MEDICAL HISTORY QUESTIONNAIRE

NAME ____ AGE: _________ DATE: _________________

WEIGHT: ____________ HEIGHT: ____________ MARITAL STATUS: ____________ GENDER: ___________

WHY ARE YOU HERE TODAY? ____

HOW AND WHEN DID SYMPTOMS/PAIN BEGIN? ____

____

OTHER TREATMENT (PT, CHIROPRACTIC, ETC): ____

DATE OF LAST PHYSICAL: ______________ TESTS (XRAY, MRI, BONE SCAN, ETC): ________________

ALLERGIES: ____ ARE YOU ALLERGIC TO LATEX : YES / NO

CURRENT MEDICATIONS: ____

____

____

SURGERIES (in the last 5 yrs): ____

Have you or any immediate family member been told you have? Please circle YES or NO.

	SELF	FAMILY		SELF	FAMILY
Cancer	YES / NO	YES / NO	Diabetes	YES / NO	YES / NO
High Blood Pressure	YES / NO	YES / NO	Heart Disease	YES / NO	YES / NO
Angina/Chest Pain	YES / NO	YES / NO	Stroke	YES / NO	YES / NO
Osteoporosis	YES / NO	YES / NO	Tuberculosis	YES / NO	YES / NO
Arthritis	YES / NO	YES / NO	Thyroid condition	YES / NO	YES / NO

Do you have a history of:

Allergies/Asthma	YES / NO	Headaches	YES / NO	Bronchitis	YES / NO
Kidney Disease	YES / NO	Rheumatic fever	YES / NO	Ulcers	YES / NO
Seizures	YES / NO	Hepatitis	YES / NO		

In the past 3 months have you had or do you experience:

A change in your health	YES / NO	Nausea	YES / NO
Fever/chills/sweats	YES / NO	Unexplained weight change	YES / NO
Numbness/tingling	YES / NO	Changes in appetite	YES / NO
Difficulty swallowing	YES / NO	Changes in bowel	YES / NO
Shortness of breath	YES / NO	Changes in bladder function	YES / NO
Dizziness	YES / NO	Upper respiratory infection	YES / NO
Urinary tract infection	YES / NO		

Are you currently:

Pregnant YES / NO

Depressed YES / NO

Under stress YES / NO

Have a pacemaker YES / NO

How are you sleeping at night? (circle one)

Fine Moderate difficulty Only with medication

Do you or have you smoked tobacco? YES / NO

If yes: # packs/day ________

years ________ Last use: ______

I currently have difficulty with: (check all that apply)

☐ Driving ☐ Getting up from a chair ☐ Walking ☐ Bending at the waist

In case of emergency, please contact:

____#_____________________________________

OR ____#___________________________________

Patient Name:________________________________

HOW DID YOU HEAR ABOUT PANTHER PHYSICAL THERAPY?

- ❑ I am a returning patient
- ❑ Doctor
- ❑ Employer
- ❑ Former Patient (Name)____
- ❑ Mailing
- ❑ Health Club
- ❑ Insurance Company/Case Manager (Name)_______________________
- ❑ Magazine
- ❑ Television
- ❑ Newspaper
- ❑ Radio
- ❑ School
- ❑ Sign on Building
- ❑ Yellow Pages
- ❑ Panther's Website
- ❑ Google Ad
- ❑ Other____

Date: _______________

Patient Name: ______________________________________Med Rec # / Account#_________________

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND TERMS OF TREATMENT

I hereby consent to the use and disclosure of my health information for treatment provided to me by **Provider**, payment for services provided by the Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways the Provider may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

Authorization to Release Information

My signature below constitutes my permission for Provider to discuss my protected health information with following individuals:

____ ___________________ _________________
Name of Authorized Individual Relationship Phone#

____ ___________________ _________________
Name of Authorized Individual Relationship Phone#

Referring Physician/Practitioner: ____

□ I authorize Provider to send a 'thank you' acknowledgement to my referring physician/practitioner that identifies me by name.

CONSENT FOR TREATMENT:
Knowing that I have a condition requiring treatment by Provider, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of Provider.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:
I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to Provider for unpaid charges. I agree to pay Provider for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by Provider in collecting this account.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:
I consent to allow Provider to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order.

CANCELLATION AND NO SHOW POLICY:
I understand that Provider is committed to providing all of your patients with exceptional care. When a patient cancels without giving enough notice or misses an appointment, that patient prevents Provider from providing care to another patient. A cancellation is considered to be late when the appointment is not cancelled at least 24 hours prior to the scheduled appointment. To encourage timely notification and reduce missed appointments, Provider has adopted the following policy:

First late cancellation or missed appointment: **$0 fee.**
Second late cancellation or missed appointment: **$25.00 fee.**
Third late cancellation or missed appointment: **$25.00 fee** plus, at Provider's discretion, cessation of further care to the patient.

I acknowledge that the foregoing fees are **not** covered by insurance and **must** be paid by me prior to the next scheduled visit.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If I provide notice of a planned absence, my on-going schedule may be placed on "hold" for up to two (2) weeks. I acknowledge that a renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE:
In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

My signature below indicates that I understand the terms of treatment by Provider.

Patient's Signature: ____
Date: _______________
Print Name: ____ (**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: ____
Date: _______________
Print Name of Legal Representative: ____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other ______________________ (Explain and Attach Documentation)

Date: _______________

Patient Name: ______________________________________Med Rec # / Account#_________________

ADDITIONAL LIABILITY INFORMATION

The nature of your injury may alert your medical insurance company to potential liability. Completing this form in its entirety allows ***Provider*** to provide a quick response to those inquiries and prevent delays in processing your claims.

Date of injury/onset of condition / recent exacerbation? _____________________________

Describe in detail how injury occurred. ____

____

Specific name & location where injury occurred (IE: store, restaurant, intersection, etc.)
____

____

Is this injury work related? Yes___________________ No___________________

Who is responsible for accident? Self:______________________ Other: __________________

If other, who? ____

Insurance of responsible party: Name: ____
Address: ____
____
Claim #: ____
Adjuster Name: ____
Adjuster Phone: ____

Personal insurance: Name:____
Address: ____
____
Claim #: ____
Contact Name:____
Contact Phone:____

The above information is accurate and true to the best of my knowledge. I agree to immediately notify provider with any change in this information.
Patient's Signature: ____ Date: ______________
Print Name:____(**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: ____Date: ___________
Print Name of Legal Representative: ____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____________________ (Explain and Attach Documentation)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date :_______________

Patient Name: _____________________________________Med Rec # / Account#_________________

I hereby acknowledge that I have received Notice of Privacy Practices of Provider.

Patient's Signature: ____ Date: ______________
Print Name:____(**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: ____ Date: ______________
Print Name of Legal Representative: ____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____________________ (Explain and Attach Documentation)____________________________________
____

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name:____

Date:_______________________________________
The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

□ **Patient refused to sign acknowledgement.**

□ **Patient was unable to sign the acknowledgement because:**
____
____

□ **Other reason (describe below):**
____
____
____

Name of Employee Completing Form: ____

Signature:____

Date: ____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION ("PHI") AND OUR RESPONSIBILITIES TO PROTECT YOU HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dear Patient,

Federal law requires that this Notice of Privacy Practices ("**Notice**") be available to all patients and a good faith effort be made to obtain a signed document acknowledging patient's receipt of this Notice. If you have questions about this Notice, please contact the Privacy Officer at telephone number and/or address at the end of this Notice.

To Whom Does This Notice Apply

This Notice is a joint notice for all Agility Health affiliated entities, each of which follows the terms of this Notice and are referred to in this Notice as "we, us or our". A complete listing of all of the Agility Health affiliated entities and their respective locations covered by this Notice is available online at http://pantherpt.com/, at the clinic or facility where you are receiving care or by calling 616-356-5000. The list may change; however, a change to the list does not constitute a material change in the practices described in this Notice. In addition, this Notice applies to all our employees, management, contractors, student interns, and volunteers.

Effective Date of Notice

This Notice became effective April 14, 2003. We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the PHI we maintain within the scope of federal and state privacy laws. If our information practices change, we will amend our Notice. Any changes we make in our privacy practices will affect all PHI information we maintain. You are entitled to receive a revised copy of the Notice by calling our Corporate Office at (616) 356-5000 and requesting a copy. It will also be made available at each of our service locations.

Our Duties Regarding Your Private Health Information

We respect the confidentiality of your PHI. We are required by law to protect your health information and to provide you with notice of these legal duties. We are obligated to provide you with this Notice and abide by our privacy practices as of April 14, 2003.

We will only release your PHI as allowed by law or with special written authorization from you. We use the minimal amount of PHI when performing our duties. Only those who need your PHI to provide services are allowed to access it.

How We Use And Disclose Your PHI

Use of your PHI without authorization is permitted under federal and state privacy laws in the following circumstances:

For Treatment Purposes

Your therapist obtains treatment information about you and records it in your health record. During the course of your treatment the physical therapist will consult and exchange information with your physician and others who provide care to you.

For Payment Purposes

We may need to share a limited amount of your PHI to obtain payment for the services provided to you. Examples include:

▪ *To Determine Eligibility* – We may contact the company or government program that will be paying for your health care to determine your eligibility for benefits, copayments, coinsurance or deductible.

▪ *For Claims Submission* – We will submit a claim to obtain payment for services provided to you. The claim form must contain certain information to identify you, your medical diagnosis and the treatment provided to you.

Healthcare Operations

We may use and disclose your PHI to conduct our healthcare operations. Healthcare operations include, but are not limited to, activities such as:

- Quality assessment and improvement activities.
- Protocol and clinical guidelines development.
- Case management and care coordination.
- Outcome evaluation.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or healthcare practitioners learn under supervision.
- Training of non-healthcare professionals.

- Accreditation, certification, licensing and credentialing activities.
- Compliance reviews, auditing, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related to analyses and formulary development.
- Compliance reviews, auditing, medical reviews, legal services and compliance programs.
- Appointment reminders.

Incidental Uses and Disclosures
We may use or disclose your PHI when it is associated with another use or disclosure that is permitted or required by law. For example, conversations between therapists regarding your medical may, at times, be overheard. Please be assured that we have appropriate safeguards to avoid such situations as much as possible.

Appointment Reminders
We may use and disclose medical information to remind you of an appointment you scheduled for treatment with us.

Business Associates
We contract certain services with business associates such as document destruction and document storage companies. Business associates are required by federal law to protect your PHI.

For Marketing Purposes
We may use your PHI to communicate about a product covered by your health plan or about treatment alternatives related to your care coordination. We may use and disclose PHI to tell you about health-related services or benefits that may interest you. Authorization is not required for face-to-face communication.

Person Involved in Your Care
We may disclose your PHI to persons involved in your care, such as friends or family members. We may also give information to someone who pays for your care. You have the right to approve such releases, unless you are unable to function, or if there is an emergency.

Required By Law
We may use and disclose your PHI when that use or disclosure is required by law. For example, we may disclose medical information to report child abuse or to respond to a court order.

Public Health Activities
We may disclose PHI as required by law to public health or legal authorities charged with preventing or controlling disease, injury or disability.

To Conduct Health Oversight Activities
We may be required to disclose your PHI to appropriate health oversight agencies so they can monitor, investigate, inspect, discipline or license those who work in the healthcare system, or for governmental benefit programs.

Worker's Compensation
We may disclose your PHI to the extent necessary to comply with laws relating to worker's compensation.

Judicial and Administrative Proceedings
As permitted or required by law, we may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Report Abuse, Neglect or Domestic Violence
We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.

For Law Enforcement Purposes
As permitted or required by law, we may disclose your PHI to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose your PHI to the institution or its agents for your health and the health and safety of other individuals.

For Research Purposes
We may use or release your PHI for research purposes. All research projects require special permission before they begin. This process may include asking you for authorization; however, in certain circumstances your PHI may be used or released without your authorization.

Serious Threat to Health or Safety
Consistent with applicable law and ethical standards of conduct, we may disclose your PHI if we, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Specified Government Functions
We may be required to release your PHI to the proper authorities so they may carry out their duties under the law. This may be the case if you are in the military or involved in national security or intelligence activities, or if you are in the custody of law enforcement authorities.

Food & Drug Administration
We may disclose your PHI relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacements.

Coroner & Medical Examiners
We may disclose your health information to coroners and medical examiners.

Authorization to Use or Disclose PHI
Other than is stated above, we will not disclose your PHI other than with your written authorization. If you or your legal representative authorizes us to use or disclose your PHI, you may revoke that authorization in writing at any time. You may receive more information about this by contacting the Privacy Officer.

Your Health Information Rights
The health record we maintain and billing records are our physical property. The information in it, however, belongs to you. You have a right to:

Receive Notice of Privacy Practices
You have the right to receive a paper copy of this Notice at any time. You may obtain a copy of the current Notice in all service locations or by visiting our website at http://pantherpt.com/

Request Confidential Communication
You have the right to request that we communicate your PHI to you in different ways or places. For example, you may request that we only contact you by telephone at work, or by mail at home or a PO Box. We will accommodate your request when reasonably possible, however, we are not required to accommodate all requests. For information on how to make such a request, please contact our Privacy Officer.

Request Restrictions
You have the right to request restrictions or limitations on how your PHI is used or released. We have the right to deny your request.

Paid In Full
You have the right to request that we not disclose your PHI to your health plan if you have paid for the healthcare items or service in full out of your own pocket. We must honor your request to restrict your PHI for purposes of payment or healthcare operations unless the disclosure is required by law.

Inspect & Copy Your Health Information
With a few exceptions, you and/or your legal representative have the right to inspect and obtain a copy of your PHI. Some of the exceptions include

- Psychotherapy notes;
- Information gathered for court proceedings; or
- Any information your provider feels would cause you to commit serious harm to yourself or others.

You have the right to request that the copy be provided in an electronic form or format. If the form and format are not readily producible, then we will work with you to provide it in a reasonable electronic form or format. Your request for inspection or access must be submitted in writing to our Privacy Officer. In addition, we may charge you a reasonable fee to cover our expenses for copying your health information, but in no event in an amount exceeding the maximum permitted by applicable law.

Request An Amendment
You have the right to request that your health care record be amended to correct incomplete or incorrect information. You must provide the reason you are asking for the amendment. We may deny your request if:

- We did not create the information;

- We do not keep the information;
- You are not allowed to see and copy the information; or
- The information is already correct and complete.

If we deny the request, you have the right to file a statement of disagreement and require that the request for amendment and any denial be attached in all future disclosures of your PHI.

Receive A Record of Disclosures

You have the right to request a list of the disclosures of your PHI that we have made in compliance with federal and state law. This list will include:

- date of each disclosure;
- who received the PHI;
- description of the PHI disclosed; and
- purpose of the disclosure

To request a record of disclosures, you must submit a request in writing to our Privacy Officer. Unless a shorter period of time is required by applicable state law, we have 60 days to comply with your request unless you agree to a 30- day extension or unless otherwise granted by state law.

Notification of Breach

You have the right to be notified following a breach of your PHI.

State Law Requirements

To the extent that applicable state law is more restrictive than HIPAA with regards to the use or disclosure of your PHI, those restrictions will generally apply.

Changes to this Notice

We reserve the right to change this Notice. We also reserve the right to make a revised Notice effective for PHI we already have about you and PHI we receive in the future. We will post a copy of the current Notice in the facilities covered by this Notice. The Notice will contain the effective date. In addition, each time you registered at a facility for treatment, a copy of the most current Notice will be made available to you.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health & Human Services. To receive assistance with filing a complaint with us, you may contact the Privacy Officer at the address at the end of this Notice. All complaints must be submitted in writing. You will not be denied treatment, retaliated against or penalized in any way if you file a complaint.

Privacy Officer Contact Information

All communications regarding this Notice should be directed to the attention of the Privacy Officer for the Agility Health entities. The contact information for the Privacy Officer is as follows:

Telephone: 616-356-5000
Facsimile: 616-356-5001
Address: 607 Dewey Avenue NW, Ste 300
Grand Rapids, Michigan 49504

Effective Date of this Revised Notice:

January 1, 2016.