

General Information

Welcome to Foothills Physical Therapy and Sports Medicine center. We are committed to providing you with the best possible care, and we are pleased to discuss your Physical Therapy treatment with you at any time.

Our staff includes:

Teresa Johnston, Licensed Physical Therapist, Certified Athletic Trainer and Owner.

Amy Gregory, Licensed Doctor of Physical Therapy

La Dawn Wolfe, Licensed Physical Therapist Assistant and Certified Athletic Trainer

Cedric Thevenard, Licensed Physical Therapist Assistant

Bruce Whitehead, Licensed Physical Therapist Assistant

Debbie Wright, Receptionist, Technician

While your care may primarily be with one of the individuals listed above, it is possible that all may be involved in your Physical Therapy treatment. We also have part-time Physical Therapists, Physical Therapist Assistants, and rotating Physical Therapy Students that may assist in your care under the supervision of the Physical Therapists.

For your comfort, please dress in loose, comfortable clothes. You may be required to change into a clinical gown, depending upon what treatments you are to receive.

Please arrive for your therapy appointment promptly. If you arrive more than fifteen minutes late, you may be asked to reschedule your appointment. A courtesy call could possibly avoid a rescheduling necessity.

Please cancel appointments that you are unable to keep by phone. **IF WE DO NOT RECEIVE NOTIFICATION, YOU WILL BE CHARGED A \$20.00 FEE.** This fee will have to be paid before any further treatment will be rendered.

If you fail to call and cancel more than twice, we will cancel any additional appointments, and you will be billed for the \$20.00 fee. It will be necessary for you to call and reschedule if you desire further treatments. If you do not attend therapy, and your Doctors prescription expires (30 days), you will have to obtain a new prescription before we can commence treatments.

Please feel free to discuss your treatments or your concerns with your Physical Therapist. You have the right to refuse any treatment.

For the protection of everyone, we ask that if you bring family members or friends with you, please ask them to wait in the lobby. If it is necessary for someone to attend your treatments session with you, please discuss this with your Therapist,.

We appreciate your questions and comments. We also encourage feedback and input concerning your treatments. Our goal is to return you to the highest level of function possible.

Individual/Parent/Guardian/Next of
Kin

Date

PATIENT INFORMATION AND FINANCIAL AGREEMENT (PLEASE PRINT)

Foothills Physical Therapy & Sports Medicine Center
4011 Chapman Hwy Suite J Knoxville TN 37920 Phone 865-573-6458

Patient Name: First _____ MI _____ Last _____ SSN: _____

Birth Date (mm/dd/yyyy): ____/____/____ Sex: M / F Marital Status: Married [] Single [] Other: _____

Address: _____ City: _____ State: ____ Zip Code: _____

email _____ Home Ph _____ Work Ph _____ Cell: _____

Permanent Billing Address: First _____ MI _____ Last _____ Ph _____

Address: _____ City: _____ State: ____ Zip Code: _____

What is the date that your injury or condition began? We must have a specific date for your claims (mm/dd/yyyy) ____/____/____

Referring MD (who sent you here): _____ Primary Care MD _____ Ph _____

Would you like for us to send your Physical Therapy Evaluation to your Primary Care MD? [] Yes [] No

Date of your Last visit to your referring physician (mm/dd/yyyy) ____/____/____ Date of your Next MD scheduled visit: ____/____/____

Have you seen a chiropractor, or a speech, occupational or physical therapist in the last 12 months? [Yes] [No].

- o If yes, how many visits? []. Some insurance policies limit the maximum of visits covered per year.

Is the condition or injury that you seek treatment for related to?

Employment [yes] [no] Auto accident [yes] [no] Other accident [yes] [no] _____

Would you like for us to submit your claims to your: Health Insurance [] Workers Compensation [] Medicare Part B []

Auto Insurance [] Attorney [] Other: _____

If the primary health insurance subscriber is someone other than you, please supply the following information:

Subscriber Name: First _____ MI _____ Last _____ Relationship _____

DOB (mm/dd/yyyy): ____/____/____ If Legal Guardian, SSN _____ - _____ - _____ If Tricare, Sponsor ID#: _____ - _____ - _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Ph: _____ Work Ph _____ Cell _____

How Did You Hear About Us?

Physician [] Insurance Co [] Website [] Phone book [] Friend/ Family [] _____ Other _____

For Workers Compensation Claims only:

Employer: _____ BusinessPhone: _____ Supervisor _____

Case Manager's Name: _____ Phone _____

Past Medical History

Have you experienced any of the following?

Yes No

Orthopedic Surgery _____

Yes No

Heart Disease

Congestive Heart Failure (CHF)
 High Blood Pressure
 Heart Attack (Myocardial Infarction)(MI)
 Atherosclerotic Disease (CAD)
 Angioplasty

Yes No

Valvular Disease
 Stents
 Arrhythmia
 Coronary Artery Bypass
 Angina

Lung Disease

Chronic Obstructive Pulmonary Disease (COPD)
 Emphysema

Asthma
 Recent Pneumonia

Vascular Disease

Peripheral Arterial Disease
 Acquired Respiratory Distress Syndrome (ARDS)
 Diabetes
 Taking Blood Pressure Meds

Stroke/TIA
 Chronic Bronchitis
 Hypertension

General Medical Conditions

Arthritis (rheumatoid/osteoarthritis)
 Allergies
 Neurological Disease (such as MS or Parkinson's)
 Headaches
 Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
 Visual Impairment (such as cataracts, glaucoma, macular degeneration)
 Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
 Hepatitis/AIDS
 Prior Surgery(s)

Osteoporosis
 Anxiety or Panic Disorders
 Depression
 Previous Accidents
 Kidney, Bladder, Prostrate or Urination Problems
 Incontinence
 Hearing Impairment
 Sleep Dysfunction
 Prosthesis/Implants
 Cancer

Explain _____

Other Disorders _____

In Case of Emergency Contact:

_____ Relationship: _____

Home Phone: _____ Work Phone _____ Cell: _____

Signed _____

Date _____

Patient Health Questionnaire

Name _____ Age _____ Occupation _____

If you are a student are you employed: () full time () Part-time Job () Not employed

Job Duties _____

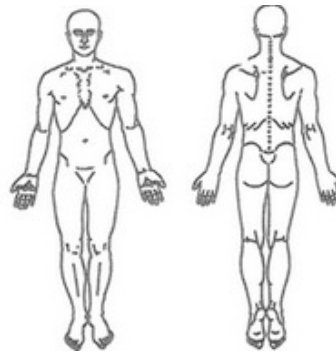
Describe the problem(s) for which you seek treatment _____

How did your symptoms begin _____

When did your symptoms start? _____

What describes the nature of your symptoms?

- () Sharp
- () Dull ache
- () Numb
- () Shooting
- () Burning
- () Tingling



How often do you experience your symptoms?

- () Constantly (76-100% of the day)
- () Frequently (51-75% of the day)
- () Occasionally (26-50% of the day)
- () Intermittently (0-25% of the day)

None

Unbearable

Indicate the average intensity of your symptoms: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Have you ever had this problem before? Yes ___ No ___. If yes, did it get better? Yes ___ No ___.

Briefly state previous treatment, if any: _____

Have you had any X-rays, CAT scans, MRIs, or other diagnostic tests for your recent injury? Yes ___ No ___. If yes, please explain the findings, as you understand them: _____

Please give us a complete list all the medicines that you currently or regularly take: _____

Current activity level (hobbies, sports, recreation, etc): _____

Activities wishing to return to: _____

Is there anything else you think I should know about your general health? Please explain and, if necessary, we can talk about it. _____

Foothills Physical Therapy & Sports Medicine Center

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date

Financial Policies

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. A clear understanding of our Financial Policy , and your responsibilities is important to our professional relationship.

When you arrive for your first visit, we will need to make a copy of your insurance card(s). We will contact your insurance company to determine if pre-certification is required , if we are in your insurance companies network, if your deductible has been met , and if a co-payment or coinsurance is required.

Medical Insurance Coverage

Insurance is a contract between you and your insurance company. As a courtesy to you, we will send your claims for physical therapy treatments to your insurance company. We will accept assignment of your insurance. However, your copay / coinsurance, any unpaid deductible, and any charges for services not covered by your insurance plan, are due at the time of service. Patient balances that are more than 30 days overdue may be referred to an outside collections company.

We will help you receive maximum benefits by providing factual information as necessary.

If we are not in your insurance company's network, acceptance of your insurance will be at our discretion. If it is acceptable, we will bill your insurance. Other arrangements may be worked out at our discretion.

If your insurance company has not paid their portion of your treatment charges within 60 days, you then may be billed. You will then have 30 days to pay the balance.

Worker's Compensation:

We will file worker's compensation claims and accept assignment of their payments. However, if your claim is denied by your worker's compensation carrier, you will be personally responsible for any and all charges. In that case, we will send you a statement and you will have 30 days to pay the balance in your account.

Minors:

Minor patients should be accompanied by an adult for at least their first visit. The accompanying adult (parent or guardian) should make arrangements for payment of the minor's treatments.

PAYMENT ASSIGNMENT

I hereby assign payments of benefits made on my behalf directly to Foothills Physical Therapy Center. This payment will not exceed the balance due of the clinic's regular charges for the professional services rendered, and I agree to pay any balance of said professional service charge over and above this insurance payment as agreed upon between myself and Foothills Physical Therapy Center management in compliance with the terms stated in the Financial Policies above.

I do hereby give my consent to and authorize Foothills Physical Therapy Center to release to my insurance company such information from my medical records as may be necessary for the completion and processing of my claim. Foothills Physical therapy Center is authorized to furnish this information even though the confidentiality of the information may be protected by Federal and State Laws and Regulations. Foothills Physical Therapy Center is hereby released and discharged of any liability.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment of my account for any professional services rendered. In the event that this account is referred to an outside collection agency, Credit Bureau, or attorney for collection I agree to pay the expenses incurred, according to the 1989 Statutes of the State of Tennessee.

I understand the above Financial Policies and agree to the terms herein.

Individual responsible for payment of charges

Date

Foothills Physical Therapy & Sports Medicine Center

NOTICE OF PATIENT INFORMATION PRACTICES Effective 06/28/2004

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Foothills Physical Therapy & Sports Medicine Center's LEGAL DUTY

Foothills Physical Therapy & Sports Medicine Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Foothills Physical Therapy & Sports Medicine Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, for treatment, we may use your personal health information to send medical information to the referring physician; for payment, we may send your chart notes to the insurance company; for healthcare operations, we may send charts to our physical therapy network for quality assurance review. Foothills Physical Therapy & Sports Medicine Center may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you.

Foothills Physical Therapy & Sports Medicine Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or for emergencies. We also provide information when required by law.

In any other situation, Foothills Physical Therapy & Sports Medicine Center's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Foothills Physical Therapy & Sports Medicine Center may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Foothills Physical Therapy & Sports Medicine Center will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Foothills Physical Therapy & Sports Medicine Center may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Foothills Physical Therapy & Sports Medicine Center's health information practices or if you have a complaint, please contact the following person:

Rod Johnston

4011 Chapman Highway Suite J, Knoxville, TN 37920

Telephone: 865-573-6458 Fax: 865-577-8147

Foothills Physical Therapy & Sports Medicine Center

PATIENT INFORMATION ACKNOWLEDGEMENT FORM Effective Date 06/28/04

I have read and fully understand Foothills Physical Therapy & Sports Medicine Center's Notice of Information Practices. I understand that Foothills Physical Therapy & Sports Medicine Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Foothills Physical Therapy & Sports Medicine Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Foothills Physical Therapy & Sports Medicine Center's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date