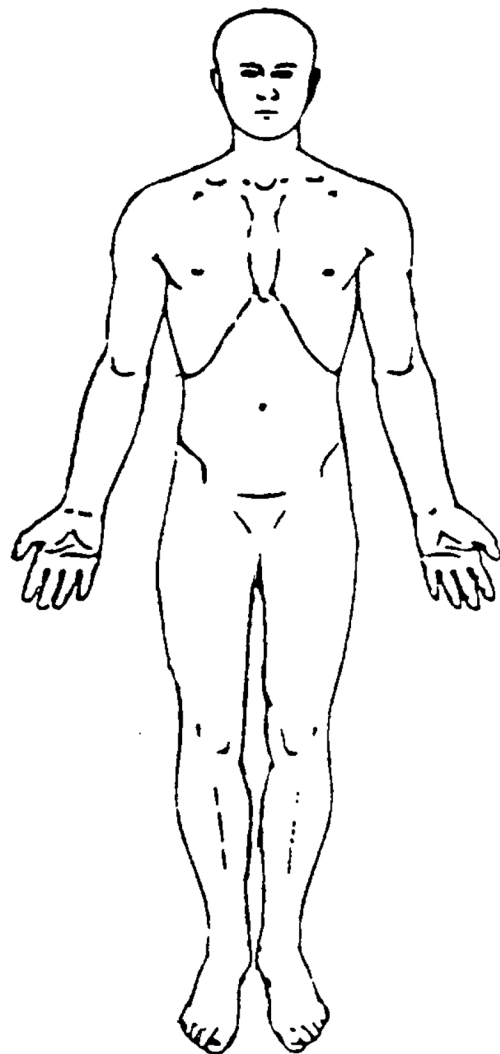
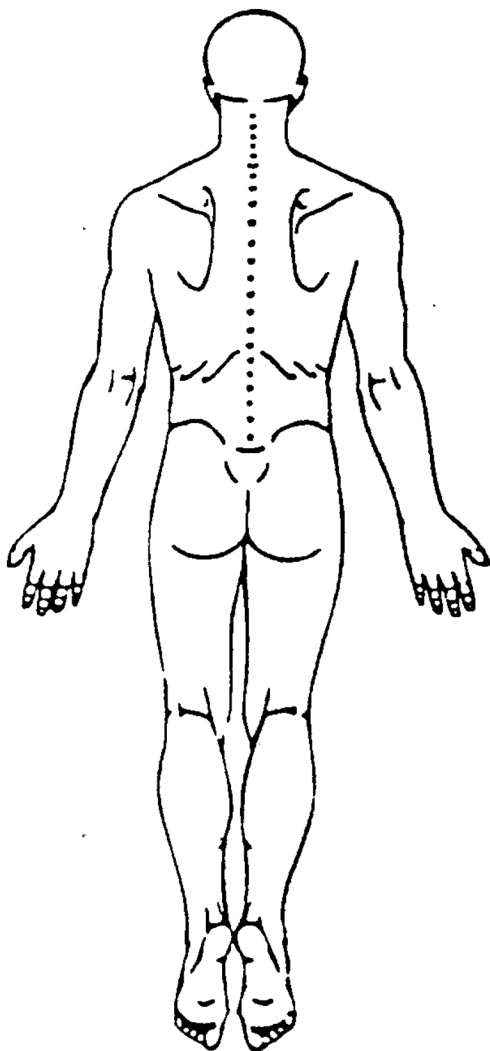


MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN OR OTHER SYMPTOMS





Longwood Rehabilitative Services

There are many words that describe pain. Some of these are grouped below. Check any words that describe the pain you are having.

1.
Flickering
Quivering
Pulsing
Throbbing
Beating
Pounding

2.
Jumping
Flashing
Shooting

3.
Pricking
Boring
Drilling
Stabbing

4.
Sharp
Cutting
Lacerating

5.
Pinching
Pressing
Gnawing
Cramping
Crushing

6.
Tugging
Pulling
Wrenching

7.
Hot
Burning
Scalding
Searing

8.
Tingling
Itchy
Smarting
Stinging

9.
Dull
Sore
Hurting
Aching
Heavy

10.
Tender
Taut
Rasping
Splitting

11.
Tiring
Exhausting

12.
Sickening
Suffocating

13.
Fearful
Frightful
Terrifying

14.
Punishing
Grueling
Cruel
Vicious
Killing

15.
Wretched
Blinding

16.
Annoying
Troublesome
Miserable
Intense
Unbearable

17.
Spreading
Radiating
Penetrating
Piercing

18.
Tight
Numb
Drawing
Squeezing
Tearing

19.
Cool
Cold
Freezing

20.
Nagging
Nauseating
Agonizing
Dreadful
Torturing



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PATIENT MEDICAL HISTORY

NAME: _____

DATE: _____

Is your current injury related to: () work injury () auto accident () home accident
() sport injury () post-surgical () unsure

Injury Date: _____ Similar injury in the past? _____

Describe how your injury occurred? _____

Have you received any treatment for this injury to date? _____

List any medications? _____

Are your symptoms: () increasing () decreasing () constant

Rate your pain: 0 = no pain 10 = you would call 911 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? _____ Better? _____

Are your symptoms affecting your ability to: () work () play () sleep () sit
() stand () walk () drive () exercise

What are your goals in attending physical therapy? _____

Had any diagnostic studies for this injury? () X-Ray () MRI () CT Scan () EMG/NCV

Do you now have or ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/Chest Pain	_____	_____	Vision or Hearing Difficulties	_____	_____
Coronary Heart Disease/Angina	_____	_____	Numbness or Tingling	_____	_____
Do you have a pacemaker?	_____	_____	Dizziness or Fainting	_____	_____
High Blood Pressure	_____	_____	Weakness	_____	_____
Heart Attack/Heart Surgery	_____	_____	Weight loss/Energy loss	_____	_____
Stroke/TIA	_____	_____	Hernia	_____	_____
Blood Clot/Emboli	_____	_____	Varicose Veins	_____	_____
Epilepsy/Seizures	_____	_____	Allergies	_____	_____
Thyroid/Goiter	_____	_____	Pins or Metal implants	_____	_____
Anemia	_____	_____	Joint Replacement	_____	_____
Infectious Disease	_____	_____	Neck Injury/Surgery	_____	_____
Diabetes	_____	_____	Shoulder Injury/Surgery	_____	_____
Cancer/Chemo/Radiation	_____	_____	Elbow/Hand Injury/Surgery	_____	_____
Osteoarthritis	_____	_____	Back Injury/Surgery	_____	_____
Osteoporosis	_____	_____	Knee Injury/Surgery	_____	_____
Gout	_____	_____	Leg Injury/Surgery	_____	_____
Sleeping Problems/Difficulties	_____	_____	Ankle/Foot Injury/Surgery	_____	_____
Emotional/Psychological Problems	_____	_____	Are you Pregnant?	_____	_____
Bowel or Bladder Problems	_____	_____	Do you smoke?	_____	_____

Patient/Guardian Signature: _____



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PATIENT DATA SHEET

NAME: _____ DATE OF BIRTH _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

E-MAIL: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

EMERGENCY CONTACT/RELATIONSHIP: _____ PHONE: _____

REFERRING PHYSICIAN: _____ NEXT DR. APPT? _____

DIAGNOSIS: _____ OCCUPATION: _____

EMPLOYER: _____

EMPLOYER ADDRESS _____
CITY STATE ZIP CODE

HOW DID YOU HEAR ABOUT LONGWOOD REHAB? _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Longwood Rehabilitative Services, Inc. to furnish physical therapy/health care and treatment to _____ considered necessary and proper in diagnosing and/or treating his/her physical condition.

PATIENT/GUARDIAN: _____ DATE: _____

BENEFIT ASSIGNMENT

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and all third party payors to Longwood Rehabilitative Services, Inc. I hereby authorize said assignee to release all information necessary, including Medical records, to secure payment. A photocopy of this assignment is to be considered as valid as the original.

PATIENT/GUARDIAN: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing or initialing below, I confirm that I have received a copy of the Notice of Privacy Practices for Longwood Rehabilitative Services, Inc.

PATIENT/GUARDIAN: _____ DATE: _____

request: however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. We reserve the unilateral right to revoke any voluntary agreement to restrict the use or disclosure of your PHI that we may enter into. In order to request a restriction in our use or disclosure of your PHI, **you must make your request in writing to: Privacy Officer; Longwood Rehabilitative Services, Inc., 2629 West State Road 434, Longwood, FL 32779**

Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. In order to inspect and/or obtain a copy of your PHI, you **must submit your request in writing to: Privacy Officer, Longwood Rehabilitative Services, Inc., 2629 West State Road 434, Longwood, FL 32779** Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, under certain circumstances, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, **your request must be made in writing** and submitted to: ***Privacy Officer, Longwood Rehabilitative Services, Inc., 2629 West State Road 434, Longwood, FL 32779***

You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented in the disclosure. Examples might include, but are not limited to, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also excluded from the accounting disclosures are records related to an authorization made by yourself. In order to obtain an accounting of disclosures, **you must submit your request in writing to: Privacy Officer, Longwood Rehabilitative Services, Inc., 2629 West State Road 434, Longwood, FL 32779**

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: ***Privacy Officer, Longwood Rehabilitative Services, Inc., 2629 West State Road 434, Longwood, FL 32779***

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with our practice, contact: ***Privacy Officer, Longwood Rehabilitative Services, Inc., 2629 West State Road 434, Longwood, FL 32779***

To file a complaint with the Office for Civil Rights: ***Office for Civil Rights, U.S. Department of Health & Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201***

All complaints must be submitted in writing. **You will not be penalized or retaliated against for filing a complaint.**

If you have any questions regarding this notice or our health information privacy policies, please do not hesitate to contact our Privacy Officer at 2629 West State Road 434, Longwood, FL 32779.



Longwood Rehabilitative Services

2629 W. State Road 434 • Longwood, FL 32779

(407) 774-1716 • Fax: (407) 774-9527 • www.longwoodrehab.com

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you as well as your health status. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws may seem complicated, but we must provide you with the following important information:

- How we may use and disclose your *protected health information* (PHI)
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices to allow for additional uses or disclosures of PHI. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer

Longwood Rehabilitative Services, Inc.

2629 West State Road 434, Longwood, FL 32779

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment.

Our practice may use and disclose your PHI to provide, treat, coordinate, and/or manage your health care and any related services. Common treatment activities include, but are not limited to: We may use the results of services ordered for you to help us reach a diagnosis or to treat your medical condition(s). Many of the people who work for our practice – including, but not limited to, our physical therapists and office staff – may use or disclose your PHI in order to treat you or to assist others in your treatment. For example, your PHI may be provided to a physician to whom we have referred you to ensure that the physician has the necessary information to diagnose or treat you. Additionally, we may disclose your PHI to others who are involved in your care or may assist in your care, such as, but not limited to, a hospital, outpatient facility, home health agency, nursing facility, or hospice agency.

2. Payment.

Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. Common payment activities include, but are not limited to: We may submit a claim to your insurance company that identifies you as well as your diagnosis, procedures, and supplies used. We may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. For example, obtaining approval for physical therapy coverage, or other outpatient service, may require that relevant PHI be disclosed to the health plan for approval for the service. We may contact your insurance company in order to review a claim or to appeal a claim. We also may use and disclose

your PHI to obtain payment from third parties that may be responsible for such costs which could include family members. We may use your PHI to bill you directly for services and items. We may use and disclose specified information to consumer reporting agencies, such as, but not limited to, a collection agency.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. Operational activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students in our office, licensing, and conducting or arranging for other business activities such as, but not limited to, medical review, legal, accounting and auditing services.

Other examples of use and disclosure of PHI for operations include, but are not limited to:

We may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate the physician or other practitioner who will be seeing you.

We may also call you, by name, from the waiting room when your physician or other employee is ready to see you.

We may have conversations and communications with you that we reasonably attempt to safeguard from incidental disclosure to others. Such incidental disclosures are not a violation of the law, and we encourage you to communicate with us using a lowered tone of voice.

We may send you results of testing in the mail utilizing our professional business name and logo.

We may send you a reminder in the mail of your next appointment or the need to schedule an appointment utilizing our professional business name and logo.

We may leave a message on your telephone answering machine/service, utilizing your name, as a reminder of an appointment or to contact our office insurance/billing department.

We may share your PHI with third party "business associates" (such as, but not limited to, an answering service, transcription service) used by the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may communicate with you regarding information about our practice or to inform you of potential treatment options or alternatives, or health related benefits that may be of interest to you.

We may contact you for fund-raising activities.

NOTE: Uses and disclosures of your PHI as listed above, or in the areas listed below, may be made using standard communications such as, but not limited to, telephone, direct mail, and facsimile. Every reasonable effort is made in our communications to ensure the accuracy and security of the information used in performing standard communications.

4. Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

D. USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI) IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your protected health information:

1. Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

2. Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made in accordance with state law for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3. Communicable Diseases: We may disclose your protected health information, according to state law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

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

5. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information under law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6. Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements.

7. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

8. Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

9. Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation and transplantation purposes.

10. 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.

11. Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

12. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

13. Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

14. Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

E. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your protected health information (PHI) may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization except to the extent that your physician or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

F. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the protected health information (PHI) that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, **you must make a written request to:** Privacy Officer, **Longwood Rehabilitative Services, Inc., 2629 West State Road 434, Longwood, FL 32779** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. **We are not required to agree to your**