SALINA ORTHO
Orthopaedics, MRI, PT/OT
523 S. Santa Fe Ave.
Salina, KS 67401
(785) 823-2215
Fax: (785) 823-7459
salinaortho.com

Bradley C. Daily, M.D.
Byron L. Grauerholz, M.D.
Gary L. Harbin, M.D.
Todd M. Herrenbruck, M.D.
Jeffrey L. Horinek, M.D.
Michael J. Johnson, M.D.
Levi W. Kindel, M.D.

Jennifer L. Alexander, APRN
Eric Jusko, PA-C, ATC
Lindsy Newton, PA-C
Amber Sawyers, PA-C, ATC

Notice of Privacy Practices Summary / Acknowledgement

Maintaining privacy of your health information is very important to us. We encourage you to read the entire Notice and ask any questions you may have regarding its contents. You may read our Notice of Privacy Practices in person, request a copy via email or mail, or online at www.salinaortho.com/patient-forms.html

I acknowledge that I have received a copy of my provider's Notice of Privacy Practices with the effective date of April 14th, 2003.

_____
Signature of Patient / Patient Representative

_____
Date

_____
Relationship to Patient

Salina Ortho Use Only

A good faith effort was made to obtain a written acknowledgment of his / her receipt of the Notice, but such acknowledgement could not be obtained because:

- ○ Patient / Personal Representative refused to sign.
- ○ Patient / Personal Representative was unable to sign.
- ○ The Patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ○ Other reason (please specify):_____
  _____
  _____

_____ _____
Signature of Workforce Member *Date*

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HIPAA Privacy Authorization Form

Authorization for use or Disclosure of Protected Health Information

1. I hereby authorize Salina Ortho to use and/or disclose my protected health information ("PHI") described below.

2. I hereby authorize the release of PHI as follows **(check all that apply)**:
   - ○ Appointment dates and times
   - ○ Tests that have been received
   - ○ Test results
   - ○ Other health information

3. In addition to the authorization for release of my PHI described in section 2 of this authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ ***Relationship:*** _____
Address: _____ ***Telephone:*** *( )* _____

Name: _____ ***Relationship:*** _____
Address: _____ ***Telephone:*** *( )* _____

Name: _____ ***Relationship:*** _____
Address: _____ ***Telephone:*** *( )* _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient *Date*

_____ _____
Print Patient Name *Date of Birth*

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Accident / Injury Form

Email Address: _____

Patient Name: _____

Date of Birth: _____

Is office visit due to an accident or injury? (Circle One)

YES OR NO

If you answered "NO" in the previous question –sign and date at the bottom of this page to complete this form.

If you answered "YES" please fill out the entire form.

Exact date the accident or injury occured: _____

How did the accident or injury occur?

_____

_____

_____

Where did the accident or injury occur?

SCHOOL WORK HOME OTHER: _____

Was your accident or injury work related? YES OR NO

If "YES", are you self employed? YES OR NO

Was the injury the result of a motor vehicle accident or of physical contact with a motor vehicle? YES OR NO

If "YES", what type of vehicle was involved? CAR MOTORCYCLE TRUCK

If you selected "MOTORCYCLE", are you the owner? YES OR NO

Was another party responsible for your injury or condition? YES OR NO

If "YES", please explain: _____

_____ _____

Signature of Patient ***Date***

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Nate Lee, DPT
Jessica Murphy, DPT
Lane Sanders, DPT
Steve Sjogren, MPT

Paige Gridley, PTA
Rilee Windholz, PTA

Val Forrester, OTR/L, CHT

Outpatient Physical & Occupational Therapy Intake Form

Patient Name: _____

Age: _____

Sex: _____

Referring Doctor: _____

I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

_____ _____

Signature of Patient ***Date***

Do you have any learning barriers? YES or NO
If yes, please explain:

_____
_____
_____

Do you exercise at least 3 days per week? YES or NO

Are you currently pregnant? YES or NO

Have you had a recent illness? YES or NO

If yes, please explain:

_____
_____

Do you take blood thinners? YES or NO

Are you allergic to latex? YES or NO

What are your personal goals for therapy at this time?

_____
_____
_____

How are you able to sleep at night? (Circle One) Fine - Moderate Difficulty - Only with Medications

During the past month, have you been feeling down, depressed, or hopeless? YES or NO

Currently I am experiencing: **(Please circle all that apply)**

Fever / Chills / Sweats	Unexplained Weight Loss	Numbness / Tingling
Poor Balance (Falls)	Changes of Appetite	Difficulty Swallowing
Depression	Shortness of Breath	Dizziness
Headaches	Nausea / Vomiting	Increase pain at night

What approximate date did your present pain start? _____

How did your pain begin? (Gradually, suddenly, injury/accident) _____

My symptoms are currently (Circle One) Getting Better - About the Same - Getting Worse

What treatments have you received for this problem so far?

_____

_____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an X-Ray, MRI, or other imaging study for this problem? YES or NO

What part(s) of your body do you feel pain? (Please indicate Right, Left, or Both when listing)

_____

_____

On a scale from 1 to 10 please rate your average level of pain over the last 48 hours _____
(1 = No Pain, 5 = Moderate Pain, 10 = Worst Possible Pain)

On a scale from 1 to 10 please rate your overall level of function_____
(1 = Can't do Anything, 10 = Able to do Everything)

Aggravating factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem.

1._____

2. _____

3. _____

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Have you received any physical or occupational therapy this calendar year? YES or NO

Are you currently in a skilled nursing facility? YES or NO

Do you receive home health services? YES or NO

If YES to above questions, who provided these services?

_____

Notice of Exclusions from Medicare Benefits (NEMB)

Fill out the bottom portion only if you have Medicare

There are items and services for which Medicare will not pay.

Medicare requires us to remind you that they do **not** pay for **all** your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.

When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

You have the right to ask us to explain if you do not understand why Medicare will not pay, and the right to ask how much these items or services will cost you.

2023 EXCLUDED SERVICES

Medicare will not pay for physical therapy, occupational therapy, home health, or skilled nursing with a cumulative total over **$2230.00** annually from January 1, 2023 through December 31, 2023.

I have read and understand this *Notice of Exclusion of Medicare Benefits.* I understand that Medicare will not pay for therapy services more than $**2230.00 annually**. I agree to be responsible for payment in full of services that exceed this amount (either personally or through other insurance.)

*I **have / have not** received physical therapy services this calendar year prior to this date.*
(Previous therapist or facility _____)

_____ _____
Signature of Patient *Date*

_____ _____
Print Patient Name *Date of Birth*

Additional Information

Weight: _____

Height: _____

Advance Care Planning

Do you have a healthcare proxy in the event you are unable to make your own medical decisions?

_____

Designee's name

_____

Designee's phone number

_____

Social History

Use of Alcohol: YES or NO Occasional _____ Social _____ Daily _____

How many times in the past year have you had 5 or more drinks in a day for men, OR 4 or more drinks in a day for women OR any adult older than 65? Choose a number between 0 and 365 _____

Use of Tobacco: YES or NO or FORMER Please Circle: Smoke or Chew Average Packs/Day: ___

Use of Street Drugs: YES or NO