Britt Zink Physical Therapy Services LLC

Britt Zink, MSPT, Cert MDT

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information

NOTICE OF PRIVACY PRACTICES

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

This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Britt Zink Physical Therapy Services LLC, whether recorded in our medical record, billing invoices, paper forms, video, or in other ways.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION:
We use or disclose your health information as follows:

- **Treatment:** We may use your health information to provide care and share it with others who are treating you. For example, we may disclose your health information to your physician.
- **Payment:** We may use and share your health information to bill and obtain payment for the healthcare services you receive. For example, we send information about you to your health insurance plan so it will pay for your services.
- **Healthcare operations:** We may use and share your health information for our day-to-day operations, to improve your care, and contact you when necessary. For example, we may use your medical information to review our treatment and services so we can evaluate how to improve our quality of care.
- **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.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and family:** We may disclose to your family and close personal friends any health information directly related to that person's involvement in your care.
- **Disaster Relief:** We may disclose your health information to disaster relief organizations in an emergency so your family can be notified about your condition and location.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law:** We will share information about you if state or federal law require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. This may include disclosing information about victims of abuse, neglect, or domestic violence.
- **Law enforcement:** We may share information for law enforcement purposes, such as when a crime is committed at one of our facilities. We may also share information to help locate a suspect, fugitive, missing person or witness.
- **For public health and safety:** We can share in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Lawsuits and legal actions:** We may share information about you in response to court or administrative order, or in response to a subpoena.
- **Worker's compensation, correctional institutions and other government requests:** We can share information to employers for workers' compensation claims. We also share information with correctional institutions about their

inmates. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.

- **Health Oversight Activities:** We may provide medical information to a health oversight agency or 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.
- **Organ and Tissue Donation:** We may provide medical information to organizations that manage, bank ro transplant organ and tissue donations if you are an organ donor.
- **National Security and Intelligence, and Protective Services Activities:** We may provide medical information about you to federal officials for intelligence, counterintelligence, or other national security activities. Such activities include protection to the President, other authorized persons or foreign heads of state to conduct special investigations.

We may contact you in the following situations:

- **Appointment Reminders:** to remind you of appointments with us or to reschedule a missed appointment.
- **Treatment options:** To provide information about treatment alternatives or other health related benefits or services that may be of interest to you.
- **Home Program Follow up:** to send you updates to your home exercise program.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION:

When it comes to your health information, you have certain rights.

- **Get a copy of your medical record:** You can ask to see or get a paper copy of your medical record and other health information we have about you. We will provide a copy or summary to you usually within 30 days of your request. We may charge a reasonable, cost-based fee. Access may be denied in some circumstances when a certain law prohibits your access. In some circumstances you may have this decision reviewed.
- **Ask us to correct your medical record:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing within 30 days of your request. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be honored..
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer for the purpose of payment or our operations. We will say "yes" unless a law requires that we share that information.
- **Get a list of those with whom we've shared information:** You can ask for a list accounting of the times we've shared your health information for six years prior, who we have shared it with, and why. We will include all disclosures (such as those you asked us to make). We will provide one accounting year for free, but we will charge a reasonable cost-based fee if you ask for another within 12 months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.

- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.

Contact Information:
Clinic Manager, Britt Zink Physical Therapy Services LLC
6236 S. Pinnacle Pl, Suite 106
Sioux Falls, SD 57108
605-215-8890

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION:

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and provide you a copy.
- We will not use or share your information other than as described here unless you tell us in writing. You may change your mind at any time by letting us know in writing.

CHANGES TO THIS NOTICE:
We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request.

EFFECTIVE DATE:
This Notice of Privacy Practices is effective May 11, 2020)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This serves as acknowledgement that you have received a copy of the Britt Zink Physical Therapy Services LLC's Notice of Privacy Practices. Please fill out the lines below.

Signature:____

Printed Name: _______________________________________ Date of Birth: ______________________

Relationship to patient: self parent guardian

CONSENT TO TREATMENT
I authorize Britt Zink Physical Therapy Services LLC to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained

health professional. I further acknowledge that no guarantee has been made to me aso the results of such care, physical examinations, procedures and/or interventions. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Britt Zink Physical Therapy Services LLC in writing. In addition, Britt Zink Physical Therapy Services LLC may terminate services by notifying me in writing. I also authorize release of such information to the third party payors.

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges related to services provided by Britt Zink Physical Therapy Services LLC. If I have questions about my financial responsibility for Britt Zink Physical Therapy Services LLC charges, I can contact Britt Zink Physical Therapy Services LLC at the contact information listed below.

ASSIGNMENT OF PAYER BENEFITS

I agree Britt Zink Physical Therapy Services LLC will bill and provide health information to any Payers. “Payers” are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges that I have incurred. All Payers may make payments directly to Britt Zink Physical Therapy Services LLC. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to Britt Zink Physical Therapy Services LLC. I agree that unless Britt Zink Physical Therapy Services LLC have agreed with the Payer to accept payment from the Payer as full payments, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services; payment is required at the time of service. Finally, I understand that failure to pay my portion of my charges may results in outstanding charges to be turned over to a collection agency.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Britt Zink Physical Therapy Services LLC for any services furnished me by Britt Zink Physical Therapy Services LLC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

AUTHORIZATION FOR RELEASE OF INFORMATION:

Britt Zink Physical Therapy Services LLC reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work related injury to your employer. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy. If this is a work-related injury I authorize Britt Zink Physical Therapy Services to provide my employer with any and all needed information related to my condition. If further care from another therapist, physician, or specialist were needed, I authorize the release of records to such party.

INSURANCE PRE-CERTIFICATION INFORMATION:

Some insurance companies have pre-certification requirements for physical therapy. If you are not sure whether your insurance company has pre-certification requirements, please check before evaluation/treatment so that you will not be denied insurance benefits for this visit.

AUTHORIZATION FOR COMMUNICATION: As a patient, I have been given or will provide Britt Zink Physical Therapy Services LLC my home phone number, mobile phone number, email address and/or other contact information. By signing below, I agree to be contacted by Britt Zink Physical Therapy Services LLC, its affiliates, and/or company hired by them using automatic dialing systems, recorded or artificial voice messages, text messages, emails and/or similar methods. The purpose of these messages may include appointment reminders or other health care messages, patient feedback, links to home exercise programs, surveys, marketing or promotional messages, upcoming events, unpaid balance messages, and/or other business messages.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted by and read by a third party.

In case of emergency, please list contact name: ____

Relationship: ____ Phone: ________________________________

ACKNOWLEDGMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am authorized representative of the patient. A copy of this form is as effective and valid as the original.

___________________________	____________________
Print Name of Client	Date of Birth
______________________________	___________________
Signature of Client, Guardian or Responsible Party	Relationship to Client
_________________________________	____________________
Private Practitioner / Witness	Date

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information

Patient Information: to be completed by patient:

Patient Name: ______________________________________ Date of Birth: ___________________________

Gender: ☐ Male ☐ Female

Address: ____

City: ____ State: _________ Zip: _______________________

Home Phone: ___________________ Mobile: __________________ Work: _______________

Email: ____

Emergency Contact: ____

Primary Care Physician: ____

Employer: ____ Occupation: _____________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ None ☐ Self Employed

Student Status: ☐Full time ☐ Part Time ☐ NA

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hobbies/Recreational Activities: ____

Is this illness/problem the result of: ☐ Accident at Work ☐ Auto Accident ☐ Other type of accident/injury

Who can we thank for referring you to our practice? How did you hear about us? _________________________

____

Primary Insurance Information:

Primary Insurance Company Name: ____

Policy Holder Name: ____ Policy Holder DOB: __________

Policy Number/ID:____ Group #: ___________________

Relationship to Policy Holder: ____

Secondary Insurance Information:

Insurance Company Name: ____

Policy Holder Name: ____ Policy Holder DOB: __________

Policy Number/ID:____ Group #: ___________________

Relationship to Policy Holder:____

Are you currently receiving or have your received Home Health Services (including any therapy, nursing, Bathing, dressing, etc) in the past 60 days?   Yes   No

Are you currently receiving or have you received other therapy services in the past 60 days?   Yes   No
If under the age of 19, please be sure to include parent(s) or legal guardians (person responsible for bill).

Mother/Legal guardian: _______________________________________ Date of Birth: ________________

Address (if different from patient):____

City: _____________________________________ State: ______________________ Zip: _____________

Home Phone: ___________________   Mobile: __________________ Work: _______________

Mother Email: ____

Mother Employer: ____ Occupation: __________________________

Father /Legal guardian: ____ Date of Birth: ________________

Address (if different from patient):____

City: _______________________________________ State: _______________________ Zip: _____________

Home Phone: ____________________ Mobile: ___________________ Work: _______________

Father Email: ____

Father Employer: ____ Occupation: __________________________

Past Medical History: Please circle any past or present medical problems that pertain to *YOU:*

☐ Cancer: Type: __________________ ☐ Diabetes ☐ Emotional Difficulty ☐ Epilepsy/Seizures

☐ HIV/AIDs ☐ Lymphoma ☐ Polio ☐ Thyroid Disease ☐ Lupus ☐ COPD ☐ Asthma ☐ Emphysema

☐ Lung Disease ☐ High Blood Pressure ☐ Heart Attack ☐ Heart Problems ☐ Pacemaker/Debrillator

☐ Heart Surgery ☐ Atrial Fibrillation ☐ Blood clots/PVT/PE ☐ Stroke ☐ Tuberulosis (TB)

☐ Bowel Disorder ☐ Gallbladder problems ☐ GI Bleed ☐ Hepatitis ☐ Hernia ☐ Kidney Problems

☐ Liver Problems ☐ GERD/Reflux Disease ☐ Chrohn's Disease ☐ Ulcers ☐ Hepatitis ☐ Hernia

☐ Kidney Problems ☐ Arthritis ☐ Fracture ☐ Osteoporosis ☐ Osteopenia ☐ Osteomyelitis

☐ Rheumatoid Arthritis ☐ Lymphedema ☐ Parkinson's Disease ☐ Organ Transplant

☐ Kidney Problems ☐ Arthritis ☐ Fracture ☐ Osteoporosis ☐ Osteopenia ☐ Osteomyelitis

☐ Headaches/Migraines ☐ Vertigo/Dizziness ☐ History of Falls ☐ Parkinson's Disease

☐ Other: Please specify: ____

Phone: 605-215-8890
Fax: 605-799-0131
email: brittzink@brittzinkpt.com
6236 S. Pinnacle Pl, Suite 106
Sioux Falls, SD 57108
www.brittzinkpt.com

Do you smoke: Yes No If "yes," how many packs per day? _______ Do you drink alcoholic beverages? Yes No

Past Surgical History: Please list any Past Surgeries

____ Year: ____________________

____ Year: ____________________

____ Year: ____________________

____ Year: ____________________

____ Year: ____________________

Allergies: ____ **Latex Allergy?** Yes No

Current Medications:

____

____

____

Have you fallen in the past year? Yes No **Is there a chance you could be pregnant at this time?** Yes No

What is the primary issue/problems that brings you in today? ____

____

What do you feel brought on this illness/problem? ____

____

As a result of this issue, what are you having difficulty with? ____

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Fax: 605-799-0131 Sioux Falls, SD 57108
email: brittzink@brittzinkpt.com www.brittzinkpt.com

____

When did your symptoms begin? ____

____

Please rate your pain in the past 48-72 hours: (using the scale “0 - 10” where 0 is no pain and 10 is the worst

Pain possible) At its Best: _______________ At its Worst: ____________ At Present: _______________

What time of day is your pain at its best? _______________________ At its worst? __________________

What activities or positions make you feel better? ____

What activities or positions make your pain worse? ____

What are your goals for treatment? ____

____

Have you received other treatment for this condition? (e.g physical therapy, massage chiropractor?)________

____

____

Patient signature Date

Name of Reviewing Therapist: ____

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Fax: 605-799-0131
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