related? YES NO Injury motor vehicle related? YES NO

If yes, are you currently working with an attorney for this? YES NO

Name of attorney? _____

Address: _____

Are you taking any medications? Please list. _____

Are you allergic to any medications? Please list. _____

Are you allergic to LATEX? YES NO

Do you now have, or have you had, any of the following:

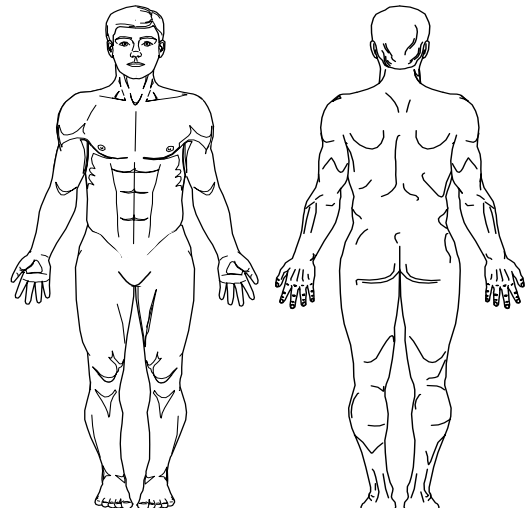
HIGH BLOOD PRESSURE	YES	NO	SEIZURES	YES	NO
HEART DISEASE/ATTACK	YES	NO	METAL IMPLANTS	YES	NO
DIZZINESS	YES	NO	CHRONIC HEADACHES	YES	NO
CANCER	YES	NO	PREVIOUS PHYSICAL THERAPY	YES	NO
PREGNANT (CURRENTLY)	YES	NO	TOOTH OR JAW PAIN	YES	NO
PREVIOUS SURGERY	YES	NO	BRACES OR MOUTH SPLINT	YES	NO
DIABETES	YES	NO	HEEL LIFT/SHOE ORTHOTICS	YES	NO
INCONTINENCE	YES	NO	MOTOR VEHICLE ACCIDENT	YES	NO
CONCUSSION	YES	NO			

If you answered YES to any of the above, please explain and give approximate dates:

PLEASE INDICATE ON THE PICTURES TO THE RIGHT THE LOCATION(S) OF YOUR PAIN

PLEASE INDICATE YOUR LEVEL OF PAIN AT ITS **WORST** AND **BEST** ON THE SCALE BELOW

0 1 2 3 4 5 6 7 8 9 10
0 = NO PAIN 10 = EXCRUCIATING PAIN



Rank your success with past care received by health practitioners: _____
(0=no success, 10=great success)

What is it you want to do that you can't do now? _____

Choose one answer in each section that best describes your condition:

Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is very moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing increased pain.
- I can look after myself normally, but it is very painful.
- It is painful to look after myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty, and I stay in bed.

Section 3 – Lifting

- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reaching

- I can reach to a high shelf without increased symptoms.
- I can reach to a high shelf with some increased symptoms.
- I can reach to a high shelf with moderate increased symptoms.
- I cannot reach my hand above my head without increased symptoms.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hr.
- Pain prevents me from sitting for more than 10 min.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without increased pain.
- I can stand as long as I want, but it increases my pain.
- Pain prevents me from standing for more than 1 hr.
- Pain prevents me from standing for more than 30 min.
- Pain prevents me from standing for more than 10 min.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/4 mile.
- Pain prevents me from walking more than 100 yards.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

Section 9 – Stairs

- I can walk stairs comfortably without a rail.
- I can walk stairs comfortably but require assistance.
- I can walk more than 1 flight of stairs, but with pain or weakness.
- I can walk less than 1 flight of stairs.
- I can manage only a single step or curb.
- I am unable to manage even a step or curb.

Section 10 – Eating

- I can eat whatever I want without pain.
- I can eat whatever I want but it gives me extra pain.
- Pain prevents me from chewing anything other than soft foods.
- I cannot chew food and I am on a liquid diet.

PATIENT REGISTRATION INFORMATION

PLEASE PRINT & COMPLETE FULLY

DATE _____

PATIENT NAME (FIRST) _____ (MI) _____ (LAST) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH -- -- _____ SEX ___M ___F

SS # (IF NEEDED FOR INSURANCE): _____ - _____ - _____ SINGLE ___ MARRIED ___ OTHER

PHONE (HOME) _____ (WORK) _____ (CELL) _____

EMPLOYER _____ JOB TITLE _____

STUDENT ___ NO ___ YES (WHERE) _____ (FULL TIME) ___ (PART TIME) ___

EMERGENCY CONTACT _____ (PHONE) _____ (RELATIONSHIP) _____

INJURY/ACCIDENT DATE: _____

REFERRING DOCTOR OR DENTIST:

(FIRST) _____ (LAST) _____ ___MD ___DDS ___DO ___DC

(CITY) _____ (STATE) _____

HOW DID YOU HEAR ABOUT US? _____

IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM _____

WOULD YOU LIKE TO BE ON OUR E-MAILING LIST? EMAIL ADDRESS: _____

PRIMARY INSURANCE INFORMATION:

TYPE OF INSURANCE ___WORK COMP ___MEDICARE ___GROUP INS ___AUTO INS(MVA)

INSURED/POLICY HOLDER NAME (FIRST) _____ (MI) _____ (LAST) _____

___ SPOUSE ___ MOTHER ___ FATHER ___ OTHER

ADDRESS _____ (CITY) _____ (STATE) _____ (ZIP) _____

HOME PHONE _____ WORK PHONE _____

SS # _____ DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY NAME _____

ADDRESS _____

ID # _____ GROUP # _____

INSURANCE COMPANY PHONE # _____

WORK COMP INFORMATION:

INSURANCE COMPANY NAME _____

ADDRESS _____

CASE MANAGER & PHONE# _____

CLAIM # _____

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and /or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at the Hruska Clinic Inc. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used to retrain, recruit & restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them

This consent shall be ongoing for a period not to exceed one year.

I (or _____ for _____) have read this form and fully understand and accept its terms and conditions.

Patient or person authorized to consent for patient / relationship Date / Time

Reason patient was unable to consent

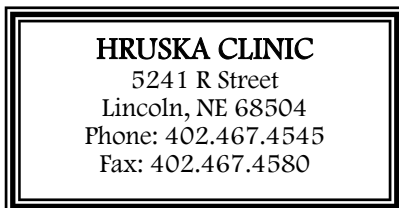
Witness signature

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Hruska Clinic, Inc., and understand that I am financially responsible for non-covered services. I understand that if Hruska Clinic Inc. does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and/or Hruska Clinic Inc. to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred at Hruska Clinic Inc.**

Signature

Date



Acknowledgement of Receipt of Notice
HRUSKA CLINIC INC.
RESTORATIVE PHYSICAL THERAPY SERVICES

BECKY FISHER, ADMINISTRATIVE SERVICES MANAGER
PRIVACY OFFICER

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices
by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate.

- Relationship:
- parent or guardian of minor patient
 - guardian or conservator of an incompetent patient
 - beneficiary or personal representative of deceased patient

Name of Patient: _____

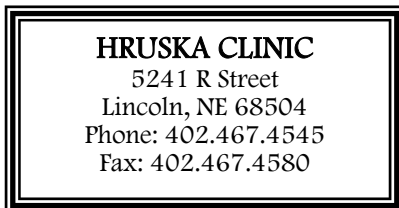
For Office Use Only:

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain:

Reasons for refusal:



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.

HRUSKA CLINIC INC. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at HRUSKA CLINIC INC. please contact: BECKY FISHER, PRIVACY OFFICER, HRUSKA CLINIC INC., (402) 467-4545

Effective Date of This Notice: APRIL 15, 2003

I. How HRUSKA CLINIC INC. may Use or Disclose Your Health Information

HRUSKA CLINIC collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of **HRUSKA CLINIC**, but the information in the medical record belongs to you. **HRUSKA CLINIC** protects the privacy of your health information. The law permits **HRUSKA CLINIC** to use or disclose your health information for the following purposes:

1. Treatment. Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient. An example of this would be a consultation/discussion with your physician regarding your plan of care, progress, or status.

2. Payment. Payment means reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities, justification of charges; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.

3. Regular Health Care Operations. Health care operations are any activity related to covered functions in which we participate in the function of our office, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; and marketing for which an authorization is not required. An example of this would be an evaluation of customer service given to patients.

4. Information provided to you.

5. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by law/ Law Enforcement. As required by law, we may use and disclose your health information, i.e.: to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

7. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

10. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

II. When HRUSKA CLINIC May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, **HRUSKA CLINIC** will not use or disclose your health information without your written authorization. If you do authorize **HRUSKA CLINIC** to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. **HRUSKA CLINIC** is not required to agree to the restriction that you requested.

2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.

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

4. You have a right to request that **HRUSKA CLINIC** amend your health information that is incorrect or incomplete. **HRUSKA CLINIC** is not required to change your health information and will provide you with information about **HRUSKA CLINIC** denial and how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your health information made by **HRUSKA CLINIC**, except that **HRUSKA CLINIC** does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you), 5 (directory listings) and 16 (certain government functions) of section I of this Notice of Privacy Practices.

6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact: Becky Fisher, Privacy Officer, Hruska Clinic (402) 467-4545

IV. Changes to this Notice of Privacy Practices

HRUSKA CLINIC reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, **HRUSKA CLINIC** is required by law to comply with this Notice. Revised notices will be given at any time requested.

V. Complaints

Complaints about this Notice of Privacy Practices or how **HRUSKA CLINIC** handles your health information should be directed to: Becky Fisher, Privacy Officer

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at <http://www.hhs.gov/ocr/regmail.html>.