ORTHOSPORT PHYSICAL THERAPY
AND
SPORTS PERFORMANCE

X_____ **CONSENT FOR TREATMENT**

INITIAL HERE I acknowledge that my consent to receive treatment was voluntary and obtained prior to my initial evaluation that will be performed for the determination of the appropriateness of my plan of care/treatment program. I understand that the practice of medicine is not an exact science; therefore, no guarantees or promises have been made to me concerning the results of my treatment and care by this health care provider. I understand that I can terminate treatment at any time if I choose.

X_____ **AUTHORIZATION TO RELEASE INFORMATION**

INITIAL HERE I authorize Orthosport Physical Therapy and Sports Performance, INC to release to representatives of local, state or federal agencies, my health care coverage carrier, or designated representative, or any other person financially responsible for my care any and all information regarding my diagnosis(es) and treatment as may be necessary for payment of my medical claim for this visit This release also allows information to be released for utilization management and financial audits. I further authorize this health care provider to release such information and made such reports regarding my health care status as may be required by law or regulation, including without limitation, the requirements of the State Medical Device Act.

X_____ **FINANCIAL AGREEMENT & NOTICE OF ASSIGNMENT**

INITIAL HERE I hereby guarantee payment of all charges incurred. I hereby assign any sick or injury benefits due to a liability of a third party, payable by any party, organization, etc. to Orthosport Physical Therapy and Sports Performance, INC. unless I pay all charges incurred in full at time of treatment. I hereby consent to Orthosport Physical Therapy and Sports Performance, INC to endorse for me any check made payable to me for benefits or claims collected under the above assignment.

X_____ **HOME HEALTH CONSOLIDATION NOTICE** ***(Medicare beneficiary's only)***

INITIAL HERE I understand Medicare WILL NOT reimburse Orthosport Physical Therapy and Sports Performance, Inc for any charges incurred if I am currently receiving treatments through a Home Health Care Agency. I acknowledge I will be responsible for any denied claims.

X_____ **HIPPA NOTICE RECEIPT ACKNOWLEDGEMENT**

INITIAL HERE I acknowledge that I have read the Notice of Privacy Practices from Orthosport Physical Therapy and Sports Performance, Inc. and may request a personal copy at anytime.

_____ _____

Patient/Personal Rep Signature Date

_____ _____

Orthosport Staff Signature Date

MEDICAL SUMMARY- Please fill out completely

CURRENT CONDITION

What body part/s are you being seen for today?_____

Date of onset-symptoms/injury_____ Date of surgery_____

Is this due to an injury? NO___ YES___ choose one: WORK___ AUTO___state___ OTHER____

How did it happen:_____

Are you or will you be seeking representation by an attorney?
NO___ YES___ Atty name_____ Ph:_____

Have you already had physical therapy treatments in the past for this condition/injury?
NO___ YES___ explain where and when_____

MEDICAL HISTORY – Please check if YOU have had any of the following

YES	NO		YES	NO		YES	NO	
___	___	angina	___	___	deep vein thrombosis	___	___	neck injury
___	___	arthritis	___	___	diabetes	___	___	neuropathy/numbness
___	___	asthma	___	___	fainting	___	___	pacemaker
___	___	back injury	___	___	ganglion cyst	___	___	Parkinson's disease
___	___	cardiac arrest	___	___	GI bleed	___	___	polio
___	___	cardiac arrhythmia	___	___	gout	___	___	seizure disorders
___	___	carpal tunnel syndrome	___	___	HIV/AIDS	___	___	shoulder inj Lt / Rt
___	___	chronic heart disease	___	___	hypertension	___	___	sleep apnea
___	___	concussion	___	___	incontinence	___	___	stroke
___	___	COPD	___	___	knee injury Lt / Rt	___	___	thyroid disorder

___ Other: please list_____

Are you currently taking any medication? (include prescription and over the counter)
NO___ YES___ please list_____

Do you have any allergies? NO___ YES___ please list_____

Have you had ANY surgeries/procedures? NO___ YES___ If yes, please list
_____ Date_____ _____ Date_____
_____ Date_____ _____ Date_____

Do you currently smoke? NO YES - # of packs per day____ # of years_____
Did you previously smoke? NO YES - # of packs per day____ when did you quit?_____
Do you consume alcohol? NO YES - # of drinks per week_____
Do you have a history of substance abuse? NO YES - explain_____

MEDICARE PATIENTS ONLY:
Are you currently under the care of a Home Healthcare Agency for any reason? NO___ YES___

PATIENT LABEL

Orthosport Physical Therapy
and
Sports Performance, Inc.

OrthoSport Physical Therapy and Sports Performance, Inc.

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

OrthoSport Physical Therapy and Sports Performance, Inc. is committed to protecting your privacy and understands the importance of safeguarding your personal health information. We are required by applicable federal and state law to maintain the privacy of medical information that identifies you or that could be used to identify you (known as PHI-Protected Health Information). We are also required to provide you with this notice about our privacy practices, our legal duties, and your rights with respect to your Protected Health Information that we collect, create and maintain. We are required by federal and state law to abide by this notice. However, we reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law and make the new terms of our notice effective for all Protected Health Information that we maintain, including medical information we created or received before we made the changes. Should we make a change in our privacy practices, we will display the revised Notice and make it available to you upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosure of Protected Health Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your PHI to treat you or disclose your PHI to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose you PHI to obtain payment for services we provide to you.

Appointment Reminders: We may use your PHI to contact you to provide appointment reminders or to follow up with you in the event there is an absence in treatment.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Operations which include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You and on Your Authorization: You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

To Your Family and Friends: We must disclose your PHI to you as described in the Individual Rights section of this notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose your PHI to notify, or assist in the notification of (including identifying of locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose your PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your health care.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Research: We may use or disclose your PHI for research purposes in limited circumstances.

Death; Organ Donation: We may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is otherwise required by state or federal law.

Law Enforcement: We may use or disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your PHI to law enforcement officials. We may disclose limited information to a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

National Security: We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement having lawful custody of PHI of inmate or individual under certain circumstances.

YOUR RIGHTS

Access: You have the right to inspect and obtain copies of your PHI, with limited exceptions. If you would like to see or copy your PHI, we are required to provide you access to your PHI for inspection and copies within 30 days after receipt of your written request. (60 days if your PHI is stored off-site). **To obtain access to your PHI, you must submit a request in writing by completing a PHI access form or by sending us a letter. Refer to the contact information at the end of this notice. You will be charged at a rate of $0.60 for each page plus postage if you request the copies be mailed to you.**

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). **{Any agreement we make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.}**

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your PHI for purposes, other than treatment, payment, health care operations or pursuant to an authorization and certain other activities, since April 14th, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. **{Your request must be in writing and must state that the information could endanger you if it is not communicated by the alternative means or the alternative location you want.}** We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your PHI. **{Your request must be in writing, and must include explain why the information should be amended.}**
We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

QUESTIONS AND COMPLAINTS

If you would like additional information about our privacy practices contact our practice's Privacy Officer, Ellen Morgan, at (702) 892-9077.

If you believe your privacy rights have been violated, you may file a complaint with either our practice or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). You have the right to report such alleged violations and we will promptly investigate the matter.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Ellen Morgan – Office Manager
Address: 2800 E Desert Inn Rd Suite 200,
Las Vegas, Nevada 89121
Phone: (702) 892-9077 Fax: (702) 892-9044

This notice is effective on April 14, 2003.