KConway Physical Therapy, Inc.

Welcome to KConway Physical Therapy, Inc.

Thank you for choosing KConway to provide your physical therapy care. In today's world, we recognize you have a lot of choices when it comes to your healthcare, and we appreciate that you chose us! We welcome you to our practice and we're very glad you're here!

KConway has worked hard to earn a reputation of being one of the best physical therapy practices in our community. Assisting you to quickly reach your goals and maintain a sense of well-being is our top priority. We take pride in partnering with our patients to ensure the best possible outcome:

As your partner, you can expect us to:

- ✓ Verify and manage as much of your health insurance requirements as permitted, for your convenience;
- ✓ Dedicate an exclusive appointment time to provide professional, one-on-one physical therapy care tailored specifically for you;
- ✓ Start your treatment promptly within minutes of your arrival and not keep you waiting;
- ✓ Attentively listen to your rehabilitation concerns and provide realistic solutions;
- ✓ Follow-up with you after your first treatment to see how you're feeling and to guarantee your questions or concerns have all been answered; and
- ✓ Stay focused on your needs throughout treatment to ensure the best possible outcome.

As our partner, we expect you to:

- ✓ Arrive for your appointment on time and ready for treatment;
- ✓ Provide all necessary insurance information, prescriptions, or referrals, as needed;
- ✓ Always ask or tell us if you have any questions or concerns about your treatment;
- ✓ Always communicate to us anything we can be doing to make your outcome more successful or comfortable for you;
- ✓ Adhere to your home exercise and care plan;
- ✓ Promptly pay any copays, coinsurances, or deductibles on your account; and
- ✓ Alert us at least 24 hours prior to any appointment when you need to reschedule, in order to avoid an automatic $45 late-cancellation or missed-appointment fee.

If you have any questions, concerns, or suggestions, please call our Office Administrator, Megan Foscue, at 410-535-9850 or email at megan.foscue@kconwaypt.com. We sincerely look forward to helping you heal and to achieve and maintain your wellness goals!

The KConway Team

MEDICAL HISTORY

Name:_____ Date of Birth:_____

Please check "past" if the condition has occurred in the past and/or "current", if you are currently experiencing any of these conditions:

Past	Current		Past	Current	
○	○	Neck Pain	○	○	High Blood Pressure
○	○	Upper Back Pain	○	○	Cardiac Problems
○	○	Mid Back Pain	○	○	Pacemaker
○	○	Low Back Pain	○	○	Stroke
○	○	Shoulder Pain	○	○	Angina
○	○	Elbow/ Upper Arm Pain	○	○	Seizures
○	○	Wrist Pain	○	○	Changes in Bladder Function
○	○	Hand Pain	○	○	Changes in Bowel Function
○	○	Hip/Upper Leg Pain	○	○	Changes in your Vision
○	○	Knee Lower Leg Pain	○	○	Osteoporosis
○	○	Ankle/Foot Pain	○	○	Diabetes
○	○	Headaches	○	○	Cancer
○	○	Joint Swelling/Stiffness	○	○	Use of assistive device (cane, walker, etc.)
○	○	Arthritis	○	○	Allergies
○	○	Shortness of Breath	○	○	Use of Tobacco
○	○	General Fatigue	○	○	Use of Alcohol
○	○	Dizziness	○	○	Dermatitis
○	○	Loss of Balance	○	○	Depression

Any other additional information you would like to inform us about? _____

_____

List all past surgeries and give brief details for each: _____

_____

List all medications you are currently taking (over-the-counter, prescription, supplements, etc.): _____

_____

Describe your overall activity level (circle one):

Sedentary Light Moderate Heavy Very Heavy

List any sports, exercise or activities you participate in (Type, Frequency, Duration): _____

_____

Patient Signature:_____ ***Date:*** _____

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Describe your symptoms: _____

When and how did this problem begin? _____

What makes your symptoms/pain worse? _____

What makes your symptoms/ pain better? _____

How often do you experience your symptoms?

- ○ Continually (9-10 or most of the day)
- ○ Regularly (8-6 or at times throughout the day)
- ○ Periodically (5-3 or once/twice a day)
- ○ Sporadically (2-0 or once in awhile)

When are your symptoms worse?

- ○ Morning
- ○ Afternoon
- ○ Evening
- ○ Inconsistent

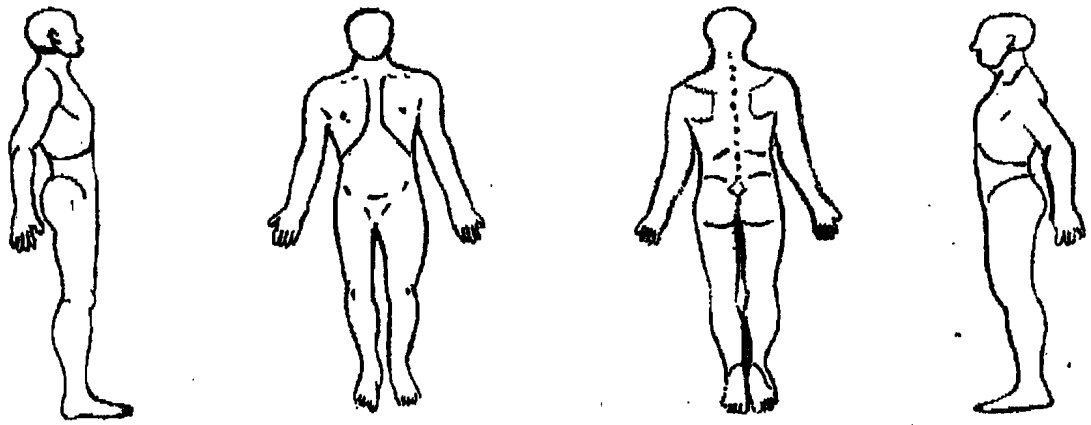
Indicate the nature of your pain and symptoms:

- ○ Sharp
- ○ Dull
- ○ Shooting
- ○ Numb
- ○ Aching
- ○ Tingling
- ○ Burning

Are your symptoms:

- ○ Improving
- ○ Stable
- ○ Worse

Indicate where you have pain/symptoms on the body charts with an **X**:



Rate your pain from 0-10 (0=no pain, 10=excruciating pain) for the following:

Worst it has been: _____ Past 2-4 weeks: _____ Past 24 hours: _____ At this moment: _____

How has this problem affected your daily life or routine?

- ○ During none of my activities
- ○ During some of my activities
- ○ During most of my activities
- ○ During all of my activities

If you have experienced similar episodes of this current problem, who did you see for it?

- ○ Physical Therapist
- ○ Acupuncture
- ○ Medical Doctor
- ○ Massage Therapist
- ○ Chiropractor
- ○ Ignored It
- ○ Other: _____
- ○ Outcome: _____

List any special tests for this condition (MRI, X-rays, etc.) _____ Date of test: _____

Please indicate the results: _____

Please List Two Goals of Physical Therapy with Time Frames:

1) _____

2) _____

Patient Signature: _____ ***Date:*** _____

Media & Marketing Survey Questions

Patient's Name: _____ Date: _____

Please circle all that apply.

1. How did you hear about us?

   a. Television
   b. Radio
   c. Newspaper
   d. Direct Mail
   e. Internet
      i. Google
      ii. Website
      iii. Facebook
   f. Friend(s)/Family
   g. Doctor's Office
   h. Law Office
   i. Insurance Company
   j. Passing By
   k. Returning Patient
   l. Community event
   m. Billboard
   n. Road Signs
   o. E-mail blasts

2. Where have you been exposed to our advertising?

   a. Television
   b. Radio
   c. Newspaper
   d. Direct Mail
   e. Internet
   f. Website
   g. Billboards
   h. Roadsigns
   i. None

3. Why did you select KConway Physical Therapy?

   a. Location
   b. Reputation
   c. Referral
   d. Good Past Experience

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I. YOUR PROTECTED HEALTH INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program requiring that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

The Practice (K Conway Physical Therapy, Inc.), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the Privacy Rule) and applicable state law, is committed to maintaining the privacy of your protected health information (PHI).

PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This notice explains how your PHI may be used and disclosed to third parties. This notice details your rights regarding your PHI.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. The general consent for release of PHI authorizes **KConway Physical Therapy, Inc.** to disclose the information in your medical record for treatment, payment, and health care operations purposes.

- **Treatment** Your information may be shared with family members, employees, contractors, and health care providers such as doctors, nurses, technicians, students, and other trainees who are treating you or consulting in your care. We may use a patient sign-in sheet in the waiting area which is accessible to all patients. We may use information about you to remind you of an appointment for treatment of medical care via phone call, voice message, text message, or email.

- **Payment** Your information may be shared with your insurer, attorney, or other third-party payer who is responsible for paying all or part of the cost of your care. Your information may also be shared with a collection agency for purposes of securing payment of a delinquent account.

- **Health Care Operations** We may use and disclose information that is necessary for our operations for the purpose of quality assurance and quality improvement activities, accreditation, licensing, training students, etc.

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under section A above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. For example, if we receive a subpoena for the records or if public responsibility requires disclosure (e.g. to protect public health). We will keep all disclosures of your medical records to the minimum necessary.

III. PATIENT PRIVACY RIGHTS

- You have the right to inspect and get a copy your PHI. There will be a fee for copying records. Workers' Comp. records may be provided to an attorney or the patient, upon request, at the conclusion of treatment. There will be a fee for copying records.

- If you feel that the health information we have about you is incomplete or inaccurate, you have the right to request an amendment to your PHI. The request must be made in writing with the reason that supports your request. If we do not agree with your request you have the right to ask that your statement be placed in the medical record.

- You have the right to find out how your PHI is used and to whom it is disclosed. You may request an accounting of your medical record disclosures made by us except for disclosures made for treatment, payment, and health care operations.

- You have the right to receive a paper copy of this notice.

IV. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time and to make new policies effective for all PHI that we maintain at the time of the change, including information that we created or received prior to the effective date of the change. We will post a copy of our current notice in our waiting area and also on our website. At any time, patients may review the current notice or request a paper copy at our front desk.

V. COMPLAINTS

We are required by law to maintain the privacy of your PHI. If you have a question or feel that we have violated your rights, you may contact our Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights at 200 Independence Avenue, S.W., Washington, D.C. 20201.*We will not retaliate in any way against a patient for making a complaint.*

I acknowledge that I have read and fully understand KConway Physical Therapy, Inc.'s Notice of Privacy Practices.

Patient/Representative Signature: _____ Date:_____

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement and understanding of KConway Physical Therapy, Inc.'s Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign

☐ Patient unable to sign

☐ Other _____

Employee Signature: _____ Date: _____