Client's Information:

Name____Birth Date ________ _____
Last First MI

____Male ___Female ___Married ___Spouses Name ______________________ ___Single ___Divorced ___Widowed

Address____ ________
Street City State Zip

Home Phone ________________Work ________________Cell ________________Social Security #_______ ________

Employer____________________________ Employer Address ____________________________

We send news, updates, info, and appointment reminders via email and sometimes text.
May we have your email address? ____________________________ AND your cell phone carrier________________

Emergency Contact______________________________ Relationship ____________________ _______

Home Phone ______________________ Work__________________ Cell ______________________

Primary Doctor ________________ Ph#___________ Referring Doctor __________________ Ph #___ _________

If client is a minor please fill in parent's information

Name____________________________________ ___________Birth Date ________ ____Male ___Female

Employer _______ ________________ Employer's Address____________________________

Name______________________________ ________________Birth Date ________ ____Male ___Female

Employer ______________________ Employer's Address____________________________

Insurance Info – Please COMPLETELY fill in the information below AND provide your insurance card to the front desk

Primary Ins Co ____________________ ID#______________________ Group __________________

Subscriber's Name __________________ _______________ SS#_________________Birth Date ______

Secondary Ins Co ____________________ ID#______________________ Group __________________

Subscriber's Name ________ _________________________ SS#_________________Birth Date ______

If you were involved in an accident please complete this section

Date of accident _______ __ Auto ____ Work ____ Other ____ City/State __________Claim# _________ Insurance Co ____________

Address _______________________ Adjuster __________________ Phone # __________

It is very important to keep your appointment time. If it is absolutely not possible, we ask that you give at least 24 hours advance notice so we can fill the slot that was reserved for you.

I hereby consent to treatment and authorize ACHIEVE to furnish my insurance companies with all information requested related to my injury. I authorize payment to be made directly to ACHIEVE by commercial or government insurance companies for treatment and supplies provided. I understand that I am financially responsible to ACHIEVE for all expenses incurred and that my insurance carrier may apply amounts to my deductible, co-pays, and/or co-insurance for which I will be billed and must pay to ACHIEVE. I further understand that payment is due at the time of service unless other arrangements have been made. If there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.

I verify the information is true and correct to the best of my knowledge.

Signature ______________________ **Printed Name**____ ____________________ **Date**____________
(If client is a minor a parent/guardian must sign)

Please tell us how you learned of our service or whom we can thank for referring you to us…

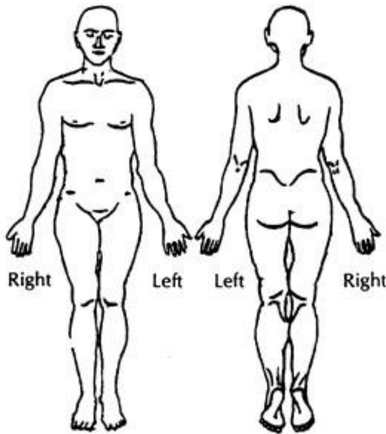
___ Family/Friend/Co-Worker ______________
___ Dex Yellow Pages
___ Yellow Book
___ Google Search
___ Dex Online
___ Clinic Sign
___ Doctor Recommendation ______________________
___ Other Internet
___ Publication/Newspaper ______________________
___ Health Club/Professional
___ Other______________________________
___ Client of ACHIEVE ______________________________

ACHIEVE
PHYSICAL THERAPY - SPORTS TRAINING

NAME: ____

AGE: ______________

PLEASE NOTE PAIN OR DISCOMFORT ON THE BODY CHART BELOW



MEDICAL AND EXERCISE HISTORY

:

PLEASE CHECK BELOW IF YOU CURRENTLY HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING

- ☐ Elevated blood pressure
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Blood clot
- ☐ Thrombophlebitis
- ☐ Congestive heart failure
- ☐ Peripheral Vascular Disease
- ☐ Diabetes
- ☐ Any other heart problem
- ☐ Respiratory dysfunction
- ☐ Asthma
- ☐ Bronchitis
- ☐ Unusual shortness of breath
- ☐ Epilepsy or seizures
- ☐ Cancer
- ☐ Rheumatism
- ☐ Current/recent pregnancy
- ☐ Osteoarthritis
- ☐ Low back/neck pain
- ☐ Joint dysfunction
- ☐ Bone dysfunction
- ☐ Muscle dysfunction
- ☐ Any physical disability that could interfere with safe exercise participation
- ☐ Latex sensitivity
- ☐ Smoking
- ☐ Other

____
____
______________________________ ______

1. Please explain any checked items
____
____

2. What is the reason for your visit today?
____
____

3. List previous surgeries
____
____

4. List all medications you are currently taking
____
____

5. List any allergies
____
____

6. Do you participate in competitive sports? Yes No
If yes, please list the sports you participate in and position
____
____

7. Do you currently exercise? Yes No
If yes, please describe the exercise type and frequency
____
____

Authorization for Medical Treatment: I understand that I am a client of ACHIEVE a private, therapist owned Physical Therapy practice. I authorize the physical therapist(s) in charge of caring for this client to administer any treatment that is necessary or advisable according to the respective diagnosis and plan of care. This authorization includes, but is not limited to: routine diagnostic procedures, manual therapy intervention, the use of physical modalities, and the prescription of therapeutic exercise. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician or physical therapist who may be involved in my care as a client.

Expected Benefits of Physical Therapy Treatment: I understand that the practice of medicine is not an exact science. Treatment can vary widely from person to person. It is not always possible to accurately predict a response to a certain therapy modality or procedure. I acknowledge that no guarantees have been made to me as to the outcomes of examination and treatment in ACHIEVE I acknowledge that my care is under the direction of my treating physician(s) and ACHIEVE

Responsibilities as a Client: I understand that it is my right to decline any part of treatment at any time before or during treatment, should I feel any discomfort or pain or have other unresolved concerns. I understand that it is my right to ask my physical therapist at ACHIEVE about the treatment that they have planned based on my individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.

Cooperation with Treatment: In order for the practice of medicine to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Physical Therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my Physical Therapist.

Assignment of Facility Benefits: I/we assign all benefits to ACHIEVE, and authorize direct payment to ACHIEVE, 11511 S. 42nd St. Ste 106, Bellevue, NE 68123 of all insurance benefits to which I/we may be entitled. This assignment will include, but is not limited to: major medical and disability insurance proceeds and benefit and/or proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I/we agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Non-covered services: Some insurance companies have certain outpatient procedures that are excluded from coverage including but not limited to routine diagnostic workups or routine physical examinations. If the client's medical chart indicates that the client's treatment is one for which no benefits are allowable, I understand that all charges incurred during treatment will be the client's own financial responsibility, There may be other limitations and charges for which the client may be responsible for. The client will be provided additional information with regard to these limitations and charges on a separate written form.

Statement of Financial Responsibility: I understand that I am financially responsible to ACHIEVE as the client, parent, guardian, conservator, or insured, for all charges, which may include any medical insurance deductibles, co-pays, and/or co-insurance. I understand that to as a Guarantor means that if the client does not pay ACHIEVE for all charges due. I, as the Guarantor, will be responsible for such payment. I further understand that the payment is due 30 days after receiving the billing statement; if there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.

Authorization to Release Information Insurance Company/Third Party Payor: I authorize ACHIEVE and any physical therapist, practitioner, or other person, any hospital including Veteran's Administration or governmental hospital, any medical service organization, any insurance company or any other institution or organization, to release any medical information about the client necessary to determine any benefits which may be payable for this treatment.

Authorization for Quality Review: I acknowledge that it may be appropriate for ACHIEVE to review the overall care provided to clients prior to and following the client's treatment. I understand that this review is for the sole purpose of maintaining and improving the overall quality of healthcare provided to ACHIEVE clients. Therefore, I ,authorize any treating practitioner who cared for the client, to provide Nebraska Doctors of Physical Therapy, P.C., with copies of records regarding my care that pertain to the treating diagnosis as needed for quality review purposes.

Personal Valuables: ACHIEVE, shall not be liable for the loss of or damage to any personal property

____
Name of Client

____
Signature of Client (Parent or Guardian if Client is under age 19)

____
Date

A copy of your signed form is available upon request

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI about you is maintained as a written and/or electronic record. Specifically, it individually identifies you and relates to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare.

We are required by law to maintain the privacy of your health information and provide you with a copy of this notice. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice, and make the revised or changed notice effective for all health information that we maintain. Any changes to this notice will be posted in our facilities and on our website. Paper copies will be available upon request.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

For Treatment. We may use health information about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care.

For Payment. We may use and disclose health information, as needed, about you so the treatment and services you receive maybe billed, and payment may be collected from you, an insurance company or a third party. For example, this may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage of health benefits.

Healthcare Operations. We may use or disclose, as-needed, your protected health information for our day-to-day health care operations to ensure that you and other patients receive quality care. For example, we may use or disclose PHI relating to the evaluation of patient care, business management activities, quality assessment and improvement, employee reviews, legal services, and auditing functions. All disclosures of your PHI will be limited to the minimum necessary or that which is contained in a limited data set (e.g. PHI that excludes certain identifiers including demographic information, photographs, et cetera).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Special Notices. We may contact you at the address and phone number you provide (including leaving a voice message) about scheduled or canceled appointments, billing and/or payment matters. We may also contact you about health related services or ACHIEVE locations that may be of interest to you. I understand that there is a chance that during the course of training and/or treatment I/my child may be photographed and/or video taped which may be used for promotional purposes.

Required by Law. We may use or disclose your health information when required to do so by federal or state law. We must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements under the Privacy Rule.

Public Health Risks. We may release your health information for public health activities. For example, disclosures related to the quality, safety or effectiveness of a product, prevention or disease control, to coroners, medical examiners and funeral directors as needed to perform their duties as required by law, and organ procurement organizations for the purpose of facilitating organ, eye or tissue donation and transplantation.

Victims of Abuse, Neglect or Violence. We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly.

Health Oversight Activities. We may disclose your health information to health agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of government regulatory programs.

Judicial and Administrative Proceedings. We may disclose your health information in the course of an administrative or judicial proceeding in response to a court order. Under most circumstances, when the request is made through a subpoena, a discovery request, or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

Law Enforcement. We may disclose your health information for law enforcement purposes.

Research. Your health information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

To Avert a Serious Threat to Health or Safety. We may disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of a particular person or the general public.

Specialized Government Functions. We may disclose health information for military and veterans' affairs, or national security and intelligence activities.

Worker's Compensation. Both state and federal law allow, without your authorization, the disclosure of your health information that is reasonably related to a worker's compensation injury. These programs may provide benefits for work-related injuries or illness.

Others Involved in Your Healthcare. Unless you object, we may disclose to a family member, relative or close friend your PHI that directly relates to that person's involvement in your care. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of PHI.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us services if the PHI is necessary for those functions or services. For example, we may use a shredding company to destroy paper medical records. To protect your health information, we require the business associate to appropriately safeguard your information.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Non-Custodial Parent. We may disclose PHI about a minor equally to the custodial and non-custodial parent unless a court order limits the noncustodial parent's access to the information.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Your decision to revoke authorization will not affect or reverse any use or disclosure that occurred before you notified us of your decision.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH, AND GENETIC INFORMATION:

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Please contact our Manager of Privacy and Compliance for more information.

YOUR HEALTH INFORMATION RIGHTS:

You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of your healthcare information. This includes health and billing records. Your request to inspect and obtain a copy of your healthcare information must be made in writing to: ACHIEVE, 11511 S. 42ND ST. STE 106 BELLEVUE, NE 68123. In addition, we may charge you a reasonable fee to cover our expenses for copying your health information.

We may deny your request to inspect and copy your PHI in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who participated in the original decision to deny the request for access.

Right to an electronic copy of electronic medical records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request an electronic copy of your record be given to you or transmitted to another individual or entity.

Right to receive a security breach notice. You have the right to receive written notification if ACHIEVE discovers a breach of unsecured PHI, and determines through a risk assessment that notification is required.

You have the right to request an amendment to your protected health information. If you believe the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. An amendment request must be made in writing, and must provide reasons to support your request. In certain cases we may deny your request for an amendment if: Your requests not in writing or does not include reasons to support the request; the medical record was not created by us, the person who created the information is no longer available to make the amendment, the record is not part of the health information we maintain, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete.

You have the right to request a restriction of your protected health information. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to family members or friends who may be involved in your care or payment for your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your requested restriction. If we agree, we will comply unless we terminate our agreement or the information is needed to provide emergency treatment to you.

Out-of-pocket payments. If you paid out-of-pocket in full for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We are required to agree to your request.

You have the right to request that you receive confidential communications. You have the right to request confidential communication from us by alternate means or at an alternate location. For example, you may ask that we only contact you at work or by mail.

You have the right to receive an accounting of certain disclosures. You have the right to receive a list of disclosures of your PHI that we have made, except for disclosures pursuant to an authorization, for purposes of treatment, payment, healthcare operations, or required by law. Your request must state a time period which may not be longer than 6 years before your request.

You have the right to obtain a paper copy of this notice, even if you agreed to receive the notice electronically.

HOW TO EXERCISE YOUR RIGHTS: To exercise your rights described in this notice, you must submit your request in writing to: Brian Inselman ACHIEVE, 11511 S. 42ND ST. STE 106, BELLEVUE, NE 68123

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our practice. We request that you file your complaint in writing so we may better assist in the investigation of your complaint. Send your written complaint to: Brian Inselman,
ACHIEVE, 11511 S. 42ND ST. STE 106, NE 68123

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Washington D.C. 20201, or the Nebraska regional office of the Office for Civil Rights at: Office for Civil Rights, Office for Civil Rights, U.S. Department of Health and Human Services, 601 East 12th Street - Room 353, Kansas City, MO 64106 Additional information can also be found on their website at www.hhs.gov/ocr/hipaa/.
You will not be penalized or otherwise retaliated against for filing a complaint.

If you want more information about our privacy practices or have questions please contact:

Dr. Brian Inselman

ACHIEVE, 11511 S. 42ND ST. STE 106, Bellevue, NE 68123 Phone: 402-502-4678; email: binselman@ndpt.org

Effective as of September 1, 2005
July 31, 2017

____

Name of Client

____

Signature of Client (Parent or Guardian if Client is under age 19)

____

Date

A copy of your signed form is available upon request