

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Patient Name: _____ Date of request: ____/____/____

Address:

Street	City	State	Zip Code
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Date of birth: ____/____/____

As required by the Privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following persons: *(you may write doctor's name and/or family member's name)*

Patient Health Information to be disclosed: *(check all that applies)*

- Physical therapy reports
- Medical tests
- Others: _____

Effective dates for this authorization: ____/____/____ to ____/____/____
(you may use date of initial visit as your start date and authorization can end up to one year from start date)

Signature of Patient / Authorize Representative

ASSIGNMENT OF BENEFITS / RIGHT FOR DIRECT PAYMENT TO PROVIDER

I hereby instruct _____ insurance company to pay Prime Care Physical Therapy, P.C. for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

I have agreed to pay my balance of said professional service charges over and above this insurance payment, including co-pay / co-insurance or deductible as approved by my insurance.

I also understand and agree that I am ultimately responsible for any professional fee due should my insurance refuse to pay my physical therapy provider.

I authorize release of any information pertinent to my case to any insurance company, health care financing administrator, adjustor or attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

Signature of patient / Authorized representative

____ / ____ / ____
Date

Name of patient / Authorized representative

NO SHOW / NO CALL CANCELLATION POLICY

Please read & write your initial on the line provided.

_____ All patients are required to call 24 hours in advance to cancel or re-schedule an appointment. Our office reserves a one-on-one appointment with the therapist for you and that slot cannot be filled up with another patient if it is a last minute cancellation or no show.

_____ Patient will be responsible for a **\$25** courtesy fee if you miss your appointment, do not call within 24 hours, or request a last-minute re-scheduling. We cannot bill your insurance for this fee or for any no show appointment.

We understand medical and personal emergencies can happen. We hope you value your therapist's time as much as we value yours. Thank you for your understanding and cooperation!

PRIME CARE PHYSICAL THERAPY

NEW PATIENT HEALTH QUESTIONNAIRE – BALANCE

Patient Name: _____ Date of Birth: ____/____/____

What is your complaint? () dizziness () spinning sensation () woozy / cloudy
Check all that applies () imbalance () walking () standing () doing usual activities
() difficulty focusing () when looking at something () reading

What medication/s are you currently taking? *Provide a copy if you have one* _____

Check if you currently have or have history of the following ear symptoms:

() ringing / buzzing () Right () Left () Both

() pressure / clogged sensation () Right () Left () Both

() difficulty hearing () Right () Left () Both

Check if you currently have or have history of the following medical conditions:

() Neuropathy () Hip/knee/foot pain or surgery () Heart problem () Hypertension

() Motion sickness () Sinus problem () Headache () Back/neck pain () Diabetes: Type _____

() Vision problem _____ () Anxiety () Other : _____

Did you smoke tobacco in the last year? () No () Yes

Have you fallen in the last year? () No () Yes, # of falls _____

Use the scale below to rate each activity as it is affected by your problem:

0 = not affected 1 = mildly affected 2 = moderately affected 3 = severely affected NA = not applicable

____ Bed mobility (lying down, getting up, turning over)

____ Transfer and turning activities (sit to stand, bending over, turning head / body)

____ Walking (indoor, outdoor, in the dark, on carpet, ramps, stairs, on uneven surfaces)

____ Shopping (checking grocery items while walking, walking in the mall / open space)

____ Household chores

____ Driving (turning head to check traffic, reading signs, coming to a stop)

____ Transportation (as a passenger in a vehicle)

____ Work/School activity: _____

Patient Name: _____

Date: _____

DIZZINESS HANDICAP INVENTORY

This 25 - item questionnaire will help your therapist to identify the difficulties you may be experiencing because of your vertigo, dizziness or unsteadiness. Please check your appropriate answer for each question. *If your symptom is better now, answer the questions based on when your symptom was still active.*

	YES	NO	SOMETIMES
P 1. Does looking up increase your problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E 2. Because of your problem, do you feel frustrated?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F 3. Because of your problem, do you restrict your travel for business or recreation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P 4. Does walking down the aisle of a supermarket increase your problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F 5. Because of your problem, do you have difficulty going into or out of bed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F 6. Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing or parties?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F 7. Because of your problem, do you have difficulty reading?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E 9. Because of your problem, are you afraid to leave home without having someone accompany you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E10. Because of your problem, have you been embarrassed in front of others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P11. Do quick movements of your head increase your problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F12. Because of your problem, do you avoid heights?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	YES	NO	SOMETIMES
P13. Does turning over in bed increase your problem?	()	()	()
F14. Because of your problem, is it difficult for you to do strenuous house or yard work?	()	()	()
E15. Because of your problem, are you afraid people might think you are intoxicated?	()	()	()
F16. Because of your problem, is it difficult for you to go for a walk?	()	()	()
P17. Does walking down a sidewalk increase your problem?	()	()	()
E18. Because of your problem, is it difficult for you to concentrate?	()	()	()
F19. Because of your problem, is it difficult for you to walk in the dark?	()	()	()
E20. Because of your problem, are you afraid to stay home alone?	()	()	()
E21. Because of your problem, do you feel handicapped?	()	()	()
E22. Has your problem placed stress on your relationship with members of your family or friends?	()	()	()
E23. Because of your problem, are you depressed?	()	()	()
F24. Does your problem interfere with your job or household responsibilities?	()	()	()
P25. Does bending over increase your problem?	()	()	()

***This part to be completed by your therapist*

Yes = 4 *Functional Scale = _____ / 36*
Sometimes = 2 *Emotional Scale = _____ / 36*
No = 0 *Physical Scale = _____ / 28*

TOTAL SCORE = _____ / 100

Patient Name: _____

Date: _____

ACTIVITIES-SPECIFIC BALANCE CONFIDENCE SCALE (ABC Scale)

For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady by choosing one of the percentage points on the scale from 0% to 100%. If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid or you had to hold on to someone to do the activity, rate your confidence as if you were using these supports.

No confidence 0% 10 20 30 40 50 60 70 80 90 100% *Completely confident*

How confident are you that you will not lose your balance or become unsteady when you.....

1. walk around the house? _____ %
2. walk up or down the stairs? _____ %
3. bend over and pick up a slipper from the front of the closet? _____ %
4. reach for a small can off a shelf at eye level? _____ %
5. stand on tiptoes and reach for something above your head? _____ %
6. stand on a chair and reach for something? _____ %
7. sweep the floor? _____ %
8. walk outside the house to a car parked in the driveway? _____ %
9. get into or out of a car? _____ %
10. walk across a parking lot to a mall? _____ %
11. walk up or down a ramp? _____ %
12. walk in a crowded mall where people rapidly walk past you? _____ %
13. are bumped into by people as you walk through the mall? _____ %
14. step onto or off an escalator while you hold onto the railing? _____ %
15. step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____ %
16. walk outside on icy sidewalks? _____ %