GPT Gronlund Physical Therapy & Assoc., LLC

General Medical Questionnaire

*****PLEASE DO NOT LEAVE <u>ANY</u> BLANK OR UNANSWERED*****

DATE:_____

NAME_____ AGE_____ HEIGHT_____ WEIGHT_____

OCCUPATION_____ HOBBIES_____

WHAT IS YOUR CHIEF COMPLAINT? _____

PLEASE CIRCLE: Left~ or ~ Right~ or ~ Both

ONSET / INJURY DATE: _____ *PLEASE CIRCLE*: SUDDEN ONSET OR GRADUAL ONSET

HOW *DID THIS CONDITION BEGIN?*

_____

_____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

_____ No other treatment _____ Massage Therapy _____ Chiropractic
_____ Physical/Occupational Therapy _____ Psychiatrist/Psychologist _____ Other: _____

IF SO, HOW MANY VISITS?_____

WORK STATUS: AT THE ***PRESENT TIME*** I AM ABLE TO:

_____ Work without restrictions
_____ Work the same job with restrictions
_____ Work a different job with restrictions
_____ Unable to work due to dysfunction
_____ Don't normally work outside the home.
_____ Homemaker
_____ Retired
_____ Other

IS AN ATTORNEY INVOLVED WITH THIS CASE? YES NO

IF YES, ATTORNEY NAME: _____PHONE:_____

HOW WOULD YOU RATE YOUR GENERAL PHYSICAL HEALTH? EXCELLENT GOOD FAIR POOR

HOW MUCH CAFFEINE (COFFEE OR DRINKS) DO YOU DRINK PER DAY? _____

DO YOU SMOKE CIGARETTES/PACKS PER DAY? _____

DO YOU USE CHEWING TOBACCO? _____

DO YOU HAVE ANY ALLERGIES? _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? _____

HAVE YOU HAD ANY DIAGNOSTIC TESTS PERFORMED FOR THIS CONDITION? (i.e. X-Ray, MRI, CT, EMG, etc…..)
Please include: WHICH TESTS, ORDERING DOCTOR AND DATE.

_____
_____
_____
_____

HAVE YOU RECENTLY NOTED?

_____FEVER	_____ CHILLS	_____ NIGHT SWEATS	_____ SHORTNESS OF BREATH
_____PINS/NEEDLES	_____ NUMBNESS	_____ SKIN RASH	_____ HEADACHES
_____VISION PROBLEMS	_____ HEARING LOSS	_____ BOWEL/BLADDER PROBLEMS	
_____ BALANCE PROBLEMS	_____ RECENT FALLS	_____ WEIGHT LOSS	_____ WEIGHT GAIN
_____ NAUSEA/VOMITING	_____ FATIGUE	_____ WEAKNESS	

PLEASE CHECK ALL THE FOLLOWING CONDITIONS THAT APPLY TO YOU EITHER PRESENTLY OR IN THE PAST.

____ HIGH BLOOD PRESSURE	_____ EPILEPSY/SEIZURES	_____ GOUT	_____ VARICOSE VEINS
____ CHEST PAIN/HEART ATTACK	_____ KIDNEY DISEASE	_____ THYROID	_____ DIZZINESS/FAINTING
____ STROKE	_____ ASTHMA	_____ ARTHRITIS	_____ RHEUMATOID ARTHRITIS
____ HEART DISEASE	_____ EMPHYSEMA/BRONCHITIS	_____ LUNG DISEASE	_____ TUBERCULOSIS
____ HEART SURGERY	_____ CIRCULATION PROBLEMS	_____ ANEMIA	_____ HIV/AIDS
____ MULTIPLE SCLEROSIS	_____ DIABETES	_____HEPATITIS	_____ DEPRESSION
____ EMOTIONAL/PHYSCOLOGICAL PROBLEMS		_____CANCER	

____ CHEMICAL DEPENDENCY (i.e. alcoholism, caffeine, prescription medications, etc…) _____

IF YES TO ANY OF THE ABOVE, PLEASE STATE WHEN, WHERE, AND WHAT KIND.

_____
_____
_____

PLEASE LIST **ANY** SURGICAL PROCEDURES YOU HAVE HAD:

DATE / YEAR	PROCEDURE

ANYONE IN YOUR ***IMMEDIATE FAMILY*** (Parents, Brothers, Sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

_____CANCER	_____HEART DISEASE	_____DIABETES	_____TUBERCULOSIS
_____ARTHRITIS	_____HIGH BLOOD PRESSURE	_____KIDNEY DISEASE	_____STROKE
_____DEPRESSION	_____MENTAL HEALTH PROBLEMS	_____RHEUMATOID ARTHRITIS	

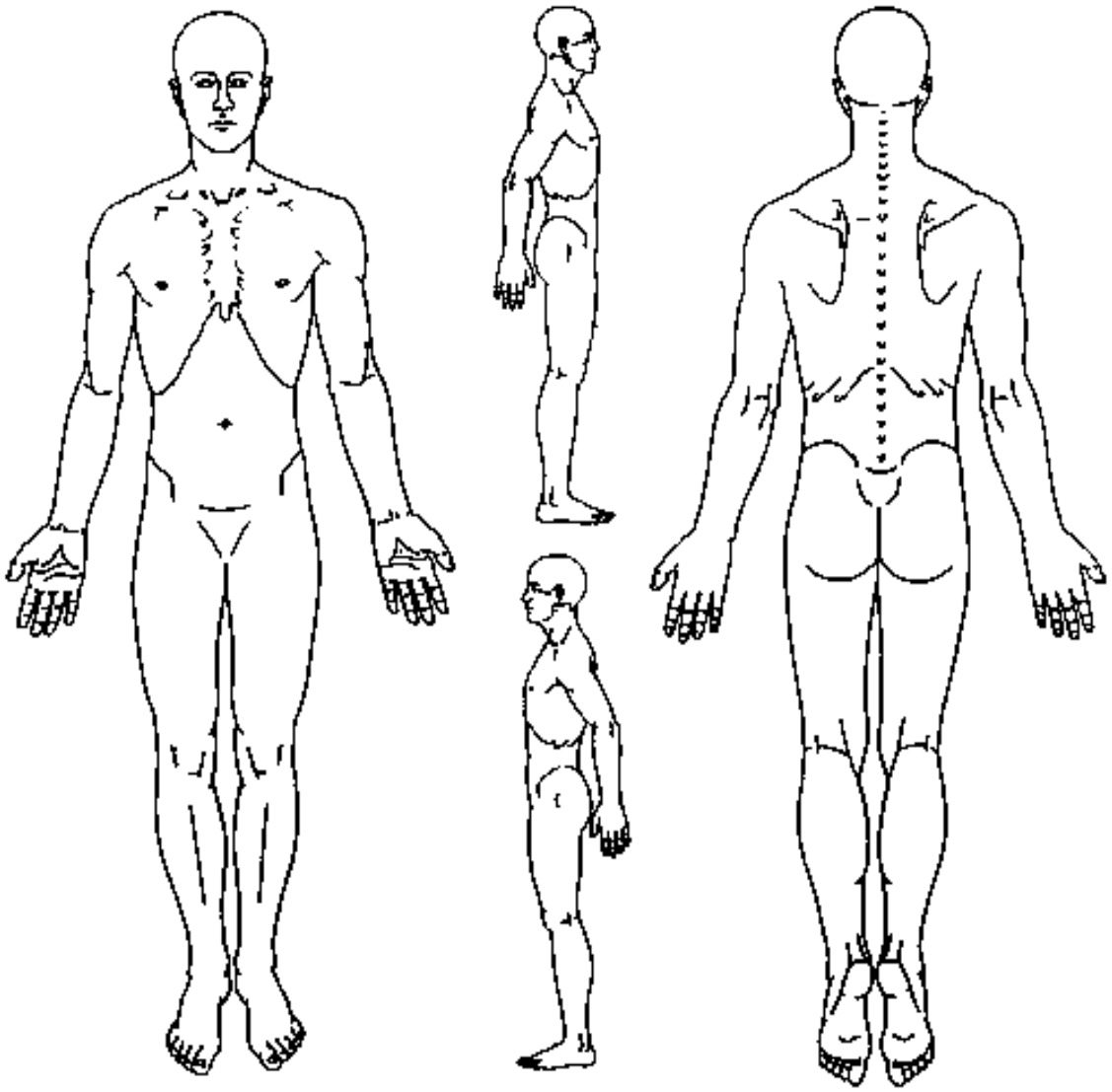
PLEASE CONTINUE TO PAGE 3

PAIN SCALE RATING 0 TO 10

1) What is your current level of pain on a scale from 0 to 10, with 0 being no pain and 10 being the worst pain?

Current Pain Level ~~~~~	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**
Best Pain Level ~~~~~~~~	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**
Worst Pain Level~~~~~~~	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**

Please shade, mark in on the body diagram exactly where you are having trouble. You may make notes of pain, weakness, numbness, tingling, burning, aching, sharp, dull, shooting, throbbing, heavy etc…



Name:_____ Date:_____

PLEASE LIST **ALL** PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING ORAL, INJECTIONS, AND/OR SKIN PATCHES):

Dosage means= *Strength* and *how many times* per day the medication is taken

Name of Medication	**Dosage/Amount** (mg., ml., etc…)	**Frequency** (how often/day)	**Route of Administration** (i.e. oral, sublingual, injection or topical)

PLEASE LIST ANY ***OVER-THE-COUNTER*** MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN IN THE PAST WEEK AND FOR WHAT REASON? (Aspirin, Tylenol, Motrin, Ibuprofen, Advil, Aleve Laxatives, Antacids, Vitamins/Mineral Supplements, Exercise Supplements)

Name of Medication	**Dosage/Amount** (mg., ml., etc…)	**Frequency** (how often/day)	**Route of Administration** (i.e. oral, sublingual, injection or topical)

GPT
Gronlund Physical Therapy & Assoc., LLC
545 E. Bruceton Road • Pleasant Hills, PA 15236 • **412-532-0144**

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

GPT is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from GPT. This Notice details how your PHI may be used and disclosed to third parties to carry out your treatment, payment for your treatment, health care operations of GPT, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

1. GPT may use and/or disclose your PHI for treatment, payment for your treatment, and health care operations of GPT. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

(a) Treatment – In order to provide, coordinate and manage your health care, GPT will provide your PHI (including electronic PHI) to those health care professionals, whether on GPT's staff or not, directly involved in your care so that they may understand your medical condition and needs, and provide advice or treatment . However, your consent is required for use or disclosure of psychotherapy notes. As of March, 2013 immunization records for students may be released without an authorization.

(b) Payment – In order to get paid for services provided to you, GPT disclose your health information to third parties such as insurance carriers or collection agencies, pursuant to their billing and payment requirements, as well as other parties that may be responsible for payment, such as family members.

(c) Health Care Operations – In order for GPT to operate in accordance with applicable law and insurance requirements and in order for GPT to continue to provide quality and efficient care, it may be necessary for GPT to compile, use and/or disclose your PHI. This includes business associates and subcontractors who may be involved in your treatment, billing, administrative support or data analysis, and these business associates will also be required by law through signed agreements to protect your health information.

AUTHORIZATION NOT REQUIRED

1. In addition to treatment, payment and health care operations, GPT may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

(a) De-Identified Information – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate, which is someone who GPT contracts with to provide a service necessary for your treatment, payment for your treatment and health care operations (e.g., billing service or transcription service). GPT will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

(e) Federal Drug Administration.- If required by the Food and Drug Administration to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

(f) Abuse, Neglect or Domestic Violence - To a government authority if GPT is required by law to make such disclosure. If GPT is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm or if GPT believes that you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.

(g) Health Oversight Activities - Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

(h) Judicial and Administrative Proceedings - For example, GPT may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(i) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of GPT; and (6) a medical emergency (not on GPT's premises) has occurred, and it appears that a crime has occurred.

(j) Coroner or Medical Examiner - GPT may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

(k) Organ, Eye or Tissue Donation - If you are an organ donor, GPT may disclose your PHI to the entity to whom you have agreed to donate your organs

(l) Research - If GPT is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board and the requirement that protocols must be followed.

(m) Avert a Threat to Health or Safety - GPT may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) Specialized Government Functions - When the appropriate conditions apply, GPT may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. GPT may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

(o) Inmates - GPT may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.

(p) Workers' Compensation - If you are involved in a Workers' Compensation claim, GPT may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(q) Disaster Relief Efforts - GPT may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

(r) Required by Law. If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization, which you may revoke at any time. This includes consent prior to the use or disclosure of any psychotherapy notes or the use of your PHI for marketing purposes.

SIGN-IN-SHEET

GPT may use a sign-in-sheet at the registration desk. GPT may also call your name in the waiting room when your physician is ready to see you.

APPOINTMENT REMINDERS

GPT may, from time to time, contact you to provide reminders for scheduled or recommended services or treatments.

TREATMENT ALTERNATIVES / BENEFITS

GPT may, from time to time, contact you about treatment alternatives, or other health benefits or services that may be of interest to you.

MARKETING AND FUNDRAISING

GPT may only use and/or disclose your PHI for marketing or fund-raising activities if we obtain from you a prior written Authorization. "Marketing" activities include communications to you that encourage you to purchase or use a product or service, and the communication is not made for your care or treatment. Marketing also includes the receipt by GPT of remuneration, directly or indirectly, from a third party whose product or service is being marketed to you. However, marketing does not include, for example, sending you a newsletter or electronic information about this Practice.

ON-CALL-COVERAGE

In order to provide on-call coverage for you, it is necessary that GPT establish relationships with other PT's or physicians who will take your call if your PT from GPT is not available. Those on-call professionals will provide GPT with whatever PHI that they create and will, by law, keep your PHI confidential.

FAMILY/FRIENDS

GPT may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. GPT may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) GPT may use or disclose your PHI if you agree, or if GPT provides you with opportunity to object and you do not object, or if GPT can reasonably infer from the circumstances, based on the exercise of its judgment, that you do not object to the use or disclosure.

(b) If you are not present, GPT will, in the exercise of its judgment, decide whether the use or disclosure is in your best interest and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to GPT's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, GPT is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to GPT's Privacy Officer. In your written request, you must inform GPT of what information you want to limit, whether you want to limit GPT's use or disclosure, or both, and to whom you want the limits to apply. If GPT agrees to your request, GPT will comply with your request unless the information is needed in order to provide you with emergency treatment. If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan, if the request is not required by law.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to GPT's Privacy Officer. GPT will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. You may also obtain an electronic copy of your PHI for information we store electronically. To inspect and/or copy your PHI, you must submit a written request to GPT's Privacy Officer. GPT can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, GPT may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to GPT's Privacy Officer. You must provide a reason that supports your request. GPT may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by GPT (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by GPT, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and (b) complete. If you disagree with GPT's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to GPT's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but GPT may charge you for the cost of providing additional lists. GPT will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from GPT upon request to GPT's Privacy Officer.

(h) Complain to GPT or to the Secretary of Health and Human Services if you feel that your privacy has been violated. To file a complaint with GPT, you must contact GPT's Privacy Officer. All complaints must be in writing.

(i) To be notified in the event of a breach of your privacy. In the event of a breach, we will take all steps required by law, including a risk assessment and the appropriate notifications, and inform you of any steps you should take to protect yourself against harm due to a breach.

(j) To request that a health plan not be informed of treatment this is paid for in full by you, and GPT's obligation to comply with your request.

(k) To opt out of communications for fundraising purposes.

(l) To obtain more information on, or have your questions about your rights answered; you may contact GPT's Privacy Officer at 412-532-0144

PRACTICE'S REQUIREMENTS

1. GPT:

(a) Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of GPT's legal duties and privacy practices with respect to your PHI.

(b) Is required to abide by the terms of this Privacy Notice.

(c) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(d) Will not retaliate against you for making a complaint.

(e) Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.

(f) Will post this Privacy Notice on GPT's web site.

EFFECTIVE DATE

This Notice is in effect as of May 23, 2007 and revised as of September 23, 2013.

I HAVE READ AND UNDERSTAND THE HIPPA "NOTICE OF INFORMATION PRACTICES" FROM GRONLUND PHYSICAL THERAPY & ASSOCIATES, LLC.

X--Signature of Patient/Guardian **X**--Date

GPT Gronlund Physical Therapy & Assoc., LLC

Patient's Name: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Gronlund Physical Therapy & Assoc., LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

_____
Patient/Guardian Initials

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, or any other health/auto insurance/workman's compensation plans to Gronlund Physical Therapy & Assoc., LLC. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary (including photocopies of medical records) to secure payment. I also understand and agree that all remittance for services rendered to me is accepted by Gronlund Physical Therapy & Assoc., LLC at 545 E. Bruceton Rd. Pleasant Hills, PA 15236. If a financial hardship exists, I will bring that situation to the attention of Gronlund Physical Therapy's billing officer.

_____
Patient/Guardian Initials

FINANCIAL POLICY STATEMENT

It is the patient's responsibility to be aware of individual plans, policies, and benefits in regards to outpatient physical therapy. An explanation of benefits from Gronlund Physical Therapy & Assoc., LLC's staff does not guarantee payment from your insurance company, nor should it be considered a binding agreement of payment and/or benefits from your insurance company.

As a patient of Gronlund Physical Therapy & Assoc., LLC you are responsible for the entire bill of services rendered should your insurance company deny payment for any reason. By signing this statement as a guarantor, you agree to pay for all services and/or supplies that are deemed patient responsibility by Gronlund Physical Therapy & Assoc., LLC or other agency involved such as insurance, attorney, etc. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Gronlund Physical Therapy & Assoc., LLC I will be responsible for all cost of collecting moneys owed.

Co-Payments and cost share percentages are expected at the time of service. If your insurance company does not remit payment within 90 days, the balance will be due in full from you. If payment is received from your insurance company after 90 days, any credit due to you will be refunded to you.

WORKERS COMPENSATION INSURANCE: Upon filing a worker's compensation claim, there is a time period when your claim may be in deferred status. Physical therapy may be provided to you during this time period causing incurred costs. After the deferred period, your claim may be accepted or denied. If your claim is accepted, we will bill your workers compensation carrier. If your claim is denied, we will bill your private medical insurance. If you do not have private medical insurance, the entire balance of your account is your responsibility.

By signing the bottom of this form, you indicate full understanding of your responsibility for payment of your account with Gronlund Physical Therapy & Assoc., LLC

_____ _____
Patient/Guardian Initials Date

EMERGENCY CARE

(For patients in Gronlund Physical Therapy & Assoc., LLC's clinic)

In the event of an emergency, I authorize Gronlund Physical Therapy & Assoc., LLC to transport me by ambulance to the nearest emergency facility and to contact the person below. I further authorize the release of necessary medical information to the appropriate health professionals providing care for said emergency. This information may include documentation on the medical record, which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information.

Person to contact in case of an emergency:

NAME: _____ PHONE:_____

CELL:_____

RELATIONSHIP: _____

RELEASE OF INFORMATION

I hereby consent to and authorize Gronlund Physical Therapy & Assoc., LLC Custodian of Records to disclose information from my medical record relating to my diagnosis and treatment.

_____

Patient/Guardian Signature