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

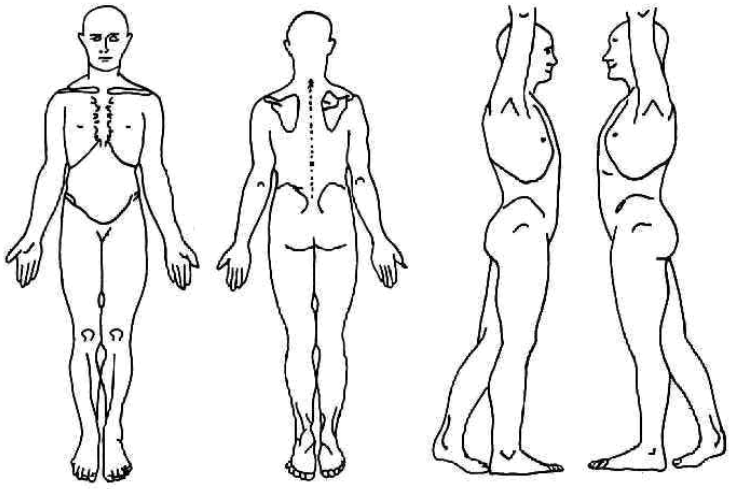
- Date when pain/injury began:
  MONTH DAY YEAR
  __ __ __ __ __ __ __ __
- How did you hurt yourself? _____
_____
_____
- Pertinent accidents or injuries and dates relating to this problem:_____
_____
- Have you had a similar problem to this in the past?
  □ Yes □ No
  If so, what? _____
- Did you seek 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:**_____

CARE CONNECTIONS

PATIENT WORKSHEET

NAME _____ DATE _____

TIME _____ AM/PM ❒ Initial Visit ❒ Discharge Visit

PROBLEM AREA (*Please check one*):

❒ Upper Extremity (A,D) ❒ Lower Extremity (B,F) ❒ Cervical/Thoracic (C,D) ❒ Lumbar (D,F) ❒ TMJ (C,E)

FUNCTIONAL INDEX

PART I: *Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.*

WALKING

❒ Symptoms do not prevent me walking any distance.
❒ Symptoms prevent me walking more than 1 mile.
❒ Symptoms prevent me walking more than 1/2 mile.
❒ Symptoms prevent me walking more than 1/4 mile.
❒ I can only walk using a stick or crutches.
❒ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

❒ I can do as much work as I want to.
❒ I can only do my usual work, but no more.
❒ I can do most of my usual work, but no more.
❒ I cannot do my usual work.
❒ I can hardly do any work at all (only light duty).
❒ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

❒ I can manage all personal care without symptoms.
❒ I can manage all personal care with some increased symptoms.
❒ Personal care requires slow, concise movements due to increased symptoms.
❒ I need help to manage some personal care.
❒ I need help to manage all personal care.
❒ I cannot manage any personal care.

SLEEPING

❒ I have no trouble sleeping.
❒ My sleep is mildly disturbed (less than 1 hr. sleepless).
❒ My sleep is mildly disturbed (1–2 hrs. sleepless).
❒ My sleep is moderately disturbed (2–3 hrs. sleepless).
❒ My sleep is greatly disturbed (3–5 hrs. sleepless).
❒ My sleep is completely disturbed (5–7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

❒ I am able to engage in all my recreational/sports activities without increased symptoms.
❒ I am able to engage in all my recreational/sports activities with some increased symptoms.
❒ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
❒ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
❒ I can hardly do any recreational/sports activities because of increased symptoms.
❒ I cannot do any recreational/sports activities at all.

ACUITY (*Answer on initial visit.*)

How many days ago did onset/injury occur? _____days

PART II: *Choose the one answer that best describes your condition in the sections designated by your therapist.*

■ A. UPPER EXTREMITY

CARRYING

❒ I can carry heavy loads without increased symptoms.
❒ I can carry heavy loads with some increased symptoms.
❒ I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
❒ I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
❒ I can carry very light weights with some increased symptoms.
❒ I cannot lift or carry anything at all.

DRESSING

❒ I can put on a shirt or blouse without symptoms.
❒ I can put on a shirt or blouse with some increased symptoms.
❒ It is painful to put on a shirt or blouse and I am slow and careful.
❒ I need some help but I manage most of my shirt or blouse dressing.
❒ I need help in most aspects of putting on my shirt or blouse.
❒ I cannot put on a shirt or blouse at all.

REACHING

❒ I can reach to a high shelf to place an empty cup without increased symptoms.
❒ I can reach to a high shelf to place an empty cup with some increased symptoms.
❒ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
❒ I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
❒ I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
❒ I cannot reach my hand above waist level without increased symptoms.

■ B. LOWER EXTREMITY

STAIRS

❒ I can walk stairs comfortably without a rail.
❒ I can walk stairs comfortably, but with a crutch, cane, or rail.
❒ I can walk more than 1 flight of stairs, but with increased symptoms.
❒ I can walk less than 1 flight of stairs.
❒ I can manage only a single step or curb.
❒ I am unable to manage even a step or curb.

UNEVEN GROUND

❒ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
❒ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
❒ I have to walk very carefully on uneven ground without using a cane or crutches.
❒ I have to walk very carefully on uneven ground even when using a cane or crutches.
❒ I have to walk very carefully on uneven ground and require physical assistance to manage it.
❒ I am unable to walk on uneven ground.

ID:_____ DOB:_____ INS:_____ Surgery: Y/N DR: _____ PT:_____ DX:_____

■ C. CERVICAL/TMJ

CONCENTRATION
- ❒ I can concentrate fully when I want to with no difficulty
- ❒ I can concentrate fully when I want to with slight difficulty.
- ❒ I have a fair degree of difficulty in concentrating when I want to.
- ❒ I have a lot of difficulty in concentrating when I want to.
- ❒ I have a great deal of difficulty in concentrating when I want to.
- ❒ I cannot concentrate at all.

HEADACHES
- ❒ I have no headaches at all.
- ❒ I have slight headaches which come less than 3 per week.
- ❒ I have moderate headaches which come infrequently.
- ❒ I have moderate headaches which come 4 or more per week.
- ❒ I have severe headaches which come frequently.
- ❒ I have headaches almost all of the time.

READING
- ❒ I can read as much as I want without increased symptoms.
- ❒ I can read as much as I want with slight symptoms.
- ❒ I can read as much as I want with moderate symptoms.
- ❒ I cannot read as much as I want because of moderate symptoms.
- ❒ I can hardly read at all because of severe symptoms.
- ❒ I cannot read at all.

■ D. LUMBAR*/CERVICAL/UPPER EXTREMITY

DRIVING
- ❒ I can drive my car or travel without any extra symptoms.
- ❒ I can drive my car or travel as long as I want with slight symptoms.
- ❒ I can drive my car or travel as long as I want with moderate symptoms.
- ❒ I cannot drive my car or travel as long as I want because of moderate symptoms.
- ❒ I can hardly drive at all or travel because of severe symptoms.
- ❒ I cannot drive my car or travel at all.

LIFTING
- ❒ I can lift heavy weights without extra symptoms.
- ❒ I can lift heavy weights but it gives extra symptoms.
- ❒ My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- ❒ My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
- ❒ I can lift only very light weights.
- ❒ I cannot lift or carry anything at all.

■ E. TMJ

TALKING
- ❒ I can talk without any increased symptoms.
- ❒ I can talk as long as I want with slight symptoms in my jaws.
- ❒ I can talk as long as I want with moderate symptoms in my jaws.
- ❒ I cannot talk as long as I want because of moderate symptoms in my jaws.
- ❒ I can hardly talk at all because of severe symptoms in my jaws.
- ❒ I cannot talk at all.

EATING
- ❒ I can eat whatever I want without symptoms.
- ❒ I can eat whatever I want but it gives extra symptoms.
- ❒ Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- ❒ Symptoms prevent me from chewing anything other than soft foods.
- ❒ I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- ❒ I cannot chew at all and maintain a liquid diet.

■ F. LUMBAR*/LOWER EXTREMITY

STANDING
- ❒ I can stand as long as I want without increased symptoms.
- ❒ I can stand as long as I want, but it gives me extra symptoms.
- ❒ Symptoms prevent me from standing for more than 1 hour.
- ❒ Symptoms prevent me from standing for more than 30 minutes.
- ❒ Symptoms prevent me from standing for more than 10 minutes.
- ❒ Symptoms prevent me from standing at all.

SQUATTING
- ❒ I can squat fully without the use of my arms for support.
- ❒ I can squat fully, but with symptoms or using my arms for support.
- ❒ I can squat 3/4 of my normal depth, but less than fully.
- ❒ I can squat 1/2 of my normal depth, but less than 3/4.
- ❒ I can squat 1/4 of my normal depth, but less than 1/2.
- ❒ I am unable to squat any distance due to symptoms.

SITTING
- ❒ I can sit in any chair as long as I like.
- ❒ I can only sit in my favorite chair as long as I like.
- ❒ My symptoms prevent me sitting more than 1 hour.
- ❒ My symptoms prevent me sitting more than 1/2 hour.
- ❒ My symptoms prevent me sitting more than 10 minutes.
- ❒ My symptoms prevent me from sitting at all.

** Lumbar questions adapted from Oswestry.*

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——————————— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)

-7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7

Very Much Worse — Unchanged — Completely Recovered

■ WORK STATUS *(check most appropriate)*

1. ❒ No lost work time
2. ❒ Return to work without restriction
3. ❒ Return to work with modification
4. ❒ Have not returned to work
5. ❒ Not employed outside the home

Work days lost due to condition:_____days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____