PACER PHYSICAL THERAPY, INC

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I have read and fully understand Pacer Physical Therapy's Notice of Patient Privacy Practices. I understand Pacer Physical Therapy 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 and payment. I understand that I have the right to request restrictions of how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Pacer Physical Therapy is not obligated to agree to my request.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Pacer Physical Therapy's Notice of Patient Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name (Please Print)

_____ _____
Signature Date

Relationship to Patient (if patient is a minor)_____

PATIENT INFORMATION CONSENT

I authorize Pacer Physical Therapy to use my health information to contact me with information regarding ***new services, treatment alternatives, and Pacer Physical Therapy's open house events.***

I understand that I have the right to revoke this authorization at any time, at which point I will no longer receive marketing information from Pacer Physical Therapy. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or health care operations.

_____
Patient Name (Please Print)

_____ _____
Signature Date

Relationship to patient (if patient is a minor) _____

PACER PHYSICAL THERAPY PATIENT INFORMATION

Last Name	First Name	MI	Birthdate	Age	Sex

Address	Street	City	State	Zip

Primary Phone: (____)_____ Is this phone ___ Home ___ Cellular ___ Work

Secondary Phone: (____)_____ Is this phone ___ Home ___ Cellular ___ Work

Email:_____ May we email appointment reminders? _____yes ____no

Do we have your permission to leave messages with information about your appointments or to return your call on your primary phone? _____yes _____no Secondary phone? _____yes _____no

Diagnosis_____ Referring Physician_____

Does injury involve ( ) Auto Accident ( ) Employment ( ) Litigation

Emergency Contact Name _____ Phone _____

Insurance Information

Primary Insurance_____ _____PPO ____HMO ____Other

Policyholder's Name: _____ Birthdate:_____

Policyholder's Address _____

Policyholder's Phone No. (_____)_____ Relationship to patient_____

Employment Information

Is employment information for _____ patient _____ spouse _____ parent _____ policyholder

Employer Name_____

Emp. Address_____City_____ State_____ Zip_____

Emp. Phone (_____)_____ Occupation_____

Worker Comp. Patients: Date of Injury _____ Claim #_____ Adjuster_____

Adjuster's Phone #_____ Insurance Co._____

Insurance Co. Address_____

Signed_____ **Relationship to Patient**_____ **Date:**_____

Rev 12/17

PACER
Physical Therapy Inc.

MEDICAL INFORMATION FORM

Name: _____ **Date:**_____

Referring Physician: _____ **Diagnosis:**_____

Date of Birth:_____

Age:_____ **Height:**_____ **Weight:**_____

Occupation:_____

Recreational Activities:_____

Have you had a fall within the last year? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No
Do you have a pacemaker? ❑ Yes ❑ No
Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

ALLERGIES (medications, latex etc…)_____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue
❑ fever/chills/sweats
❑ nausea/vomiting
❑ weight loss/gain
❑ difficulty maintaining balance while walking
❑ falls
❑ infection
❑ numbness or tingling
❑ muscle weakness
❑ dizziness/lightheadedness
❑ heartburn/indigestion
❑ difficulty swallowing
❑ changes in bowel or bladder function
❑ constipation
❑ diarrhea
❑ shortness of breath
❑ fainting
❑ cough
❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer
❑ heart problems
❑ chest pain/angina
❑ high blood pressure
❑ circulation problems
❑ blood clots
❑ stroke
❑ anemia
❑ bone or joint infection
❑ chemical dependency (i.e., alcoholism)
❑ depression
❑ lung problems
❑ tuberculosis
❑ asthma
❑ rheumatoid arthritis
❑ other arthritic condition
❑ bladder/urinary tract infection
❑ kidney problem/infection
❑ sexually transmitted disease/HIV
❑ pelvic inflammatory disease
❑ thyroid problems
❑ diabetes
❑ osteoporosis
❑ multiple sclerosis
❑ epilepsy
❑ eye problem/infection
❑ ulcers
❑ liver problems
❑ hepatitis
❑ pneumonia

During the past month have you been feeling down, depressed or hopeless? ❑ Yes ❑ No
During the past month have you been bothered by having little interest or pleasure in doing things? ❑ Yes ❑ No
Is this something with which you would like help? ❑ Yes ❑ Yes, but not today. ❑ No

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Please list any medications and dosages you are currently taking:

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? ❑ Yes ❑ No
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ❑ Yes ❑ No

Name:_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____

Special Tests (x-ray, MRI, labs, etc) _____

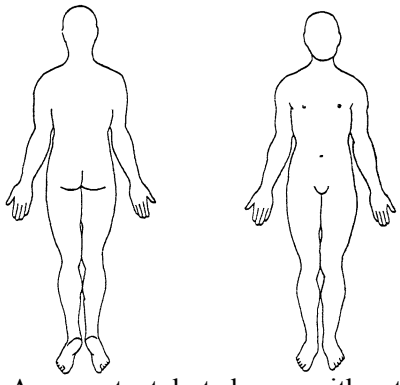
Have you ever had this problem before: ❑ Yes ❑ No

When_____ Treatment received_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you
feel your symptoms on the body chart:



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 activities or positions that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 activities or positions that make your symptoms better:
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

PACER PHYSICAL THERAPY POLICY INFORMATION

Welcome to PACER Physical Therapy. During your physical therapy sessions, we will evaluate, treat and continually monitor your progress. We will identify any and all procedures administered and teach you to be an active participant in your recovery. In order to provide you with the best possible care, it is important that you understand and follow our established office procedures.

Appointments:

To ensure we can provide the best care for all of our patients, we kindly ask that you let us know as soon as possible if you need to cancel or reschedule an appointment. If we receive less than 24 hours notice, a **$45 cancellation fee** may apply. After three (3) late cancellations or missed appointments, we may cancel any remaining scheduled visits and move you to same-day scheduling for any future appointments. We truly appreciate your understanding as this helps us stay on time and make appointments available for other patients who need care.

Payment Policy and Billing Procedures:

- Co-payments will be collected at time of service.
- Any deductibles, co-insurance, or services not covered by insurance, will be billed to the patient.
- A service charge of $40 will be assessed for all returned checks.

****Note: Patient account balance is due within 15 days of billing. A $5.00 rebilling fee will be assessed for each subsequent re-billing necessary to collect payment.**

I have read and agreed to the terms stated above. I authorize payment of benefits on my behalf be made to PACER Physical Therapy for services rendered. I authorize PACER Physical Therapy to release any medical information necessary to process insurance claims.

Signed: _____ Date: _____

Print Name: _____

(Rev 7/25)

PACER PHYSICAL THERAPY, INC.

NOTICE OF PATIENT PRIVACY PRACTICES

PACER PHYSICAL THERAPY'S LEGAL DUTY

Your privacy and personal health information is important to Pacer Physical Therapy and is protected by law. All of Pacer Physical Therapy's employees, officers, contractors, volunteers, and relevant business associates are required to follow the practices laid out in this notice. This notice is required to be made available to all patients. It is posted in the waiting room at all times and a copy is available to patients upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

- **Provide treatment & obtain payment:** information may be shared with our staff, volunteers, medical students, doctors, or other medical personnel, to provide quality treatment and billing. Information on your diagnosis, dates, and treatment shared with your insurance company to process claims and receive payment. Includes individuals involved in your care or responsible for payment for your care. We may release your medical information to a family member or other individual involved in your medical care. We may also give information to people who help pay for your care unless you request otherwise in writing.
- **For internal administrative activities:** conducting internal administrative activities and evaluating the quality of care that we provide, when working with relevant vendors or business associates (e.g. software updates, etc).
- **For appointment reminders:** we may contact you by phone or email to remind you of your appointment.
- **When required by law:** when required by Federal, state or local laws. Including court administrative orders for records for lawsuits and disputes, required reporting to the governmental health agencies, and information on suspected physical and/or sexual abuse including elder abuse.
- **Clinician Communication:** we may contact you to check in with you on your progress.
- **Marketing:** You may be contacted about treatment and health alternatives that may be of interest to you or to inform you of updates to our facility or new products and services offered. Pacer Physical Therapy will not sell your information. Selling protected health information requires your individual authorization and is not practiced by Pacer PT.
- **In an emergency:** in emergencies when needed to prevent a serious threat to your health or safety or the health and safety of other individuals. Disclosure would be confined to only those needing the information to prevent the threat.

In any other situation not described in this Notice, Pacer Physical Therapy must 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.

PATIENT'S INDIVIDUAL RIGHTS:

- You have the right to review or obtain a physical or digital copy of your personal health information at any time. There may be a fee for the costs of copying, mailing, and any other supplies associated with your request.
- You have the right to request that we correct any inaccurate or incomplete information in your records.
- You 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 request a restriction or limitation on the medical information we use or disclose about your treatment, payment or health care operations except when specifically authorized by you, when required by law or in emergency circumstances. Pacer Physical Therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.
- You also may request that we communicate with you about medical matters in a certain way or location such as by mail or on a certain phone number. We will try to accommodate all reasonable written requests.
- You have the right to restrict disclosures of Protected Health Information to health plans where you pay out of pocket in full for the healthcare item or service.
- Affected individuals will receive notification following a breach of unsecured Protected Health Information.

CHANGES TO THIS NOTICE: Pacer Physical Therapy may change its policy at any time. When changes are made, a new Notice of Patient Privacy Practices will be posted in the waiting room 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.

CONCERNS AND COMPLAINTS: If you have any questions about this notice or if you are concerned that Pacer Physical Therapy 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 or if you have a complaint, please contact the Business Manager at **(925) 930-6680.** You may also send a written complaint to the U.S. Department of Health and Human Services.