ACHIEVE
Health and Wellness
www.ahwpt.com

406 Roy Martin Rd. Suite 9
Gray, TN 37615
423-477-1101
Fax 423-477-1102

1732 North Eastman Rd. Suite 1A
Kingsport, TN 37664
423-765-1611
Fax 423-765-1612

FINANCIAL POLICY

AS A COURTESY TO OUR PATIENTS, WE CHECK THE INSURANCE COVERAGE AND BENEFITS FOR THERAPY SERVICES; HOWEVER, IT IS THE PATIENT'S RESPONSIBILITY TO VERIFY COVERAGE, UNDERSTAND THEIR PARTICULAR INSURANCE AND INSURE THAT PAYMENT IS MADE.

In the information below, we are ESTIMATING the amount of money you will need to pay after you insurance has been filed. **The information below does not guarantee insurance coverage or insurance payment. When insurance benefits are verified, the insurance company does not guarantee payment. If the insurance company denies coverage, you will receive a bill for those services.**

Achieve Health and Wellness does not accept third party liability insurance. If you have been involved in an accident where there is third party coverage, you will be responsible for paying for therapy services rendered by Achieve Health and Wellness at the time that services are rendered.

The amount not covered by the primary insurance company is ESTIMATED below. That amount is payable on the date that services are rendered. This estimate is determined by benefits from your plan or from a predetermination from your insurance company. Please understand that this is only an estimate and that insurance companies have their own schedule of what they consider to be "usual and customary". These fees often vary between plans. Our charges are based solely on the amount of time, skill and care that is provided by your therapist for each individual treatment session. Therefore, it is not uncommon to find a difference in our charges and the insurance payment. If we are in network for your insurance carrier, you will be responsible for the insurance allowable. If we are not in network for your insurance, you will be responsible for the difference between the allowable and the charge. Please understand that your insurance is an agreement between you, your employer and the insurance carrier.

PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED.

If you have NOT met your deductible, we will take a deposit from you towards your deductible at each visit until you meet the deductible. You will receive a bill for the difference between the deposit and the insurance allowable after the insurance has communicated the allowable. *If you have had a recent procedure that should apply to your deductible, it may not have been billed by the hospital or physician's office and therefore, may not be listed when we checked your benefits*. If you have a co-insurance percentage that you are expected to pay, we will collect an estimated amount on that co-insurance and you will receive a bill for the difference between what you paid and what the insurance company allows.

If Medicare denies payment, you will be notified that payment has been denied. If Medicare assignment is accepted, at no time will the charges on those items be more than the yearly deductible plus the 20% that Medicare does not pay. In Many cases, the deductible amount and the 20% is paid by other insurances. We will follow through with the appeal process on Medicare claims that are denied.

IT IS THE CUSTOMER'S RESPONSIBILITY TO:

- Provide us with all insurance information necessary to file your claim and notify our office of any changes or loss of insurance coverage
- Pay all deductible and balance remaining after secondary insurance is filed
- Payment in full of all claims not covered by your insurance carrier.
- Any arrangement or agreement for payment other than those described above must have approval from the manager.

It is your obligation to pay any and all charges related to the collection of the bill if Achieve Health and Wellness deems it necessary or appropriate to retain a collection agency and/or attorney for the collection of this bill. These charges may include, but are not limited to, collection costs of forty (40%) percent of the obligated debt plus other expenses such as court cost, reasonable attorney fees, and past due interest.

WE ENCOURAGE YOU TO CONTACT YOUR INSURANCE COMPANY TO BETTER UNDERSTAND YOUR BENEFIT FOR THERAPY SERVICES.

- ☐ You have satisfied your deductable and your out of pocket.
- ☐ Your individual deductible is $_____
- ☐ You have met $_____ of your individual deductible
- ☐ Your family deductible is $_____
- ☐ You have met $_____ of your family deductible
- ☐ We require a payment of $_____ towards your deductible
- ☐ Your co-pay for each visit is $_____
- ☐ You are responsible for a co-ins of $_____
- ☐ We require a payment of $_____ per visit for co-ins after deductable
- ☐ Your total out of pocket is $_____
- ☐ Your total family out of pocket is $_____
- ☐ You have met $_____ of your total out of pocket expenses

- ☐ Your insurance allows $_____ for therapy each benefit year. We estimate that to be _____ visits. **This does not guarantee the number of visits.**
- ☐ Your benefits allow you _____ PT/OT visits each benefit year.
- ☐ Your Workers Compensation Ins. has approved _____ visits. **In the event they do not pay; you are ultimately responsible for payment.**

- ☐ Your benefits are pending because: _____

THIS QUOTE OF BENEFITS AND/OR AUTHORIZATION DOES NOT GUARANTEE PAYMENT OR VERIFY ELIGIBILITY. PAYMENTS ARE SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS, AND EXCLUSIONS OF THE MEMBERS' INSURANCE CONTRACT AT THE TIME OF SERVICE. SECONDARY INSURANCES ARE NO DIFFERENT AND HAVE THE SAME STIPULATIONS AS PRIMARY INSURANCES AND MAY NOT COVER THE SERVICES PROVIDED.

I HAVE READ THE INFORMATION ABOVE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

Patient / Guardian Signature	Print Name	Date

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CONSENT TO TREAT AND CONDITIONS OF ADMISSION

1. CONSENT TO REHABILITATION PROCEDURES: The undersigned consents to the procedures which may be performed during this and future outpatient physical therapy visits that are performed at Achieve Health and Wellness.

2. LEGAL RELATIONSHIP BETWEEN ACHIEVE HEALTH AND WELLNESS PHYSICAL THERAPISTS: All Physical Therapists, and Physical Therapist assistants are employed by Achieve Health and Wellness, Inc.

3. RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Achieve Health and Wellness may make available certain basic information about the patient in accordance with HIPAA regulations, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning or other condition) general nature of the injury, burn, poisoning or other condition, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Achieve Health and Wellness for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Achieve Health and Wellness may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Achieve Health and Wellness's charges, including but not limited to government agencies (e.g., Medicare, Medicaid, insurance companies, health care service plans, or workers compensation carriers). By signing below, I acknowledge that I have received Achieve Health and Wellness's Notice of Privacy Practices.

4. FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Achieve Health and Wellness in accordance with the regular rates and terms of Achieve Health and Wellness. All accounts are handled in house, including billing, collections and all other matters relating to the account.

5. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Achieve Health and Wellness of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed Achieve Health and Wellness's regular charges. It is agreed that payment to Achieve Health and Wellness, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. Any pre-certification of insurance benefits is the patient's sole responsibility. The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient for all services furnished by Achieve Health and Wellness. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

6. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR PAYMENT: I hereby authorize the release of all information from the patient's medical record that may be necessary to make reimbursement or payment for any or all the services rendered by the Therapist involved in my care with Achieve Health and Wellness. I hereby authorize my Insurer or any third party responsible for the payment of covered medical/surgical benefits on my behalf to make payment directly to Achieve Health and Wellness. As a patient I understand that I am responsible for my insurance benefits and understand my in network and out of network coverage.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

Patient / Guardian Signature	Print Name	Date

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PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost in professionalism and service excellence. Our commitment to your well being and improvement in your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In instances of repeated cancellations without 24-48 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $50 fee as allowed by insurance contracts.

Please initial that you understand the above sentence:_____

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

INCLEMENT WEATHER POLICY

We will make every effort to maintain normal work hours even during inclement weather. On days when weather conditions worsen as the day progresses, we may decide to close early. In such cases, a decision and an announcement will be made and patient will be informed.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Achieve Health and Wellness

I HAVE READ AND UNDERSTAND THE PATIENT MISSED APPOINTMENT POLICY AND THE INCLEMENT WEATHER POLICY

Patient / Guardian Signature	Print Name	Date

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ACKNOWLEDGEMENT OF RECEIPT OF PATIENT INFORMATION PACKET

I, the undersigned hereby acknowledge that I have received the Patient Packet from Achieve Health & Wellness. I am either the patient or a representative of the patient signing on behalf of the patient. The company representative has explained the sections of the packet, and I have had the opportunity to ask questions and my questions answered. The following sections of the packet were discussed:

- Mission Statement
- Questions and Complaints
- Consent to Treat and Conditions of Admission
- Financial Policy
- Missed Appointments
- Notice of Privacy Practices
- Bill of Rights and Responsibilities
- Advance Directives
- Patient Satisfaction

I am aware that, should I have any questions or problems, I can call the Company at the telephone numbers provided to me. I know the company seeks to provide the best possible services that comply with its contractual obligations, state laws and federal laws and regulations. I can contact the company at anytime if I have concerns or questions about the services that I am receiving or about the company's billing practices.

Patient / Guardian Signature	Print Name	Date

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MISSION STATEMENT

The mission of Achieve Health & Wellness is to set the standard of excellence in our community by providing the patient, their families, and their physicians with confidence that we are dedicated, committed, and capable of delivering responsive, professional, and caring physical therapy services to each and every patient, as part of, a successful plan of care.

OFFICE HOURS

Monday-Friday
8:00a.m- 5:00p.m.

QUESTIONS AND COMPLAINTS

If you want more information on our privacy practices or have questions or concerns, please contact us with the information below. If you are concerned that we have violated your privacy rights, or you disagree with the decision made about access to your PHI, or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative location, you may complain to us using the contact information below. You may also submit a written complaint to the US Department of Health and Human Services.

Achieve Health & Wellness supports your right to protect the privacy of your PHI. There will be no retaliation in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

THANK YOU

Thank you for choosing Achieve Health & Wellness for your Physical Therapy & Wellness needs. If there is anything we can do or be of assistance, please let us know. For any emergency, call and leave a message and we will respond the next business day or in the event of an emergency please proceed to the nearest Emergency Room.

We have included in this packet a Customer Satisfaction Survey we ask that you take a few moments of your time and return this survey to the front office reception or mail your response to either of the address above.

Thank you,

Jody Musick PT
President / Owner

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BILL OF RIGHTS AND RESPONSIBILITIES

Patient Rights

The following are the rights of Achieve Health & Wellness's patients:

- The right to be fully informed in advance about the care, treatments, and/or services to be provided, including the disciplines that furnish care and the frequency of visits as well as any modifications to the plan of care.
- The right to be able to identify visiting staff members through proper identification.
- The right to be cared for and choose an organization that adheres to ethical care and business practices.
- The right to be informed of care, treatment, and/or service limitations.
- The right to be involved in his or her care.
- The right to have the plan of care adapted to his or her specific needs and limitations.
- The right to make informed decisions regarding care.
- The right to have their values and preferences, including decisions to refuse care, discontinue care treatments, and services respected.
- The right to confidentiality of the information collected about them and to control access to this information.
- The right to privacy and security and to have their property respected.
- The right to have care, treatments, and services provided in a manner that safeguards each patent's dignity and cultural, psychosocial, and spiritual values.
- The right to be free from mental, physical, sexual, verbal abuse, neglect, and exploitation.
- The right to have a complaint heard, reviewed, and, if possible, resolved.
- The right to be involved in resolving conflicts, dilemmas or ethical issues about care or service decisions.
- The right to formulate advance directives.
- The right to be involved in decisions to withhold resuscitation and decisions to forgo or withdraw life-sustaining care.
- The right to be involved in decisions when the organization's review results in a denial of care, treatment, services, or payment.
- The right to choose whether or not to participate in research, investigational or experimental studies, or clinical trials.
- The right to be communicated with, both directly, and indirectly through other providers, in an ethical and efficient manner.
- The right to help patients, family members, and other care providers understand and exercise their rights.
- The right to be informed of his or her responsibilities in the provision of care, treatments, and services.
- The right to be informed of any obligation Achieve Health & Wellness has under applicable laws and/or regulations.
- The right to have consequences of any requested modifications and actions that are not recommended explained and to have alternative care, treatments, and services explained.
- The right to be provided with information about the charges for which the patient is responsible.
- The right to access, request amendments to, and receive an accounting of disclosures regarding their own health information as permitted under applicable law.
- The right to be informed of any existing or potential conflict of interest, including financial benefits that can affect provision of care when referred to an organization.

Patient Responsibilities

Safety and health care delivery provided is enhanced when Achieve Health & Wellness's patients, as appropriate to their care, are partners in the health care process. Achieve Health & Wellness is entitled to reasonable and responsible behavior on the part of the patients, within his or her capabilities, and their families. The following are defined as the responsibilities for Achieve Health & Wellness's patients:

- Responsibility to provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- Responsibility to report perceived risks in their care and unexpected changes in his or her condition.
- Responsibility to help Achieve Health & Wellness understand his or her environment by providing feedback about service needs and expectations.
- Responsibility to ask questions when he or she does not understand care, treatments, and services or expectations.
- Responsibility to follow the care, treatments, and services as planned.
- Responsibility for the outcomes if he or she does not follow Achieve Health & Wellness's care, treatments, and services.
- Responsibility to follow Achieve Health & Wellness's rules and regulations.
- Responsibility to be considerate of Achieve Health & Wellness's staff and property.
- Responsibility to meet any financial obligation agreed to with Achieve Health & Wellness.

By understanding and respecting these values, Achieve Health & Wellness, can meet care, treatment, and service needs and preferences.

ADVANCED DIRECTIVES

As a part of our mission at Achieve Health & Wellness we recognize your right to participate in the formulation of the decisions that may impact your care. This includes respecting your wishes on the level of care you desire when confronted with a health situation. These decision made by you, in a legally appropriate manner defined by the state, are referred to as Advance Directives.

Advanced Directives give direction to your family and healthcare providers regarding your wishes to withhold extraordinary measures to revive you in the event of a cardiac or respiratory emergency. Some examples of these are a Living Will, Durable Power of Attorney, and Do Not Resuscitate order (DNR). In the event that you have already formulated an Advanced Directive, please inform us of your wishes and provide us a written copy of your directions. It is our policy that, unless directed otherwise by an Advanced Directive, any associate who encounters a patient who is unresponsive will call *911* to activate the emergency medical system. At no time can an associate of Achieve Health & Wellness participate in the withdrawal of life support equipment. Medical orders from your doctor are needed in almost every event that we participate.

Should you wish to execute an Advanced Directive, please inform your Physician, attorney, caregiver, and support team of your wishes. If in the future you make a change in your Advanced Directive, please inform us of the changes so that we can update your records at our office.
Your decision regarding whether or not to execute an Advanced Directive will never be a condition of providing care or a basis for discrimination for or against you as a patient.

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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.

Your health information is personal, and we are committed to protecting it. Your health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice applies to all records about your care that occurs at any of our Achieve Health and Wellness facilities. This Notice applies to all records about your care at our facilities or affiliated entities.

HIPAA does not apply to information disclosed in connection with a worker's compensation matter. Pursuant to law, your health information relevant to a worker's compensation matter will be disclosed to your employer's workers compensation insurer or third party administrator and to your employer.

I. We Are Legally Required to Safeguard Your Protected Health Information. We are required by law to:

A. Maintain the privacy of your health information, also known as "protected health information" or "PHI;"

B. Provide you with this Notice, and

C. Comply with this Notice.

II. Future Changes to Our Practices and This Notice. We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting 406 Roy Martin Rd Suite #9 Gray, TN 37615. We will also make any revised Notice available in our clinics.

III. How We May Use and Disclose Your Protected Health Information. The law requires us to have your written authorization to some uses and disclosures. In other circumstances, the law allows us to use or disclose PHI without your written authorization. This Section gives examples of each of these circumstances.

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use or disclose your PHI to provide treatment to you. For example, we may disclose your PHI to physicians, nurses, and other health care personnel who are involved in your care. We may also use and disclose your PHI to contact you as a reminder that you have an appointment for treatment at our facility, to tell you about or recommend possible treatment options or alternatives, or about health-related benefits or services that may interest you.

We may also use or disclose your PHI to your insurance carrier in order to get paid for treatment provided to you. For example, we may use your PHI to create the bills that we submit to the insurance company, or we may disclose certain portions of your PHI to our business associates who perform billing and claims processing services to us.

We may also use or disclose your PHI in order to operate this facility. For example, we may use your PHI to evaluate the quality of care you received from us, or to evaluate the performance of those involved with your care. We may also provide your PHI to our attorneys, accountants and other consultants to make sure we are complying with the laws that affect us.

B. Uses and Disclosures That Require Us to Give You the Opportunity to Object. If you do not object, we may include your name and location in our facility in the patient directory that we use when responding to requests by those who ask for you by name. Unless you object, we may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your health care or in helping you get payment for your health care. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends. Unless you object, we may also disclose your PHI to persons performing disaster relief notification activities.

C. Certain Uses and Disclosures Do Not Require Your Written Authorization Other than Uses and Disclosures for Treatment, Payment and Health Care Operations. The law allows us to disclose PHI without your written authorization in the following circumstances:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm, PHI may be provided to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Child Abuse and Neglect Reporting law if there is a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Elder/Dependent Adult Abuse Reporting law if there is a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. If disclosure is compelled or permitted by the fact that you report the commission of or contemplation of a commission of a crime.

11. For public health activities.

12. For quality review health oversight activities.

13. For specific government functions which impact national security, or veterans or military personnel.

14. For research purposes which may result in improved practices.

15. For Workers' Compensation compliance purposes.

16. If an arbitrator or arbitration panel compels disclosure.

17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, such as HIPAA compliance.

18. If disclosure is otherwise specifically required by law.

For some types of PHI, there may be stricter restrictions on our use or disclosure of PHI. For example, drug and alcohol abuse patient treatment information, HIV test results, mental health information, and genetic testing results may be subject to greater protection of your privacy.

In general, we may disclose a minor patient's PHI to a parent or guardian, but we may deny the parents' access to the minor patient's PHI in some situations.

IV. Other Uses and Disclosures of Your Protected Health Information. Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclosure your PHI for the purposes specified in the written authorization, except that we are unable to take back any disclosures we have already made with your permission, and are required to retain certain records of the uses and disclosures made when the authorization was in effect.

V. Your Rights Related to Your Protected Health Information. You have the following rights:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI, as long as you are not asking us to limit uses and disclosures that we are required or authorized to make to the Secretary of the federal Department of Health Services, related to our facility's patient directory, or any of the disclosures described in Section III, above. Any such request must be submitted in writing to our Privacy Officer.
We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment.

B. The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to our Privacy Officer.

C. The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI if you ask in writing to do so. Any such request must be addressed to Medical Records, which will respond to your request within 30 days (or 60 days if the extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your right to have the denial reviewed.
If you ask us to copy your PHI, we will charge you $25.00 processing fee and $.65 per page

D. The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to our Medical Records, and must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask you who else you would like us to notify of the amendment.

We may deny your request if you ask us to amend information that:

1. was not created by us, unless the person who created the information is no longer available to make the amendment
2. is not part of the PHI we keep about you
3. is not part of the PHI that you would be allowed to see or copy
4. is determined by us to be accurate and complete

If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

E. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include disclosures we have made for our treatment, payment and health care operations purposes, those made directly to you or your family or friends or through our facility directory, or for disaster notification purposes. Neither will the list include disclosures we have made with your written authorization, for national security purposes or to law enforcement personnel, disclosure of limited data set, or disclosures made before April 14, 2003.

Your request for a list of disclosures must be made in writing and be addressed to our Medical Records. We will respond to your request within 60 days (or 90 days if the extra time is needed). The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

F. The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive the Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy of this Notice by contacting 406 Roy Martin Rd Suite #9 Gray, TN 37615. The Notice is also available in our clinics.

VI. Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Human Services. To file a complaint with us, put your compliant in writing and address it to our Owner/President . We will not retaliate against you for filing a complaint. You may also contact our Owner/President if you have questions or comments about our privacy practices.

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IMPAIRMENT %: _____
FUNCTION %: _____
ACCOUNT #: _____
ICD 10: _____
VISIT: _____

Name: _____ **DOB:** _____ **Date:** _____

Instructions: You may find it hard to do some of the things you usually do. Please mark the box in each section that best describes your current situation. Also rate how limited you are in each section.

Mobility:	Overall Mobility is:
☐ I have no problem with mobility: walking and moving around	☐ Not Limited
☐ I find it difficult to turn over in bed	☐ Minimally Limited
☐ I am unable to go up or down a flight of stairs	☐ Moderately Limited
☐ I am unable to walk more than a block	☐ Severely Limited
☐ I have to hold on to something to get out of a chair	☐ Disabled

Body Positioning:	Overall Body Positioning is:
☐ I have no problem with changing and maintaining body positioning	☐ Not Limited
☐ I change positions frequently	☐ Minimally Limited
☐ I am unable to sit or stand longer than 30 minutes	☐ Moderately Limited
☐ I am unable to sit or stand longer than 15 minutes	☐ Severely Limited
☐ I am unable to sit or stand longer than 5 minutes	☐ Disabled

Carrying:	Overall Carrying is:
☐ I have no problem with carrying, moving and handling objects	☐ Not Limited
☐ I am not able to lift heavy weights but can manage light weights	☐ Minimally Limited
☐ I have difficulty taking care of the laundry	☐ Moderately Limited
☐ I am not able to lift and carry a bag of groceries	☐ Severely Limited
☐ I am not able to carry or lift anything	☐ Disabled

Self Care:	Overall Self Care is:
☐ I have no problems with self care: bathing, dressing, and eating	☐ Not Limited
☐ I have difficulty shaving or doing my hair	☐ Minimally Limited
☐ I have difficulty putting on my shoes or socks	☐ Moderately Limited
☐ I am unable to bath or shower without someone helping me	☐ Severely Limited
☐ I get dressed with the help from someone else	☐ Disabled

Other Limitations:	Overall Other Limitations are:
☐ I have no problem with emotional or other physical related activities	☐ Not Limited
☐ I lose sleep because of my pain or problem	☐ Minimally Limited
☐ I am more irritable and bad tempered with others	☐ Moderately Limited
☐ I have difficulty completing my usual activities	☐ Severely Limited
☐ I am unable to do my usual activities	☐ Disabled

PLACE A MARK ON THE LINE BELOW DOCUMENTING YOUR OVERALL OR TOTAL FUNCTION

I **CANNOT** do anything.
0% Function

I **CAN** do whatever I want.
100% Function

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FEAR AVOIDANCE BELIEFS QUESTIONNAIRE (FABQ)

Name: _____ **DOB:** _____ **Date:** _____

For each statement please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect your pain.

	COMPLETELY DISAGREE			UNSURE		COMPLETELY AGREE		
1. My pain was caused by physical activity	0	1	2	3	4	5	6	
2. Physical activity makes my pain worse	0	1	2	3	4	5	6	
3. Physical activity might harm me	0	1	2	3	4	5	6	
4. I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6	
5. I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6	

FABQPA (2-5): _____/24

The following statements are about how your normal work affects or would affect your pain.

	COMPLETELY DISAGREE			UNSURE		COMPLETELY AGREE		
6. My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6	
7. My work aggravated my pain	0	1	2	3	4	5	6	
8. I have a claim for compensation for my pain	0	1	2	3	4	5	6	
9. My work is too heavy for me	0	1	2	3	4	5	6	
10. My work makes or would make my pain worse	0	1	2	3	4	5	6	
11. My work might harm my back	0	1	2	3	4	5	6	
12. I should not do my normal work with my present pain	0	1	2	3	4	5	6	
13. I cannot do my normal work with my present pain	0	1	2	3	4	5	6	
14. I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6	
15. I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6	
16. I do not think that I will ever be able to go	0	1	2	3	4	5	6	

FABQW (6,7,9,10,11,12,15): _____/42

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NEW PATIENT DEMOGRAPHICS SHEET

Welcome to Our Practice!

Please help us serve you better by providing all of the following information.

Title | **Last Name** | **First Name** | **MI** | **Social Security #** | **Account #**

Street Address | **Apartment Number**

City | **State** | **Zip Code**

Home Phone: ☐ **Primary** | **Cell Phone:** ☐ **Primary** | **Primary Doctor (full name)**

Age | **DOB** | **Sex (M, F)** | **Referring Doctor (full name)**

Employer | **Employer Phone Number**

Emergency Contact Name | **Emergency Contact Number**

Marital
- ☐ Married
- ☐ Widowed
- ☐ Single
- ☐ Divorced
- ☐ Separated

Employment
- ☐ Full
- ☐ Part
- ☐ Retired
- ☐ None

Living Status
- ☐ Rent
- ☐ Own
- ☐ Other:_____

Relationship to Insured
- ☐ Self
- ☐ Spouse
- ☐ Other
- ☐ Child

COMPLETE IF INSURANCE IS IN ANOTHER PERSONS NAME: Spouse / Parent / Caregiver

Last Name | **First Name** | **MI** | **Social Security #**

Home Phone: | **Cell Phone:**

Age | **DOB** | **Sex (M, F)** | **Relationship to Insured:**

ACCIDENT DETAILS

Employment Related: ☐ Yes ☐ No

Accident Related: ☐ Auto ☐ Other ☐ No

State Accident Occurred In:

Date of Accident:

Give Details of Accident:

Patient / Guardian Signature | Print Name | Date

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PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Have you had TWO or more falls in the past year or ANY fall WITH injury in the past year? YES NO

Are you currently receiving or in the past calendar year received Home Health Services of any kind? YES NO

Date of Injury or Surgery_____ Body Part Affected _____

What do you think caused your symptoms? _____

Have you ever had this problem before? YES NO When _____ Treatment received YES NO

How long did it take for you to feel better? _____

Are you on a work restriction from your doctor? YES NO

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan

Do you smoke? YES NO

Are you latex sensitive? YES NO

Do you have a pacemaker? YES NO

Are you currently pregnant or think you might be pregnant? YES NO N/A

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Have you RECENTLY noted any of the following symptoms during you current episode? (check all that apply)

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ falls
- ☐ difficulty maintaining balance while walking
- ☐ numbness or tingling
- ☐ muscle weakness
- ☐ headaches
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ difficulty swallowing
- ☐ changes in bowel or bladder function
- ☐ constipation
- ☐ diarrhea
- ☐ shortness of breath
- ☐ fainting
- ☐ cough

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency
- ☐ Recent Infection
- ☐ Depression
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Eye irritation/infection
- ☐ Sexually transmitted disease/HIV
- ☐ Incontinence
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Kidney problems
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis

ALLERGIES: List any medication, food, or other substances you are allergic to: _____

_____

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse

1. _____

2. _____

3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better

1. _____

2. _____

3. _____

How are you currently able to sleep at night due to your symptoms?

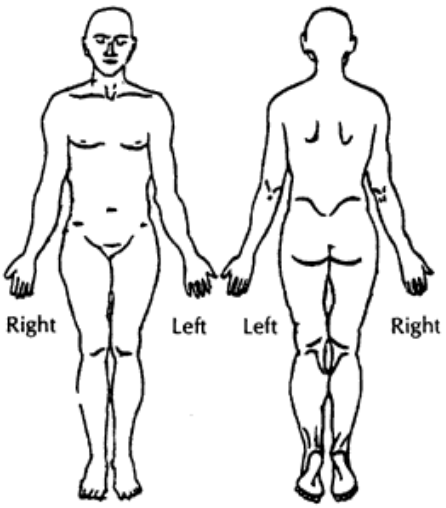
☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

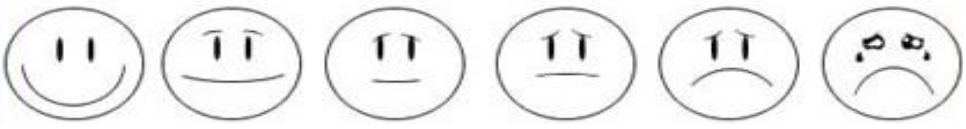
Body Chart: Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms: (you may also use this space to describe your pain in your own words)

X Shooting/sharp pain
O Dull/aching pain
/ Numbness
= Tingling



My symptoms currently: ☐ Come and go ☐ Are Constant ☐ Are constant, but change with activity

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:



Your **CURRENT** level of pain while completing this survey: _____

The **BEST** your pain has been during the past 24 hours: _____

The **WORST** your pain has been during the past 24 hours: _____

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MEDICATION LIST

Include all prescription, over the counter, and supplements currently taking

Name: _____ **DOB:** _____ **Date:**_____

☐ Please see attached Medication list provided by patient.

1: _____

Dosage: _____ Frequency: _____ Administered: _____

2: _____

Dosage: _____ Frequency: _____ Administered: _____

3: _____

Dosage: _____ Frequency: _____ Administered: _____

4: _____

Dosage: _____ Frequency: _____ Administered: _____

5: _____

Dosage: _____ Frequency: _____ Administered: _____

6: _____

Dosage: _____ Frequency: _____ Administered: _____

7: _____

Dosage: _____ Frequency: _____ Administered: _____

8: _____

Dosage: _____ Frequency: _____ Administered: _____

9: _____

Dosage: _____ Frequency: _____ Administered: _____

10: _____

Dosage: _____ Frequency: _____ Administered: _____