"You'll Make PROGRESS Everyday"

Welcome to our practice and thank you for choosing Progress Physical Therapy. Your quality of life is important to us. Your ability to do the things you want and need to do, whether it is at work or play, is our concern. We provide the highest level of rehabilitative care. The primary goal is to return you to the lifestyle you are accustomed to as quickly and safely as possible. Our mission is to accomplish this in a way that fits in with your busy life.

Progress Physical Therapy is a premier provider of outpatient therapy services in the region. We understand that the quality of our patient's lives depends on our commitment to service and clinical excellence. We are staffed by more than 60 professionals possessing over a combined 300 years of clinical experience specializing in physical, occupational, aquatic, hand, and other therapies. Many of our therapists hold advanced degrees and specialist certifications keeping us on the forefront of cutting-edge treatment and providing you with the latest care techniques in a friendly inviting atmosphere. Our professional staff is community-based, as we practice where we live and see our work as an integral part of giving back to our communities.

On your first visit, your physical therapist will perform an examination/evaluation to determine what deficits and/or problems you have that can be addressed in therapy. The examination/evaluation involves a thorough history, a physical assessment, and tests and measures that allow the therapist to get a more specific understanding of your condition. Your therapist will make a clinical judgment as to an appropriate treatment program that will be customized to your individual condition. Your program will be designed to address problems identified and achieve the goals you established during your initial consultation.

The treatments you receive will depend on what the physical therapist finds in the examination/evaluation. Our treatment programs include coordination among all individuals involved in your care including your physician, rehab nurse, case manager, or other healthcare provider. Detailed communication is necessary to ensure a good exchange of information, thorough documentation of the care and services provided, and instruction to you and others involved in your care to promote and optimize your health.

We would like to thank you for choosing Progress Physical Therapy for your rehabilitation needs. We sincerely appreciate your patronage. We take the responsibility and trust you have placed in our organization very seriously. **Please read and sign this notification prior to your initial evaluation. Your therapist will also review this information with you during your initial appointment and answer any questions you may have about our scheduling process.**

To facilitate the most effective and successful start to your treatment program, we would like to give you some important scheduling information prior to your initial appointment.

Your physician has referred or recommended that you be evaluated and treated by a Physical and/or Occupational Therapist. This referral or prescription for treatment will often include a recommended frequency and duration for our services. If a frequency and duration has not been specified by your physician your therapist will determine an appropriate frequency and duration during your initial evaluation.

Your treatment will be professionally monitored and may be progressed, modified, or discontinued during any of your weekly visits to our facility. **Therefore, it is imperative that you attend all of your scheduled appointments.**

We are committed to offering our patients a practical and flexible appointment schedule. **If for any reason you must cancel an appointment, please call prior to that time** and we will reschedule your appointment for a different time or day during the same week.

Your therapist is required to maintain contact with your physician and/or insurance carrier on a regular basis. Your treatment progress will therefore be continually monitored and evaluated. This again requires your regular attendance for your appointments.

Your therapist will develop a home activity program for your performance on days you are not attending therapy. Your compliance with this activity program and professional instruction is critical for your success in treatment.

I hereby have read, reviewed, and understand the Patient Compliance Information Sheet. This information has subsequently been reviewed with my evaluating therapist.

______________________________ ______________________________

Patient Signature / Date Therapist's Signature / Date

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: ________________________________ Occupation: _____________________________

Height: ____________ Weight: ___________ Age: ______________ Gender: ____________

Leisure Activities: ____

Allergies: List any medications you are allergic to: _______________________________________

Are you latex sensitive? Yes No List any allergies we should know about: _________________

Have you declared the Advanced Clinical Directive or a DNR? YES NO

Please check any of the following whose care you are under:

__Medical Doctor __Psychiatrist/Psychologist __Neurologist __Osteopath __Physical Therapist
__Pain Management __Dentist __Chiropractor Other______________

If you have seen any of the above in the past three months, please describe for what reason (illness, medical condition, physical, etc.)

____

____

Have you had any in-home physical, occupational, or speech language therapy this year? YES NO

Have you had any outpatient physical, occupation, or speech language therapy this year? YES NO

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer, if YES, describe: ____
YES NO Heart Problems, if YES, describe: ______________________________________

YES	NO	High Blood Pressure	YES	NO	Multiple Sclerosis
YES	NO	Circulation Problems	YES	NO	Rheumatoid Arthritis
YES	NO	Asthma	YES	NO	Other Arthritic Conditions
YES	NO	Emphysema/Bronchitis	YES	NO	Depression
YES	NO	Chemical Dependency (i.e., alcoholism)	YES	NO	Hepatitis
YES	NO	Thyroid Problems	YES	NO	Tuberculosis
YES	NO	Diabetes	YES	NO	Stroke

Therapist Initials: _______

YES NO Kidney Disease
YES NO Anemia
YES NO Epilepsy
YES NO Other ____________________________________

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

Recently have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home or has anyone hit or tried to injure you in any way? YES NO

WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	REASON FOR HOSPITALIZATION/SURGERY
1. ________________	____
2. ________________	____
3. ________________	____
4. ________________	____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, and sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_________	__________________	__________	____________________
_________	__________________	__________	____________________
_________	__________________	__________	____________________

Has anyone in your immediate family (parents or siblings) ever been treated for the following:

YES	NO	Diabetes	YES	NO	Cancer	YES	NO	Tuberculosis
YES	NO	Arthritis	YES	NO	Heart Disease	YES	NO	Anemia
YES	NO	High Blood Pressure	YES	NO	Headaches	YES	NO	Stroke
YES	NO	Epilepsy	YES	NO	Kidney Disease	YES	NO	Alcoholism
YES	NO	Mental Illness						

Which of the following OVER-THE-COUNTER medications have you taken in the past week? (Circle all that apply)

Aspirin Advil/Motrin/Ibuprofen Vitamins/Minerals/Supplements Decongestants
Antacids Tylenol Laxatives Antihistamines
Other ______________________________________

Therapist Initials: _______

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches)

1. ________________________________ 4. ____________________________________
2. ________________________________ 5. ____________________________________
3. ________________________________ 6. ____________________________________

How many caffeinated coffee or caffeine containing beverages do you drink daily? __________
How many packs of cigarettes do you smoke daily? ____________________
How many days per week do you drink alcohol? _____________________
If one drink equals one beer or glass of wine, how many do you drink at an average sitting? __________

Have you recently experienced any of the following symptoms:

YES NO Weight loss/gain
YES NO Nausea/Vomiting
YES NO Fatigue
YES NO Weakness
YES NO Fever/Chills/Sweats
YES NO Numbness or Tingling

Please indicate on the line your current pain level in relation to the two extremes:

Therapist Signature: _____________________________________ **Date**: ___________________

Patient Signature: _______________________________________ **Date**: ___________________

Therapist Initials: _______

PROGRESS PHYSICAL THERAPY

FINANCIAL RESPONSIBILITY

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PROGRESS PHYSICAL THERAPY, FOR PROFESSIONAL SERVICES RENDERED.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCCESS THIS CLAIM.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL OUTSTANDING BALANCES FOR TREATMENT RENDERED AT PROGRESS PHYSICAL THERAPY.

I AGREE TO SURRENDER ANY AND ALL PAYMENTS MADE TO ME PERSONALLY BY THE INSURANCE CARRIER FOR SERVICES PROVIDED TO PROGRESS PHYSICAL THERAPY.

PATIENT SIGNATURE: ____________________________________ DATE: _________________

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Progress Physical Therapy, LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: Progress Physical Therapy, LLC, 900 Sproul Road, Suite 104, Springfield, PA 19064, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):
   ____
   ____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

______________________________ ______________
Signature of Patient or Representative Date

____
Patient's Name

____
Date of Birth

____
Social Security Number

______________________________ ______________
Name of Personal Representative (if applicable) Relationship to Patient

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To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_________ Accepted _________ Denied _________ Not Applicable

_________Other (explain) ____

______________________________________ ______________
Signature of Authorized Practice Representative Date

9/23/2013

Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes Progress Physical Therapy, LLC (the "Practice") to obtain, use and disclose the personally identifiable health information specifically referenced in this Authorization.

Please read the following information carefully:

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information: Progress Physical Therapy, LLC
2. I authorize the following person(s) or class of persons to receive the information: ______________________________
3. The following is a description of the information that I authorize to be used and/or disclosed: ______________________________ ______________________________
4. The information will be used and/or disclosed only for the following purposes: ______________________________ ______________________________
5. I understand and acknowledge that if the person or entity that receives the information is not a health care provider, health plan, or other entity covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
6. **(If applicable)** I understand that the Practice will receive compensation for its use and/or disclosure of the information.
7. I understand and acknowledge that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that I may inspect or copy any information used and/or disclosed under this Authorization.
8. I understand and acknowledge that I may revoke this Authorization at any time by sending a written revocation to the Practice at the following address: 900 Sproul Road, Suite 104, Springfield, PA 19064, Attention: Compliance Officer. However, I also understand and acknowledge that if I revoke this Authorization, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Authorization.
9. This Authorization expires ______________________________ (insert applicable date or event).

I understand all of the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

______________________________ ______________________________
Signature of Patient or Representative Date

____
Patient's Name

____
Date of Birth

____
Social Security Number

______________________________ ______________________________
Name of Personal Representative (if applicable) Relationship to Patient

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A copy of the completed and signed Authorization form has been provided to the patient or representative:

________Yes ________No

______________________________ ______________________________
Signature of Authorized Practice Representative Date