Redbud Physical Therapy
www.redbudpt.com

Welcome to Redbud Physical Therapy. The purpose of this letter is to provide you with some helpful information to prepare you for your first visit to the facility.

Prior to your evaluation being scheduled your primary insurance will be verified and if necessary authorization obtained. If there is secondary insurance that also will require verification and authorization. It is suggested that you call the Member Service department at your insurance company and verify what your responsibilities may be regarding copays, deductibles, referrals, etc. Please remember that benefits quoted are not a guarantee of payment per your insurance.

When you arrive for the evaluation please come to the Reception Desk in the Outpatient area and have with you:

1. **The script from your physician to evaluate and treat**
2. Your insurance card.
3. Any copays or referrals as required by your insurance company.
4. Copy of driver's license of the parent or legal guardian.

Please have all of the above items with you when you arrive or it will be necessary to reschedule your appointment.

After the evaluation has been completed, the therapist will discuss with you a treatment program.

If you have any questions or I can be of any assistance to you please call me at 918-622-4126.

We look forward to seeing you.

Sincerely,

Redbud Physical Therapy

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Date:

Last Name: First Name: Social Security #:
Address: Apt/PO Box: Sex:
City: State: Zip: Date of Birth: Email Address:
Marital Status: Home Phone: Cell Phone:
Work Phone:

Emergency Contact

Last Name: First Name:
Emergency Contact Phone: Relationship:

Employer

Name: Address: Suite/Office Number:
Employment Status: City: State: Zip:
Employer Phone:

Referral Information

Problem:
Referred by: Date of Onset: Surgery Date: / /
Employment Related: Yes No Employer Name:
Auto Related: Yes No State Accident Occurred:
Primary Care Physician: Return to Dr: / /

Primary Insurance

Insurance: Group Number: ID Number:
Deductible: Copay: Claim Number:
Coinsurance: % Max Annual Benefit:
Subscriber Name:
Subscriber Date of Birth: Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Secondary Insurance

Insurance: Group Number: ID Number:
Deductible: Copay: Claim Number:
Coinsurance: Max Annual Benefit:
Subscriber Name: Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber Date of Birth:

Attorney Information

Attorney Name: Telephone:
Address: City: State: Zip:

Appointment Reminder: Complete this section and sign below to give your permission for Redbud Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message.

☐ may send email messages to confirm my upcoming appointments to:

☐ may send cell phone text messages to confirm my upcoming appointments to: _____ . ***Normal text messaging rates may apply.***

Cell phone carrier: _____*We cannot set your account up to send text message reminders without knowing your cell phone carrier.

1. What influenced your decision to come to Redbud Physical Therapy?
   Friend/Relative Radio TV Newspaper Phone Book Other: _____
2. Are you presently under the care of Home Health? Yes No
3. Are you under the age of 65, covered by Medicare and disabled? Yes No
4. Is this a Worker's Compensation claim? Yes No *Is this condition a result of a motor vehicle accident? Yes No
   If yes, do you have Med Pay coverage? Yes No Unknown
5. Have you had physical therapy prior to this? Yes No If yes, list dates: _____

Consent for treatment: I hereby consent to evaluation and subsequent patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient of Redbud Physical Therapy.

Authorization to discuss medical information with family or friends: Do you wish for us to verbally discuss your information with family members or friends? Yes No Please indicate below who you are authorizing us to speak with and what we may discuss. (i.e. Financial, Scheduling, Diagnosis &/or Treatment) *This authorization shall remain valid until revoked by me in writing.*

Name	Phone	Information to disclose	Relationship
Name	Phone	Information to disclose	Relationship

Authorization of release of information/assignment benefits: I hereby authorize Redbud Physical Therapy and its agents to furnish information it may have regarding my condition (treatment, diagnosis, prognosis, recommendation) to the insurance company or its representatives, my employer, my physician or my attorney upon their request during treatment and progress conferences. This authorization shall remain valid until revoked by me in writing.

Guaranty of account: I hereby authorize payment of medical benefits to Redbud Physical Therapy for services rendered and accept total responsibility for all services not paid in full by my insurance company or payer source. I understand that I am responsible for paying copays, deductible, and coinsurance at each service as applicable.

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices for Redbud Physical Rehabilitation, d/b/a Redbud Physical Therapy.

Home Health Attestation *(for Medicare patients only):* It is our desire that patients who receive care at Redbud Physical Therapy know what to expect in regard to their insurance coverage. The purpose of this letter is to inform you of Medicare coverage limitations when Home Health Services and Outpatient Physical Therapy are performed at the same time. *Please be aware that Medicare will not pay for outpatient physical therapy if someone is coming to your home to provide any kind of medical care of housekeeping.* For this reason, we ask that you acknowledge the following statements by initialing ***each item.***

1. _____ I am not currently receiving Home Health services.

2. _____ If any physician places me on Home Health during my care with Redbud Physical Therapy, I will notify Redbud Physical Therapy immediately.

3. _____ In the event that I do not make Redbud Physical Therapy aware that I am receiving Home Health services, I do accept financial responsibility for the services rendered.

Attendance Policy: I understand that attendance at all scheduled physical therapy appointments is vital to my rehabilitation. It is Redbud Physical Therapy's policy that my physician, case manager, insurance adjustor and employer, if applicable , may be notified regarding any no shows or unjustified cancellations. In addition, I also understand that a total of any combination of cancellations or no shows greater than three will serve as reason for discharge from physical therapy services, unless indicated by my physician.

Disclaimer: While Redbud Physical Therapy makes every effort to obtain correct information regarding copay, coinsurance and deductible, we cannot guarantee the information we receive from your insurance company to be completely accurate. I understand that Redbud Physical Therapy cannot be held responsible for information provided to them incorrectly from my insurance company. In addition, Redbud Physical Therapy does not assume responsibility for loss, damage or destruction of patient's personal property, including patient's vehicle. The patient specifically agrees to release, indemnify, and hold Redbud Physical Therapy harmless from and against any and all claims, demands, and/or causes of action of any and every nature related to or arising from any accident, casualty or event involving patient's property which may occur in, on or about Redbud Physical Therapy properties unless such claims shall be based on intentional, negligent or malicious acts by Redbud Physical Therapy or its employees.

Patient Signature & Date: _____ Parent or legal guardian signature & Date (if patient is a minor): _____

Guarantor of account for minor patient (please print): Legal Name: _____

Relationship to minor patient:_____ Date of Birth:_____Social Security Number:_____

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Please check ☒any of the following conditions that you have EVER been diagnosed as having:

☐ Anemia	☐ Diabetes	☐ Osteoporosis/Osteopenia
☐ Anxiety/ Panic Attacks	☐ Emphysema/Bronchitis	☐ Other Arthritic Conditions
☐ Asthma	☐ Fainting Disorders	☐ Pacemaker
☐ Bleeding/ Bruising	☐ Heart Problems	☐ Seizures
☐ Blood Disorders	☐ Hepatitis	☐ Shortness of Breath
☐ Cancer, if so what kind _____	☐ High Blood Pressure	☐ Spinal Cord Injury
☐ Chemical Dependency/Alcoholism	☐ High Cholesterol	☐ Stroke
☐ Chest pain, Angina, Heart Attack	☐ HIV/ AIDS	☐ Swelling of Extremities
☐ Circulation Problems	☐ Kidney Disease	☐ Thyroid Problems
☐ Concussion	☐ Light-Headedness	☐ Traumatic Brain Injury
☐ Depression	☐ Multiple Sclerosis/Parkinson's	☐ Tuberculosis

Please check ☒any of the following symptoms you have recently experienced:

☐ Accidents	☐ Do you cough or choke when you eat or drink?	☐ Fever/Chills/Night Sweats	☐ Numbness/Tingling
☐ Burning		☐ Nausea/Vomiting	☐ Unexplained Weight Loss
☐ Dizziness	☐ Fatigue	☐ Night Pain	☐ Weakness

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 surgery/hospitalization

Do you have allergies to medications? ☐ yes (please list) ☐ no _____
Do you have allergies to other substances? ☐ yes (please list) ☐ no _____
How many ounces of caffeinated beverages do you drink per day? _____
Do you use tobacco products? ☐ yes ☐ no
If so, what kind and how many per day? ☐ Cigarettes, day ☐ Cigars, day ☐ Smokeless, day
How many days per week do you drink alcohol? _____
If one beer or glass of wine equals one drink, how much do you drink at an average sitting? _____

Are you pregnant or think you might be pregnant? ☐Yes ☐No Due Date?_____

Fall Risk Assessment:			**Notes:**
Have you fallen more than two times in the past 12 months?	☐Yes	☐No	
Have you sustained an injury from a fall in the past 12 months?	☐Yes	☐No	
Do you experience dizziness or Vertigo?	☐Yes	☐No	
Are you afraid of falling?	☐Yes	☐No	
Do you have memory/cognitive difficulties?	☐Yes	☐No	
Do you use sedatives that affect your arousal during the day?	☐Yes	☐No	
Do you have a lower extremity disability that affects walking?	☐Yes	☐No	
Do you have vision problems that are not corrected by glasses?	☐Yes	☐No	
Have you recently felt unsteady on your feet, or in your wheelchair?	☐Yes	☐No	

Patient Signature: **Date:**

Relationship if other than patient/parent/guardian (if minor):

Medication List for
Date:

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

Patient Signature: ______________________________ Date: _____________

Reviewed by: _________________________________ 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 _____

_____

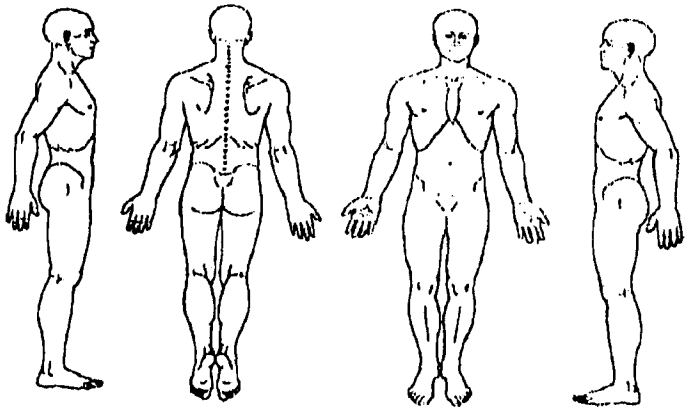
a. When did your symptoms start? _____

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

8. Who have you seen for your symptoms?

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

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 ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

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

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

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

Patient Signature _____ *Date* _____

OVER

11. What activities, positions, or movements make your symptoms worse?

12. What activities, positions, or movements help decrease your symptoms?

13. Please indicate any other past or current medical problems or injuries:

REDBUD PHYSICAL THERAPY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Uses and Disclosure

Treatment. Your health information may be used by staff members or disclosed to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the service provided, and the medical condition being treated. If you choose to pay cash for your health services, you have the right to request those services not be reported to your health plan.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Redbud Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information can be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on treatment and management of your medical condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and receive an electronic copy of your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed

Redbud Physical Therapy Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or the Privacy Officer.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Cynthia Hall, Privacy Officer
Redbud Physical Therapy
4812 E 33rd St
Tulsa, Oklahoma 74135

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact the Front Desk Staff person at your clinic location.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Cynthia Hall, Privacy Officer
Redbud Physical Therapy
4812 E 33rd St
Tulsa, Oklahoma 74135

Address for filing complaints with the U.S. Dept. of Health and Human Services

For complaints involving covered entities located in Arkansas, Louisiana, New Mexico, Oklahoma and Texas:

Office of Civil Rights, Region VI
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202

Voice phone	(214) 767-4056
FAX	(214) 767-0432
TDD	(214) 767-8940

For all complaints filed by e-mail send to: OCRComplaint@hss.gov

Effective Date
This notice is effective on or after March 26, 2013.