Kleinpeter
PHYSICAL THERAPY
EXPERT CARE WITH A PERSONAL TOUCH.

Today is your first appointment here at our clinic, and I hope your first experience meets or exceeds your expectations.

As Executive Director, I want you to know that your feedback is very important to me. Please save this cover letter so you can contact me directly with any suggestions, questions, concerns, or other comments.

Learning from your experience is an important part of our effort to make your experience here as good as possible.

Thank you for choosing Kleinpeter PT. Please feel free to contact me at karl@kleinpeterpt.com or call 225-658-7751.

Sincerely,

Karl Kleinpeter, PT, DPT

Executive Director

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Account #_____

PLEASE COMPLETE ALL FIELDS:

Patient Name: _____ Sex: **M** **F** Today's Date:_____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip:_____ SSN: _____

Home Ph: _____ Work Ph:_____ Cell Ph: _____

Employer: _____ Email: _____

Employer Address: _____

Spouse's Name (if appl.):_____ Cell Ph: _____

Spouse's Employer: _____ Work Ph: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Do you have a follow-up appointment scheduled with your referring physician? **Y** **N** Date: _____

Was this condition related to an accident or injury? **Y** **N** If so, what type? **Auto** **Work** **Other**

Date of injury: _____ Details: _____

Responsible Party: ☐ **Workman's Comp** ☐ **Auto Insurance** ☐ **Attorney** ☐ **Health Insurance**

Claim # _____ Contact Person: _____ Ph: _____

Primary Insurance:_____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Date of Birth: _____ Date of Birth: _____

Relationship to Patient: **Self** **Spouse** **Parent** Relationship to Patient: **Self** **Spouse** **Parent**

How did you hear about us?

☐ Physician ☐ Attorney ☐ Yellow Page Ad ☐ Brochure ☐ Newspaper Ad ☐ Insurance Company

☐ Friend/ Relative _____ ☐ Other _____

_____ _____

Signature of Patient or Guardian Date

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

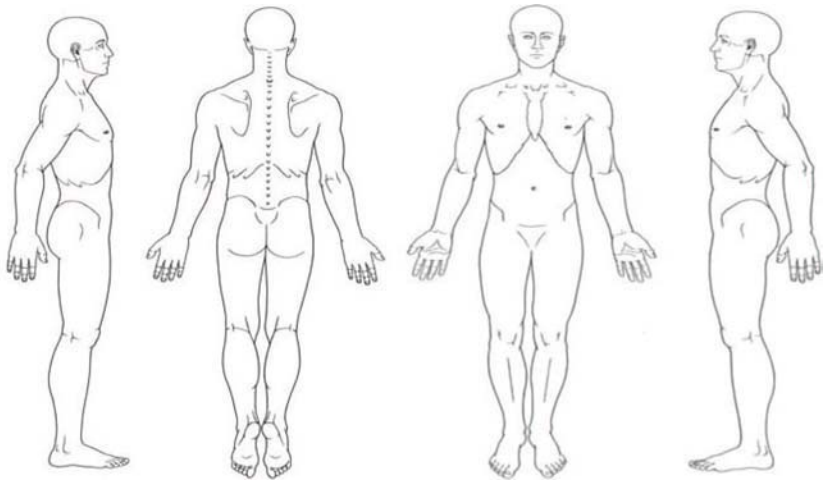
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

PATIENT MEDICAL HISTORY

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

Past	Present	Condition	Supporting Remarks / Dates
		Pregnant	
		Diabetes	
		Chest Pain / Agina	
		High Blood Pressure	
		Heart Disease	
		Pacemaker	
		Hernia	
		Headaches	
		Seizures	
		Metal Implants	
		Dizziness / Fainting	
		Cancer	
		Recent Fractures	
		Bowel / Bladder Abnormalities	
		Skin Abnormalities	
		Nausea / Vomiting	
		Ringing in your Ears	
		Rheumatoid Arthritis	
		Arthritis	
		Stroke	
		Asthma	
		HIV / AIDS	
		Tumor	
		Systemic Lupus	
		Hepatitis	
		Epilepsy	
		Latex Allergies	
		Other Allergies: _____	
		Tobacco - Packs a Day: _____	
		Drug or Alcohol Dependency	
		Other: _____	

Hospitalization / Surgical Procedures (List If not described elsewhere)_____

_____

Medications:_____

_____

_____ _____

Patient's Signature *Date*

Kleinpeter
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Appointment Policy

Welcome and thank you for choosing Kleinpeter Physical Therapy. The rehabilitation program that you are starting has been designed specifically for you. Our professional staff is committed to working with you to achieve your goals and to help you return to a fully productive and independent lifestyle.

The rehabilitation program takes a great degree of discipline and commitment to achieve your goal**. Consistent and timely attendance to your scheduled therapy sessions is vital to accomplishing your desired results and returning you to your daily activities as quickly as possible. Missing appointments may adversely affect your recovery and result in a longer duration of care, poor outcomes, and a delayed return to your daily activities.**

Please keep in mind, our cancellation policy is as follows **"You must give 24 hours notice of any cancellations. A series of 3 cancellations during your plan of care period or as few as 1 "no show" may result in immediate discontinuation of services. At this point, we will notify your physician of discharge due to noncompliance and a new prescription will be required to resume therapy".**

The staff at Kleinpeter Physical Therapy is committed to helping you achieve optimal results, but this can only occur with dedication to your own rehabilitative success.

Zachary Location Office Hours:
7:00 AM to 6:00 PM Monday through Thursday
7:00 AM to 12:00 PM Friday
Phone #225-658-7751

Baton Rouge Location Office Hours:
7:30 AM to 5:30 PM Monday through Thursday
7:30 AM to 12:00 PM Friday
225-768-7676

HEALTH INFORMATION PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Document Carefully.

1. About Protected Health Information (PHI).

   In this Notice, "we", "our" or "us" means this FACILITY and our workforce of employees, contractors and volunteers. "you" and "your" refers to each of our patients who are entitled to a copy of this Notice.

   We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information we call this Protected Health Information---or "PHI". In this Notice, we tell you about:

   - How we use your PHI
   - When we may disclose your PHI to others
   - Your privacy rights and how to use them
   - Our privacy duties
   - Who to contact for more information or a complaint

2. Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

   We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

Cont. 2. Uses and Disclosures

- Treatment

  We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optical care is rendered.

- Payment

  After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payor may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

- Health Care Operations

  We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of real patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

- Special Uses

  We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

  i. Remind you of appointments
  ii. Carry out follow ups on home programs that you have been taught
  iii. Advise you of new or updated services or home supplies

Cont 2. Uses and Disclosures

- Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

i. If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
ii. We may use your PHI in an emergency if you are not able to express yourself
iii. If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research

Required:

i. When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
ii. For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
iii. To report neglect, abuse or domestic violence
iv. To the government regulators or its agents to determine whether we comply with applicable rules and regulations
v. In judicial or administrative proceedings such as a response to a valid subpoena
vi. When properly requested by law enforcement officials or other legal requirements such as reporting gun shot wounds
vii. To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
viii. Deemed necessary by appropriate military command authorities if you are in the Armed Forces
ix. In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

We will follow any and all State regulations should they be stricter than these federal privacy regulations

3. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to

give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication
  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing
- Your Right to Inspect and Copy
  You have the right to inspect and copy your PHI. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record

Cont. 4 Your Privacy Rights and How To Exercise Them

- Your Right to Know Who Else Sees your PHI
  You have the right to request an accounting of certain disclosure that we have made over the past six years; however you may not ask for disclosures that occurred prior to April 14, 2003. We do not

have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually, we have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.

- Your Right to Complain
  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint with us please contact the person identified below in this Notice. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

5. Some of Our Privacy Obligations and How We Perform Them

   We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you Notice of our Privacy Practices. This document is our Notice. If you did not get a paper copy of this Notice, you may request one. We will abide by the privacy practices set forth in this Notice. However, we reserve the right to change this Notice and our Privacy Practices when permitted or required by law.

   If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

6. Contact Information

   If you have questions about this Notice, or if you have a complaint or concern, please contact:

   Name: Leah Beyl, Administrator
   Kleinpeter Physical Therapy
   1219 Church Street
   Zachary, LA 70791
   Phone 225-658-7751

7. Effective Date: This notice takes effect on April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Kleinpeter Physical Therapy, LLC. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Kleinpeter Physical Therapy, LLC, to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature