SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Apex Physical Therapy, PLLC

Effective Date: April 1, 2003

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

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Robert M. Paull, Privacy Officer at (509) 465-1749.

WHO WILL FOLLOW THIS NOTICE:

- Apex Physical Therapy, PLLC
- Apex Physical Therapy – North
- Apex Physical Therapy – Cheney
- Apex Physical Therapy – Airway Heights
- Apex Physical Therapy – Fairways Plaza

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you, and:
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Appointment Reminders**
- **Research**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Robert M. Paull, Privacy Officer at (509) 465-1749

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Robert M. Paull, Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

MEDICAL HISTORY SCREEN

Name:_____
LAST FIRST M.I.

Primary Care Provider: _____ **Referring Doctor (if other):** _____

CURRENT/CHIEF COMPLAINT

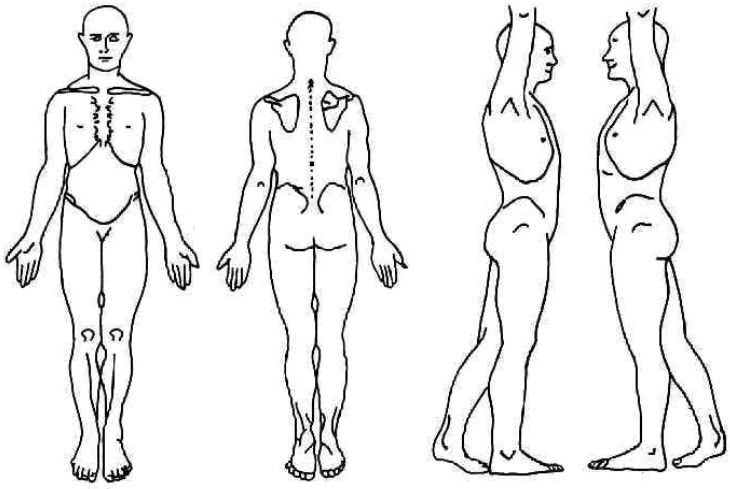
- Date when pain/injury began:
  MONTH DAY YEAR
  __ __ __ __ __ __ __ __
- How did you hurt yourself? _____
_____
_____
- Pertinent accidents or injuries and dates relating to this problem:_____
_____
- Have you had a similar problem to this in the past?
  □ Yes □ No
  If so, what? _____
- Did you seek physical therapy? □ Yes □ No
- Activities/ you are unable to do/Aggravating factors to pain (sit, stand, run, stairs):
_____
_____
- Easing factors to decrease pain _____
_____
- Next scheduled doctor recheck appointment
_____
- Personal Goals for Physical Therapy?
  1)_____
  2)_____
  3)_____

CURRENT TREATMENTS:

Have you or are you going to see any other healthcare providers for you current condition? Check all that apply:

□ Another physical therapist
□ Acupuncturist
□ Chiropractor
□ Dentist
□ Family Practitioner
□ Massage Therapist
□ Neurologist
□ Occupational therapist
□ Orthopedist
□ Osteopath
□ OB/Gyn
□ Podiatrist
□ Primary Care
□ Rheumatologist
□ Other:_____

- Please mark on the body chart below your area(s) of pain or discomfort.



- Have you, or are you currently experiencing any of the following problems? If so please check all that apply:

□ Difficulty Sleeping
□ Dropping items
□ Pain with coughing or sneezing
□ Bowel or bladder problems
□ Loss of consciousness/fainting
□ Hearing/Vision difficulties
□ Numbness around the groin or buttocks
□ Difficulty Swallowing
□ Loss of appetite
□ Numbness
□ Dizziness
□ Other (please specify)_____
□ Excessive weight gain/loss
□ Shortness of breath
□ Heart palpitations
□ Chest Pain
□ Night Pain
□ Nausea/Vomiting
□ Headaches
□ Fever/Sweats
□ Weakness (arms/leg)
□ Dislocating of Joints
□ Locking of Joints

- Does your PCP know about these complaints?
  □Yes □No
- Have you fallen in the last 12 months?
  □Yes □No

CURRENT/GENERAL HEALTH

- Overall Perceived Health

□ Excellent □ Good □ Fair □ Poor

- How often do you exercise?

□ >5x/week □ 3-4x/week □ <3x/week □ Rarely

- Do you smoke? □ Yes □ No

Estimated packs/day: _____

If not currently, quit date: _____

- Alcohol?

Days/week you drink _____

How many drinks/day _____

- Employment:

□ Full Time □ Student
□ Part Time □ Homemaker
□ Retired □ Unemployed

Occupation: _____

- ***YOUR* MEDICAL HISTORY** (check all that apply)

□ Arthritis □ Broken bones/Fractures
□ Osteoporosis □ Diabetes Type I__ II__
□ Cancer □ Heart/Lung Disorders
□ Allergies □ Muscular dystrophy
□ Asthma □ Epilepsy/Seizures
□ Depression □ Kidney difficulties
□ Vascular Issues □ High Blood Pressure
□ Thyroid □ Low blood sugar
□ Skin diseases □ Infectious diseases
□ Blood disorders □ Parkinson's Disease
□ Multiple Sclerosis
□Other (please specify) _____

- FEMALES: Are you or could you be pregnant?

□ Yes □ No

SURGICAL HISTORY

- Have you ever had surgery? □ Yes □ No

Applicable procedures and dates:

a)_____

b) _____

c)_____

- Do you require any special needs? If so, please specify:_____

_____

MEDICATIONS

- Please list all current medications you are taking:

□ Tylenol □ Ibuprofen
□ Pain Medication
Please specify:_____
□ Muscle Relaxant
Please specify:_____
□ Anti-inflammatory
Please specify:_____
□
Other:_____
_____
_____
_____
_____

- Please check all known clinical tests you have undergone in the past year for this condition.

□ Bone Scan □ Cardio/Respriatory Testing
□ MRI □ Neurologic Testing
□ X-rays □ Arthroscopy
□ Ultrasound □ Biopsy
□ Blood Tests □ Myelogram
□ CT Scan
□ Other (please specify): _____

- Have you experienced any difficulty/abnormal finding(s) over the past year that you may or may not associate with your current symptom(s) that you are concerned about?
- □ Yes □ No

Please specify:_____

Signature:_____ **Date:**_____