Personal Treatment with Professional Results

OUR MISSION: To enhance the quality of life of every patient by providing the highest quality in comprehensive and individualized services.

Vision: Max Potential Rehabilitation will uphold the highest of professional standards by maintaining the trust and confidence of all patients and providers. By striving to conscientiously support and encourage our patients with dignity and respect, we will create a new standard in the field of Physical Therapy. Max Potential Rehabilitation will offer prompt, courteous and accessible care. We will continuously strive to improve our knowledge, standard of care and available services. We will be recognized as a dependable and respected provider within our community.

Core Values:

Because I CARE, I will

- **I**ntegrity …….. uphold the highest of professional standards to maintain the trust and confidence of all our patients, providers and employees.
- **C**ommitment .. work conscientiously to serve our patients and providers.
- **A**dvocacy ….. tirelessly support and encourage our patients and staff.
- **R**espect …….. treat everyone with dignity and respect.
- **E**xcellence …. strive to continuously improve the quality and accessibility of care by being thoughtful, decisive and accountable in all aspects of our services.

Our Commitment: Max Potential Rehabilitation is committed to achieving the highest standards of excellence. We welcome all feedback regarding you care and services. If your ever have a question or concern, please speak with your therapist, the office administrator or the Clinic Director, Jason Martin.

Your First Visit: The purpose of this initial visit is to introduce our staff to you, evaluate your physical condition, explain the treatment your physician has prescribed, and establish your rehabilitation goals based on your physician's and your personal expectations.

Max Potential Rehabilitation

Health History

Patient Name: _____ Date: _____
Last First MI

Have you had any falls in the past year Yes No Are you? Right-handed Left-handed

Living Environment: Which of the following does your home have?

Stairs with no railing Stairs with railing Ramps Obstacles: _____

Uneven terrain Elevator Assistive devices(Ex: raised commode): _____

With whom do you live? Alone Spouse Children Parents Other

How did you hear about us?
_____

Employment/ Work/Student

Occupation: _____ Full time Part time Homemaker/Student Retired Unemployed

Health Habits
Smoking Currently: Yes No Alcohol: Current Past Never
Do you exercise beyond normal, daily activities and chores? Yes No

Medical / Surgical History

Please circle any of the following conditions that you have been treated for by a physician:

Cancer	Arthritis	Osteoporosis	Broken bones/fractures
Diabetes	Circulation/vascular problems	Depression	Skin diseases
Fibromyalgia	Stroke	Lung problems	Hypoglycemia/low blood sugar
Obesity	Thyroid problems	Kidney problems	Ulcers/stomach problems
Heart Condition	Parkinson's Disease	Multiple Sclerosis	Allergies
High Blood Pressure	Latex allergy	Seizures or epilepsy	Developmental or growth problems

Multiple Treatment Area Infectious disease (Ex: tuberculosis, hepatitis), Disease: _____
Surgery for the problem, Date of surgery:_____

Within the past year, have you had any of the following symptoms? (circle all that apply)

Chest pain	Bowel problems	Urinary problems
Headaches	Shortness of breath	Dizziness or blackouts
Coordination problems	Weakness in arms or legs	Loss of balance
Difficulty walking	Joint pain or swelling	Pain at night
Difficulty sleeping	Loss of appetite	Fever / chills / sweats
Hearing problems	Vision problems	Other: _____

Please list all allergies: _____

Please list any surgeries and include approximate date (month/year):

_____ ___/___
_____ ___/___
_____ ___/___

For men only:	Have you been diagnosed with prostate disease?	yes	no
For women only:	Are you pregnant or think you might be pregnant?	yes	no
	Have you ben diagnosed with other OB/GYN difficulties?	yes	no
	Have you ever had surgery related to women's health?	yes	no

Max Potential Rehabilitation

Current Condition/Chief Complaints

Patient Name: _____ Date: _____
Last First MI

When did the problem(s) begin? (month/day/year) ____/____/____
What happened? _____
Have you ever had this problem before? Yes No
If Yes: How long did the problem last? _____

What did you do for the problem? _____
Did the problem get better? Yes No

How are you taking care of the problem now? _____

What are your goals for physical therapy? _____

Are you seeing any health care providers for your current problem? Physician: _____

Please list all medications that you have taken in the last 3 months:_____

_____

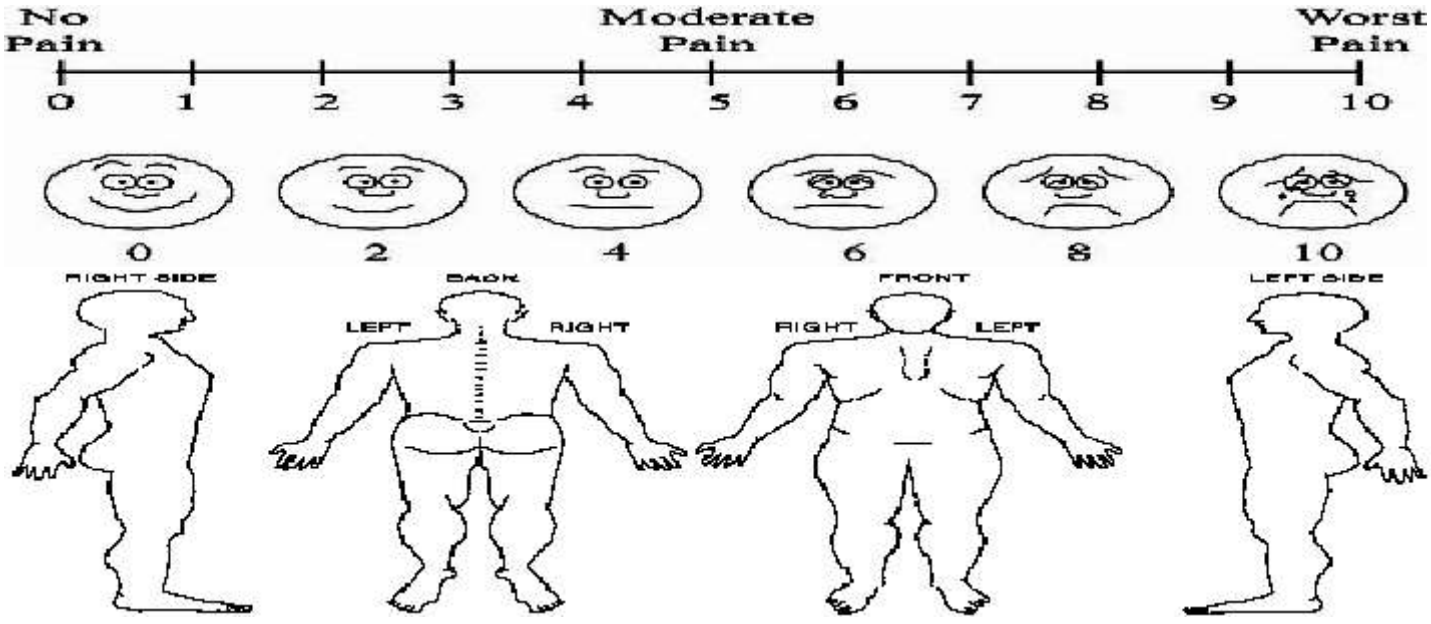
Please list any medications that you have taken in the past for your problem: _____

_____

Please circle any tests performed for your current condition:

Angiogram (heart catheter) Bone Scan CT scan
EKG (electrocardiogram) Mammogram MRI
NCV (nerve conduction velocity) X-rays Stress test(ex: tread mill, bicycle)
Other: _____

Please indicate your level of pain at this time by marking either the numerical or visual scale:



Please mark on the diagram above where you are having your symptoms/pain.

Max Potential Rehabilitation

Demographics and Insurance Information

Patient Name: _____ Date: _____
Last First MI

Social Security #: _____Date of Birth: _____ Sex: M F

Primary Phone: _____Alternate Phone: _____

Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Guarantor's Name: _____ DOB: _____

Guarantor's Address:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance: _____Member ID #: _____Group # :_____

Subscriber's Name: _____ Subscriber's DOB: _____

SECONDARY INSURANCE

Name of Payor: _____ Member ID #: _____ Group # : _____

Subscriber's Name: _____ Subscriber's DOB: _____

I have reviewed the above information and verified that it is accurate and current.

_____ _____
Signature of Patient (Parent or Guardian) **Date**

Max Potential Rehabilitation

Policies

Patient Name: _____ Date: _____
Last First MI

CANCELLATION POLICY

We value you as a patient and want you to receive the maximum benefit from our therapy program. We schedule specific appointment times so that you can conveniently and efficiently make use of your time and ours. We ask that you do the same for us by keeping your appointment schedule. If you must change your appointment, please do so in advance. Our policy is listed below:

_____ Throughout the course of therapy, if you cancel three appointments without rescheduling, we are required to contact your physician.

_____ Throughout the course of therapy, if you No Show or No call three times, we cancel all scheduled appointments and contact your physician.

_____ If you are more than 15 minutes late for your scheduled appointment time, we reserve the right to ask you to reschedule your appointments.

ASSIGNMENT OF BENEFITS AND CONSENT FOR CARE

I herein assign my right to payment and/or benefits from any/all sources of payment, regardless of whether I am the policyholder, regardless of whether the payment source specifically identifies me as a beneficiary, to Max Potential Rehabilitation and agree to have that payment remitted to Max Potential Rehabilitation at an address that is named on a standardized UB-04 or CSm-1500 claim form. I herein assign my benefits in exchange for Max Potential Rehabilitation providing service. I herein give consent to receive treatment from Max Potential Rehabilitation by a therapist or assistant, employee or its agents, as determined by Max Potential Rehabilitation, in conjunction with my plan of care and health care services ordered by an appropriate licensed health care professional.

FINANCIAL RESPONSIBILITY

I herein agree and understand that I am responsible for the cost of care or treatment and that Max Potential Rehabilitation will make reasonable efforts to obtain payment for services. I also agree and understand tha any discussion or printed document that is for the purpose of understanding what my payment source will pay is only an estimate based upon the information received from my payment source. I herein agree and understand that I am responsible for understanding the amount that is paid from my payment source even if that amount is zero, regardless of what may have been explained to me by Max Potential Rehabilitation, its employees, agents or contractors. I also herein agree and understand that I am responsible for any/all costs of collection, should my account become delinquent as defined by Max Potential Rehabilitation, including but not limited to late fees, attorney's fees, court costs or fees paid to a collection agency.

MEDICARE PATIENTS

I hereby certify that the information given by me is applying for payment for Medicare benefits under the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Center for Medicare and Medicaid Services, or any of its intermediaries or carriers any information needed for this or a related Medicare claim. I understand that unless I qualify for the cap exception Medicare will not pay for therapy services that exceed the Medicare allowable caps - which in $1,880 for PT. If services qualify for the exception process then standard Medicare deductibles and co-insurance will continue to apply toward my charges.

I have reviewed the above information and agree to the terms for treatment at Max Potential Rehabilitation.

_____ _____
Signature of Patient or Guardian) Date

Max Potential Rehabilitation

Notice of Privacy Practices

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

Max Potential Rehabilitation is required by state and federal law to maintain the privacy of you Protected Health Information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to PHI. This Notice of Privacy Practices describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. I also describes your rights to access and control you PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this notice at any time. Changes will apply to all PHI that we maintain at that time. Upon request, we will provide you any revised Notice of Privacy Practices.

Uses and Disclosures of PHI

The following describes way we may use or disclose your protected health information without your authorization. The examples provided are not exhaustive; however, all uses and disclosures for treatment, payment or health care operations will fall into one of these categories.

Treatment: We may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes disclosure of health information to referring providers of others involved in your care. For example, evaluations may be provided to the referring physician for review of the plan of care outlined by the therapist to ensure the most appropriate care is provided.

Payment: We may use and disclose your protected health information to obtain payment for treatment and services rendered. This may include requests from your health insurance plan for purposes such as: making a determination of eligibility or coverage for insurance benefits, reviewing treatments for medical necessity and performing utilization reviews. For example, a bill submitted to an insurance company may include your name, diagnosis and details of the treatment you are receiving.

Health Care Operations: We may us and disclose your protected health information to support business activities including, but not limited to, quality assessment, employee review, licensing/credentialing, fund raising, business planning and auditing of medical records. For example, we may use your health record to monitor the performance of the staff providing treatment to you.

We may disclose your health information to business associates, as necessary, for the third party to provide a service to us. A written contract outlining the terms that will protect the privacy of your protected health information will be obtained from each business associate prior to the use or disclosure of your protected health information.

We may use and disclose your protected health information to contact you to remind you of your appointments and to provide you with information regarding treatment alternatives or other health related benefits and services that may be of interest to you. Please notify our Privacy Officer if you would like to request that your information not be used to contact you for these purposes. If you have provided your email address you may elect to receive this information via email.

We may use and disclose you demographic information and the dates that you received services to contact you as part of a fund raising effort. If you would like to request that you not be contacted for fund raising purposes, please contact our Privacy Officer and all reasonable efforts will be taken for you to not receive any future fund raising communications.

Other permitted and required uses and disclosures that may be made without your authorization of opportunity to agree or object

Required by Law: We will use and disclose your protected health information when required to do so by federal, state, or local law.

Public Health: We may disclose your protected health information to public health agencies for activities with the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may use or disclose your protected health information to contact you or another individual

who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law. Oversight agencies include the Department of Health Services, Department of Health and Human Services and other agencies that oversee the health care system, government benefit programs, regulatory agencies and civil rights laws to perform such activities as audits, investigations, inspections and licensure.

Abuse or Neglect: We may disclose your protected health information to an authorized government authority if we reasonably believe you are the victim of abuse or neglect. We will only disclose information to the extent allowed by law or if you agree to this disclosure.

Food and Drug Administration (FDA): We may disclose your protected health information to persons or companies under the jurisdiction of the FDA with respect to quality, safety of effectiveness of FDA regulated products or activities relative to adverse events, product defects, problems or recalls or to conduct post marketing surveillance.

Legal Proceedings: We may discloser your protected health information in response to any judicial or administrative proceeding. We may also disclose your protected health information in response to a subpoena, discovery request, court order or other legal process but only if efforts have been made to tell you about the request giving you the opportunity to pursue an order protecting the information requested.

Law Enforcement: We may disclose protected health information for law enforcement purposes including legal processes, for identification and location purposes, concerning victims of a crime, in the event a crime occurs on the premises of our practice and in emergency circumstances in which a crime is likely to have occurred.

Coroners, Funeral Directors and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or other duties authorized by law. We may also disclose protected health information to a funeral director as allowed by law to enable them to carry out their duties. Protected health information may be used and disclose for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Military Activity and National Security: We may use or disclose the protected health information of Armed Forces member as required by military command authorities, for determining benefits through the Department of Veteran's Affair and about foreign military personnel to the appropriate foreign military authority. We may also use and disclose your protected health information to federal officials concerning national security, intelligence activities, protective services to the President and other activities authorized by law.

Workers' Compensation: We may use or disclose your protected health information to the extent authorized by and to the extent necessary to comply with the laws relating to workers' compensation or other similar programs established by law.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility to the institution or its agents the health information necessary for your health and the health and safety of other individuals.

Others involved in your health care of payment for your care: We may disclose your protected health information to a family member, relative, close friend or any other person you identify, information directly relevant to that person's involvement in your care, unless you otherwise object.

Other uses and Disclosures: Uses and disclosures of your protected health information will be made only following your written authorization for purposes other than as described above or as permitted or required by law. You may revoke an authorization in writing at any time and we will no longer use or disclose your protected health information as indicated in the authorization except to the extent that we have already acted in accordance with the authorization.

Your Rights

The following are your rights regarding your protected health information:

Right to inspect and copy: You have the right to inspect and obtain a copy of the protected health information that we use to make decisions about you for so long as we maintain the information. You must submit a written request in order to inspect and/or receive a copy of the record and as permitted by federal or state law, we may charge you a reasonable fee to fulfill your request. We may deny your request to inspect and/or copy your records in certain limited circumstances under federal law. If you are denied access to your records you may request that the denial be reviewed.

Right to request a restriction: You have the right to request that we not use or disclose any part of your protected health information for treatment, payment or health care operations. You also have the right to request that any part of your protected health information not be disclosed to family, relatives, or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices.

We are not required to agree to a restriction request except to the extent such disclosure is to a health plan for purposes of payment but not for treatment or health care operations, and you have paid for the service in full and out of pocket; however, if we do agree to the requested restriction we shall honor that agreement unless it is needed to provide emergency treatment. You may request a restriction by contacting our Privacy Officer.

Right to request to receive confidential communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate all reasonable requests without requesting an explanation from you as to the reason for this request. To make a request of this nature please contact our Privacy Officer.

Right to Amend: You have the right to request an amendment of protected health information about you that you feel is incorrect or incomplete. To request an amendment you must send a written request to our Privacy Officer including a reason that supports your request. In certain cases, we may deny your request for amendment.

Right to receive an accounting of disclosure: You have the right to receive an accounting of the disclosures we have made of your protected health information for purposes other than treatment, payment or health care operations. An accounting of disclosures made through an electronic health record will also account for disclosures for the treatment, payment and health care operation purposes, during the three years prior to your request, at such time as the Secretary of the Department of Health and Human Services provides regulations addressing this requirement. It may also exclude any disclosures made based on your written authorization and a limited number of special circumstances including for national security, law enforcement and correctional institutions. To obtain this account, you must submit your request in writing to our Privacy Officer stating the time period for which you want an accounting and not including dates more than six years prior to the request. The right to receive an accounting is subject to certain exceptions, restrictions and limitations.

Right to obtain a paper copy of this notice: You have the right to request a paper copy of this notice, even if you have agreed to accept this notice electronically. You may ask us to give you a copy of this notice at any time.

Changes to this notice

We reserve the right to change the terms of this notice and to make the new provisions effective for the health information we maintain at that time. We will post a copy of the current notice at each affiliated site and on our website with its effective date clearly stated.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary to Health and Human Services. You may file a complaint with us by notifying our Privacy Officer of your complaint. You will not be penalized or otherwise retaliated against for filing a complaint.

You may contact our Privacy Officer, Jason Martin, at (865) 947-6622 or Jmartin@maxpotential.info for further information about the complaint process.

This notice was published and becomes effective September 24, 2013.

Max Potential Rehabilitation

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

Patient Name: _____ Date: _____
Last First MI

_____(Initial Here) I acknowledge that I have been provided with a copy of the Notice of Privacy Practices.
or
_____(Initial Here) I refuse to acknowledge receipt of the Notice of Privacy Practices. I understand that Max Potential Rehabilitation will not refuse to provide services to me even if I refuse to acknowledge such receipt.

_____ _____
Signature of Patient or Personal Representative Witness

_____ _____
Name of Patient or Personal Representative Date

For Staff Only: If patient or personal representative refused to acknowledge receipt, provide and explanation here:_____

_____ _____
Employee Signature Date

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the clinicians of this group. This includes, but is not limited to: appointments times, plan of care, billing information, etc.

Signature: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

I AGREE TO NOTIFY MAX POTENTIAL REHABILITATION IN WRITING IT THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED.