Makovicka
PHYSICAL THERAPY
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR DEPENDENT(S) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who will follow this policy:

- the physical therapist(s) and staff of Makovicka Physical Therapy
- residents, students and any volunteer approved by the physical therapist to assist in the operation of Makovicka Physical Therapy

OUR RESPONSIBILITIES

WE ARE REQUIRED BY LAW TO:

- make sure that medical information about you and your dependent(s) is kept private;
- give you this notice of our legal duties and privacy practices, including the version and effective date of the current policy;
- follow the terms of the privacy notice that is currently in effect for our practice;
- provide you with an updated privacy policy at first contact if the policy changes for any reason. We reserve the right to change the terms of our privacy practices and retain the right to make the most current privacy practice notice effective for medical information we already have about you and/or your dependent(s) as well as any information we receive in the future;
- notify you if we are unable to agree with your written request

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU AND/OR YOUR DEPENDENT(S): Following are some examples of how we may use and disclose medical information; however, not every use and disclosure is listed.

For Treatment – We may provide information from our patient's medical records to other physicians, hospitals, laboratories, or other healthcare providers. For example, if you were scheduled to see a specialist for a problem not being treated at our office. Records about your treatment in our office including types and number of antibiotics may be forwarded to the specialist.

For Payment – We may use medical information so that services can be billed and payment collected from you, your insurance company, or a third party. For example, the patient name, birth date, address, and diagnosis are among needed information on and insurance claim to allow processing for insurance benefits. We may also share similar information with other healthcare professionals who provide services to you and/or your dependent(s). For example, billing and/or health information may be given to a radiology clinic when x-rays are ordered at the facility for you.

For Healthcare Operations – We may use medical information for healthcare operations that may help us to provide quality care. For example, we may use information to determine if additional services should be offered, or if staff should be increased.

Business Associates – We may provide medical information to other persons or organizations who provide services for us under contract. We require business associates to protect the medical information we provide to them.

Appointment Reminders – We may use personal health information to contact you as a reminder for an upcoming appointment or to reschedule a missed appointment.

Individuals Involved in the Care of Payment of You and/or Your Dependent(s) – We may provide medical information to a friend, family member or other person you say is involved in you/your dependent(s)'s medical care or in the payment for such care. This information will be provided only if you tell us or we believe it is appropriate and in the best interest of you and/or your dependent(s). For example, we may provide medical information about you and/or your dependent(s) if you will be gone or to someone helping in a disaster relief effort so that your family can be notified about you/your dependent(s) condition.

As Required By Law – Medical information will be provided about you/your dependent(s) when required by federal, state or local law enforcement. Examples include:

- Response to a court order, subpoena, warrant, summons or similar process;
- Identify or locate a suspect, fugitive, material witness, or missing person;
- Inquiries as to the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- Inquiries as to the death we believe may be the result of criminal conduct;
- To report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Public Health Activities – We may provide medical information about you/your dependent(s) for public health activities or as required by lay. These activities generally include:

- To prevent or control disease, injury or disability;
- To report births or deaths;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for getting or spreading a disease or condition;
- To notify the government if we suspect a patient has been the victim of abuse, neglect or domestic violence.

To Avert a Serious Threat to Health or Safety – We may use and provide medical information about you/your dependent(s) when needed to prevent a serious threat to you/your dependent(s)'s health and safety or the health and safety of other people. This information will only be provided to someone able to help prevent the threat.

Health Oversight Activities – We may provide medical information to a health oversight agency for activities allowed by law. These activities allow the government to monitor health care systems, government programs, and compliance with civil rights laws and include audit, investigations, and inspections.

Coroners, Medical Examiners, and Funeral Directors – We may provide medical information to a coroner or medical examiner. For example, to identify a person who has died or to determine the cause of death. We may also provide medical information about patients to funeral directors that need to carry out their duties.

Inmates – We may provide medical information about you/your dependent(s) to a correctional institution or law enforcement official if you/he/she are/is an inmate of a correctional institution or under the custody of a law enforcement official.

Organ and Tissue Donation – We may provide medical information to organizations that manage, bank or transplant organ and tissue donations if you/your dependent(s) are/is an organ donor.

Worker's Compensation – We may provide medical information about you/your dependent(s) for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence, and Protective Service Activities – We may provide medical information about you/your dependent(s) to federal officials for intelligence, counterintelligence, and other national security activities. Such activities include protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

OTHER USES OF MEDICAL INFORMATION. We may not use or share medical information about you/your dependent(s) for any reason other than described above or as the laws apply to us, without your written permission.

YOUR RIGHTS

Restrict Medical Information – You may restrict the uses and disclosures of medical information about you/your dependent(s) as outlined above. Your restriction notice must be written. We are not required to honor your request and we may decide not to provide further treatment to you/your dependent(s).

Look At and/or Copy – This includes medical and billing records. Your request to look at or have information copied must be in writing. We may charge a fee for the cost of copying and mailing records.

Change the Record – If you feel the medical information about you/your dependent(s) is not correct; you may request that the information be changed. You must provide a written reason why you want the information changed. Your request may be denied and you will be notified in writing within 30 days why your request was denied.

Receive a List of Disclosures – You may ask for a list of companies, agencies, and/or persons who have received medical information about you/your dependent(s). Your written request must state a time period no longer than six years and may not include dates prior to January 1, 2003.

Ask for Private Communication – You may request that we communicate with you about medical matters in a certain way or at a certain place. All reasonable requests will be honored.

COMPLAINTS

If you think the privacy rights of you/your dependent(s) have been violated you may send your written complaint to the Privacy Officer of Makovicka/Harms Group, P.C. or to the Secretary of the U.S. Department of Health and Human Services. Nothing will be held against you if you do file a complaint.

If you have any questions regarding the Privacy Policy of Makovicka/Harms Group, P.C., you may contact the Privacy Officer at 10831 Old Mill Road, Suite 300 Omaha, NE 68154; or you may telephone (402) 932-6791.

Effective date: July 1, 2009

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This serves as an acknowledgement that you have received a copy of Makovicka Physical Therapy's Notice of Privacy Practices. Please fill out the lines below. Thank you!

Signature: _____

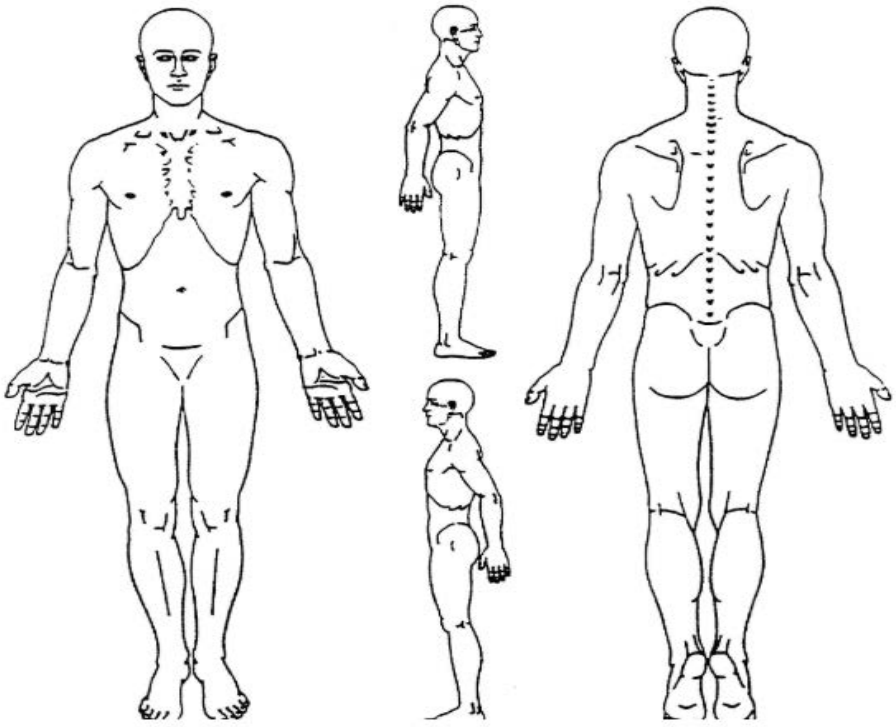
Printed Name: _____ Date: _____

Please List the Names of Any Additional Persons Who are Authorized to Receive Medical Information

_____

_____

Please Use a Pen or Pencil to Mark the Areas of Your Symptoms



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Date: _____ *Patient's Birthdate:*_____ *Patient's Age:*_____

*Name:*_____ *M*_____*F* _____

*Address:*_____*City:*_____*St:*_____*Zip:* _____

Mailing Address (PO Box): _____*City:* _____*ST:* _____ *Zip:* _____

*Home Phone:*_____ *Work:*_____*Cell:* _____

Email Address: _____

*Employer:*_____*Occupation:* _____

Primary Care Physician: _____

In case of emergency, please list contact name: _____

*Relationship:*_____ *Phone:* _____

Primary Insurance Carrier: _____

*Policyholder name:*_____*Policyholder Birthdate:*_____

*Secondary Insurance Carrier (If Applicable):*_____

*Policyholder name:*_____*Policyholder Birthdate:*_____

If under the age of 19, please be sure to also include parent(s) or legal guardian names (person responsible for bill).

*Mother/Legal Guardian:*_____ *Date of Birth:* _____

Address (if different from patient): _____ City:_____ ST:____ Zip:_____

*Father/Legal Guardian:*_____ *Date of Birth: :*_____

Address (if different from patient): _____ City:_____ ST:____ Zip:_____

Home Phone: _____ *Work:* _____ *Cell:* _____

Mother Email *Father/Guardian Email*

_____

Mother Employer: *Occupation:*

_____ _____

Father Employer: _____ *Occupation:* _____

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PERSONAL HEALTH HISTORY

Patient Name: _____ Height: _____ Weight: _____

Referring Doctor: _____ Primary Doctor: _____

What are we seeing you for today? _____

How did injury/condition occur? _____

Injury occurred at: _____

Date of injury/surgery: _____ OR when did you first notice symptoms: _____

Are you currently receiving home healthcare? Yes ☐ No ☐ Discharge Date: _____

Have you had x-rays or an MRI taken? Yes ☐ No ☐

Results: _____

Are you currently pregnant? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐ If 'yes', how many packs per day: _____

Do you have any allergies? Yes ☐ No ☐

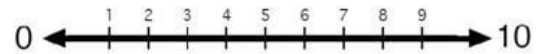
If 'yes', indicate what you are allergic to and reaction.

_____

_____

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



_____ What number on the pain scale (0-10) best describes your pain **right now**?

_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

Do you have, or have you had: (please check if yes)

- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke/TIA
- ☐ Chronic Bronchitis
- ☐ Peripheral Neuropathy
- ☐ Osteoarthritis
- ☐ Liver Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Rheumatoid Arthritis
- ☐ Epilepsy
- ☐ Stomach Ulcers
- ☐ Angina/ Chest Pain
- ☐ Polio
- ☐ COPD /Emphysema
- ☐ Peripheral Artery Disease
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Cortisone Drug
- ☐ Anemia
- ☐ Tuberculosis
- ☐ Other issue/concern
- ☐ Diabetic Ulcer

Past Medical History: (Surgeries/ Fractures) Year

_____ _____

_____ _____

_____ _____

MEDICATIONS: What medications are you taking now?

(**Include prescription, over-the-counter drugs, supplements such as vitamins, and herbals**.)

Medication name	Dosage	Frequency	Route of Administration (i.e.: oral, injection)

Have you fallen in the last year? Yes ☐ / ☐ No

If yes, how many times in the last year? _____

If you have fallen in the last year, were you injured? Yes / No If yes, please explain _____

_____

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1. CONSENT TO TREATMENT
I, knowing that I have a condition requiring diagnosis, treatment, or related care do hereby consent to such care, physical therapy examination, procedures, interventions, and/or treatment by physical therapists, their assistants/aides, as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, physical therapy examinations, procedures, and/or interventions. I also authorize release of such information to the third party payer(s).

2. ASSIGNMENTS OF BENEFITS
I hereby assign to Makovicka/Harms Group, P.C. dba Makovicka Physical Therapy and to all therapists providing treatment(s) all right, title, and interest, in and to benefits payable affording clinic and therapist's coverage. I direct that such benefits be paid directly to said clinic and therapists. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and unpaid balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service.

3. INSURANCE PRE-CERTIFICATION INFORMATION
Many insurance companies have pre-certification requirements for physical therapy. If you are not sure whether your insurance company had pre-certification requirements, please check before evaluation/treatment so that you will not be denied insurance benefits for this visit.

4. AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize Makovicka/Harms Group, P.C. dba Makovicka Physical Therapy to furnish records from any treatments, photocopies of such records and/or information, and excerpts from such records to the attending physician, his/her associates, and/or consultants, and third-party payer (whether an insurance company, government agency, or self-insured employer) and/or any transferee health care facility and/or agency for the purposes of obtaining payment for services rendered while under clinic care, performing utilization review, and/or post care and treatment. If this is a work-related injury I authorize Makovicka/Harms Group, P.C. dba Makovicka Physical Therapy to provide my employer with any and all needed information related to my condition. Finally, if further care from another therapist, physician, or specialist were needed I authorize the release of my records to such a party.

5. AUTHORIZATION FOR COMMUNICATION
By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication. I agree our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

X_____ X_____
Signature of Patient/Responsible Party/Insured Signature of Witness

X_____ X_____
Signature of Patient/Responsible Party/Insured Date and Time