Phone: (859) 268-8190 Fax (859) 268-9823

Body Structure Clinic

Health History

Name: ______________________ Date of Birth: ___/___/___AGE_____SSN or Drivers Lic#_________

Address: ____

Street City State Zip

Phone: (H)________________ (W) ______________(C) _________________

Email:_______________________

Sex________Height______Weight_______ Are you = right handed_____ left handed_____

In case of emergency, whom may we contact?

Name: ___________________ Relationship: ___________________ Phone: ________________

Personal Physician:

Name:_______________________ Phone:________________________

Address:____

Are you currently taking any medication(s)? Yes or No If yes, what are you taking and for what condition(s):____

____

How were you referred to this program? (Please be specific.)__________________________

____

Present History:

Have you ever had, or are currently experiencing, any of the following:

Rheumatic fever	Y	N	****Chest pain/discomfort at rest or with mild exertion/exercise**	Y	N
****Heart attack**	Y	N			
****Heart surgery**	Y	N	****Shortness of breath (unexplained)**	Y	N
****Disease of any artery**	Y	N	****Swelling of the feet or ankles**	Y	N
Kidney disease	Y	N	Skipped heart beats	Y	N
Gout	Y	N	Coughing up blood	Y	N
Thyroid disease	Y	N	Arthritis/swollen, stiff joints	Y	N
Epilepsy	Y	N	****Dizziness or fainting**	Y	N
Depression	Y	N	Frequent headaches	Y	N
Asthma	Y	N	Frequent colds	Y	N
Emphysema	Y	N	Recurrent Sore throat	Y	N
Chronic Bronchitis	Y	N	Recurrent nose bleeds	Y	N
Liver disease	Y	N	Indigestion	Y	N
Vomiting blood	Y	N	Wheezing spells	Y	N
***Diabetes**	Y	N	****Heart murmur**	Y	N
****Rapid Heart Rate**	Y	N	****Need to sit up to breathe comfortably**	Y	N

Family History:

*Have any of your immediate family members (parents, grandparents, or siblings) had or ever had any of the following?

Heart attack	Y	N	Whom:______________________	Age:_________
Heart surgery	Y	N	Whom:______________________	Age:_________
High blood pressure	Y	N	Whom:______________________	Age:_________
Stroke	Y	N	Whom:______________________	Age:_________
Diabetes	Y	N	Whom:______________________	Age:_________
High cholesterol	Y	N	Whom:______________________	Age:_________

**Heart Disease:

Have you ever been told by a physician that you had:

An abnormal EKG Y N

Heart disease Y N

*High Blood Pressure:

Have you ever been told you have high blood pressure? Y N

If yes, did you receive treatment? Y N

What was the treatment and are you still undergoing any treatment?________________

____

*Cholesterol:

Have you ever been told you have high cholesterol? Y N

If yes, what is your most recent cholesterol level?__________________

*Smoking:

Do you smoke currently? Y N

Have you smoked regularly within the past 6 months? Y N

*Exercise:

Are you currently exercising at least 30 minutes most days of the week? Y N

Has your physician ever advised you against exercise? Y N

Orthopedic:

Do you have any orthopedic (including back) injuries, arthritis, or osteoporosis, which would interfere with your daily activity or ability to exercise? Y N

If yes, please explain:____

____

Are you presently receiving any physical therapy or any form of treatment for any injuries? Y N

If yes, please explain:____

____

Hospitalization:

Have you ever been hospitalized with any illness or injury? Y N

If yes, please explain:____

Pertinent Information:

Is there any pertinent information not already described? Y N

If yes, please explain____

____

Signature: __________________________________ Date: _________________

Consultant: _________________________________ Date: _________________

Medical Fitness Facility
2600 Gribbin Dr, Lexington, KY 40517
(859) 268-8190

PLEASE FILL OUT **PRIMARY INSURANCE INFORMATION,** AND IF THIS IS A **MOTOR VEHICLE OR WORK INJURY,** PLEASE FILL OUT THE ADDITIONAL INFORMATION.

PRIMARY INSURANCE INFORMATION

INSURANCE NAME: ___________________ EFFECTIVE DATE:__________________
POLICY #:______________________________ GROUP #:___________________________
CUSTOMER SERVICE PHONE NUMBER: ____________________________________

MOTOR VEHICLE ACCIDENT/WORK INJURY INSURANCE INFORMATION

INSURANCE COMPANY:__________________ PHONE # _______________________
BILLING ADDRESS: ___________________________ CITY:_____________ ZIP:______
CLAIM NUMBER:_____________________________ DATE OF INJURY:__/__/__
ADJUSTER:___________________________________
DATE LAST WORKED: ___/___/___ ANY OTHER DOCTOR SEEN:_____________

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS). I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS PAGE AND HAVE COMPLETED THE ABOVE ANSWERES. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WIL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR THE ABOVE INFORMATION.

____________________________________ ________________________________
SIGNATURE DATE

_____________________________________ ________________________________
PARENT (IF MINOR) DATE

Body Structure Clinic

Medical Fitness Facility
2600 Gribbin Dr

Welcome to Body Structure Clinic, our goal is to provide you with the highest quality physical therapy care available. We want to strongly emphasize the importance of patient compliance and responsibility in abiding by the recommended treatment. You must notify us within 6 hours of your appointment if you need to reschedule. Not showing or canceling your appointment without a 6-hour notice will result in a $30.00 fee. We can not help you if you do not show up for your appointment. ***Initial:*** ______________

Consent for treatment:

I, hereby, give my permission for Body Structure Clinic to render treatment to me/my dependent. I realize that I will be given all available pertinent information, prior to the treatment being rendered. I will be given the opportunity to ask questions, and have them answered to my satisfaction. I understand that I may decline recommended treatment at any time, but if I choose to do so it is at my own medical risk.

Signature:______________________________________ Date:____________________

Consent to Release/Obtain Medical Information:

Permission, is hereby, granted to Body Structure Clinic to release information to my insurance company, employer, attorney, worker compensation carrier, physician/facility referred to for further treatment, and/or my referring/family physician. Permission, is hereby, granted to any facility where I have previously been treated to release medical records/x-rays to Body Structure.

Signature:______________________________________ Date:____________________

Authorization for Payment of Benefits:

I authorize insurance payment benefits to Body Structure Clinic for services rendered. Insurance checks and explanation of benefits sent to you for our services must be brought to us. The checks will be applied to your balance and the explanation of benefits will be copied and returned. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

Signature:______________________________________ Date:___________________

Medicare Patients Only:

I authorize payment of Medicare benefits to Body Structure Clinic for services rendered, and I authorize the release of medical information to Health Care Finance Administration (HCFA), and /or its agents. I have received the Supplier Standards Information Sheet

Signature:______________________________________ Date:___________________

Child Liability:

I understand that Body Structure Clinic will not be held responsible for the safety or welfare of any child left in the waiting room, or leaves the waiting room.

Signature:______________________________________ ***Date:***___________________

BODY Structure Clinic

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your for treatment, payment, and health care operations. For example;

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

as required by law;

for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;

to report adult abuse, neglect, or domestic violence;

in response to court and administrative orders and other lawful processes;

to law enforcement officials pursuant to subpoenas and other lawful processes, concerning You crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
to coroners, medical examiners, and funeral directors;
to an organ procurement organizations;
to avert a serious threat to health or safety;
in connection with certain research activities;
to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
to correctional institutions regarding inmates; and
as authorized by state worker's compensation laws.

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:
we may have violated your privacy right,
we made a decision about access to your health information incorrectly,
our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
we should communicate with you by alternative means or at alternative locations,
you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Brandon Sidwell, BS.
Director of Operations
859-268-8190
859-268-9823 Fax
2600 Gribbin Dr.
Lexington, KY 40517