Tennessee
Therapeutics, Inc.
PHYSICAL THERAPY

110 Skyline Drive, Suite B Maynardville, TN 37807
Mailing Address: P.O Box 71121 Knoxville, TN 37938
Phone: 865.992.6933 Fax: 865.992.6870

ACKNOWLEDGEMENT OF RECEIPT OF TENNESSEE THERAPEUTICS INC.

_____Notice of Privacy Practices Effective March 1, 2017

I have been informed of TTI's NOtice of Privacy Practices that describes how health information is used and shared. My signature below consitties my acknowledgement that I have been informed of Notice of Privacy Practice. A copy of which can be provided upon request. Patient's guest is requested to stay in our Main Lobby. Equipment is for patient's use only. The clinic is not responsible for any injuries that may occur. If the patient's guest breaks any equipment, you or they may be responsible for repair or replacement.

Social Media

TEnnessee Therapeutics Inc. Has social media account/s. Please notify us if you wish to refrain from being included on our social media account/s.

Covid-19

Have you had any symptoms related to Covid-19 including: Fever, Headache, Difficulty of Breathing?

YES or NO Circle here.

Appointment REminder

By signing below you give us consent to text/call/email you regarding your appointment and your permission to add your information such as pictures and testimonials to our social media page.

Print Name _____ Date _____

Signature of the Patient or legal representative _____

If signed by a legal representative, please list your relation to the patient. _____

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PATIENT INFORMATION

Date: _____

Patient Name: _____ Insurance #: _____

D.O.B_____ Age: _____ Male ☐ Female ☐ Social Security # _____/_____/_____

Home Phone# _____ Work Phone/Cell Phone# _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Information:

Employer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact:_____ Relationship: _____

Address : _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Mother's Name: _____ Mother's D.O.B: _____ Contact: _____

Father's Name: _____ Father's D.O.B: _____ Contact: _____

Insurance Authorization - Patient Release and Authorization

I hereby authorize payment directly to ***Tennessee Therapeutics Inc***., for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to me, but not to exceed the physician's and/or the INstitutes regular charges for therapy for this treatment period. I further authorize the release of any medical information required by my insurance carriers(s) and/or other treating physicians. It is my responsibility to provide for services that are not covered by my insurance. **IF the insurance policy is under spouses or guarantors name please include the policy holders D.O.B___/____/___**

Patient/Parent/Guardian's Signature: _____ Date: _____

Facility's Representative Signature: _____ Date: _____

PATIENT PAIN ASSESSMENT SURVEY

Patient Name: _____ Date: _____

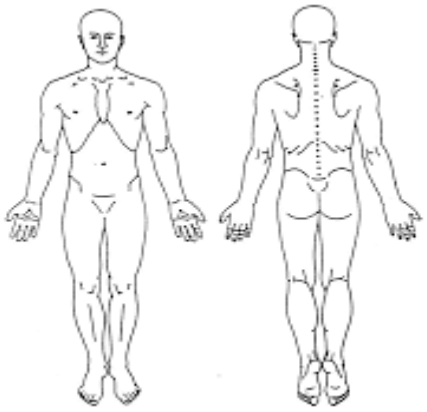
Physician: _____

Directions: Please complete the survey questions below, honestly and as completely as possible.

Your answers will assist us in treating your pain.

1. How long have you experienced your current pain? _____
2. Do you know what the cause of your pain is? _____
3. Where is your pain located? _____

Use the diagram below to locate your current pain. Circle the painful area(s) or area(s) of discomfort. Please use the following symbols to indicate what type of pain / discomfort you have.



[ACHING *] [Stabbing VVV]**
[BURNING +++] [NUMBNESS !!!]
[NEEDLES/PIN ---]

Pain Increase with: Y/N
[ ] Rest
[ ] Weight BEaring
[ ] Prolonged Weight Bearing
[ ] Gait (Walking)
[ ] Prolong Gait
[ ] Climbing Stairs
[ ] Squatting
[ ] Jumping
[ ] Lateral Movements
[ ] Transfers
[ ] Sitting
[ ] Weather/ Temperature
[ ] Running
[ ] Other: _____

Pain Decreases With:
[ ] Rest
[ ] Weight Bearing
[ ] Gait
[ ] Running
[ ] Sitting
[ ] Medicine
[ ] Other:

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1. On a scale of 1 to 10 **(0 - NO PAIN and 10 - THE MOST SEVERE PAIN YOU HAVE EXPERIENCED),** what is your current level of pain? _____
2. List the medication(s) you are taking for your pain:

   _____
3. When did you last take your pain medication? _____
4. Are these medications effective in relieving your pain? _____
5. Do you have muscle spasms associated with your pain? _____
6. What time of day is your pain most severe? _____
7. Does applying heat or ice improve your pain? _____
8. Is your pain constant or intermittent? _____
9. Does your pain limit your ability to sleep? _____
10. Have you fallen recently? ☐ Yes ☐ No If yes, when? _____
11. Do you have a pacemaker? ☐ Yes ☐ No If you do have a pacemaker give us a copy of the product card!
12. Do you have (or have you ever had) any of the following medical conditions?
    - Heart Disease ☐ Yes ☐ No
    - High Blood Pressure ☐ Yes ☐ No
    - Cancer ☐ Yes ☐ No
    - Seizures ☐ Yes ☐ No
    - Metal IMplant ☐ Yes ☐ No
    - Stroke ☐ Yes ☐ No
    - Diabetes ☐ Yes ☐ No
    - Lung Disease ☐ Yes ☐ No
    - Kidney Disease ☐ Yes ☐ No
    - Contagious Disease(s) ☐ Yes ☐ No
    - Dizziness ☐ Yes ☐ No

When? _____

- Allergy to Medications ☐ Yes ☐ No

If yes, list medication(s): _____

Please list **ALL** medications you are currently taking:

_____

What pharmacy location do you use? _____

Please describe any other chronic illnesses you may have that are not listed above:

_____

1. Please list any surgery you have undergone in the past. Begin with the most recent.

_____

2. Please include any other relevant information not previously stated, which will help us care for you.

_____

3. Have you seen any other physical therapy specialists? What were their conclusions or suggestions?

_____

THANK YOU FOR YOUR TIME IN COMPLETING THIS SURVEY. THIS INFORMATION WILL ASSIST US IN HELPING YOU REACH YOUR TREATMENT GOALS.

PATIENTS SIGNATURE _____ DATE _____

CONSENT TO TREAT

1. I hereby indicate my wish to become a participant in the rehabilitation program offered by ***Tennessee Therapeutics*** to receive PT.
2. I understand that the purpose of this program is to enhance my or my child's recovery from an injury or illness. I also understand that there exists the possibility that certain changes may occur during my or my child's treatment due to therapy.
3. I have been informed and have participated in the Plan of Care. I have also been informed of the procedures and methods of treatment that will be administered to me or my child, and I fully understand what is required of myself or my child's as a patient
4. I verify that myself or my child's participation is fully voluntary, no coercion of any sort has been used to obtain my participation, and I may withdraw myself or my child from treatment at any time if necessary.
5. I or my child have/has not been discriminated against on the basis of race, color, national origin, disability, or age in administering treatment, participation in its program, service, and admit.
6. I understand that the facility Administrator maintains an open-door policy with the following: If the therapist requests "If I or a guardian wish to enter and participate in the sesion I have the right to do so or refuse to. If I waive the right to enter a treatment session, I grant permission to the treating therapist to initiate treatment within a treatment room for the frequency and duration of the Plan of Care. " If parent/guardian is not present during the span of treatment session TT or therapist is not responsible for any accidents or incidents occurring in or on facility property.
7. I have been explained my right to lodge grievance complaints against any employee/facility concerning my/the care for treatment of my child. I understand my complaint/grievance will be investigated within 10 business days and a resolution of my concern will be given to me by the administrator.
8. Confidentially-Client records are recognized as confidential. They will be maintained against loss, destruction, or unauthorized use. I understand that:
    - A patient's/parent's/guardian's written consent is required for release of information.
    - Clinical records are to be used only by authorized staff.
    - Clinical records will be released, upon authorization from the Patient/Parent/Guardian, for the purpose of review, audits, or necessary insurance inquiries requested.
9. I understand the facility is not responsible for any lost or stolen item(s).
10. Materials will be read to vision imparied Patients/Parents/Guardians. The Patient/Parent/Guardians may choose to rely on a family member or friend as their option of preference.
11. I have had this information read or explained to me in a language or method I understand. I have been given the right to ask questions and those questions have been answered to my satisfaction.
    - Client Satisfaction
    - Advanced Directives
    - Assessment of Abuse/Neglect/Exploitation
    - Rights/ Responsibilities

In case of emergency, (Cardiopulmonary Arrest or other medical accident) I, ☐ patient ☐ parent ☐ guardian grant TT or CPR certified staff member to perform life rescuing techniques, or first aid on ☐ my child ☐ myself and to follow through with 911 emergency call on ☐ my Child's ☐ my behalf.

_____ _____

Patient's Signature Insurance ID#

Modalities/Physical Therapy GYM/Equipment Disclaimer

Throughout the rehabilitative process, the use of modalities may oftentimes increase the rate of return of function and or strength to the original and/or a normal level. Though the use of such modalities is highly recommended, there are potential side effects that one must be aware of prior to use. Though the likelihood of harm that may arise from their use is minimal, it is important that one is aware of and agrees to their use with regard to the liability involved via signature on this disclaimer.

Physical therapy gym and equipment are for PATIENTS use ONLY. There may be an instance where our patient may need to bring a guest with them during the visit. If that guest will need extra attention from our patient, we may ask that the therapy session be rescheduled at a better time.

** MODALITIES USED AND THEIR INTERACTIONS/SIDE EFFECTS**

☐ Kinesio Tex: Taping-Redness over areas taped. Blistering on some occasions. Allergic reaction to tape/adhesives

☐ Neuromuscular Electrical Stimulation (E-Stim): Skin irritation, redness, itching, blistering, cutaneous burns.

☐ Splinting-Maceration: redness around areas of pressure.

☐ Electrical Stimulation (TENS): Skin irritation, redness, itching, blistering, cutaneous burns.

☐ Ultrasound: Redness, edema, electric shock.

☐ HydroWorx: Electric Shock, skin irritations, redness, itching, water not draining, changing speed of treadmill beyond our control.

I _____ have been made aware of the possible interactions and/or side effects that may arise from the use of the aforementioned and marked. I also understand that my signature on this form releases ***Tennessee Therapeutics*** of liability for resulting interactions that may arise.

_____ _____

Patient/Parent/Guardian's Signature Date

_____ _____

Center's Representative Date

Patients Responsibilities

- Behavior that shows respect and consideration for other patients, family, visitors, and personnel of the center.
- Ensuring that the financial obligations for health care rendered are paid in a timely manner.
- Providing the center to the best of their knowledge with an accurate and complete medical history about present complaints, past illnesses, hospitalization, surgeries, and existence of advance directives, medications, and other pertinent data.
- Accepting consequences of their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given to them by the doctor or their health care team member.
- Notifying the center of any changes with the patient's condition or circumstances.
- Following the plan of treatment recommended by the doctor primarily responsible for the patient's care and/or other personnel authorized by the center to instruct patients.
- Keeping their appointment for scheduled services, If they anticipate a delay or must cancel the scheduled services it is their obligation to tell the rehjav as soon as information is received.
- Valuables/items while at the center are the sole responsibility of the guardian or patient.
- All billing activities will be done in accordance with instructions provided by Medicare and other public and private payers. The practice will attempt to collect deductibles and coinsurance as required by Medicare or by the contracts with other payers. The practice will write off any portion of the charges that exceed the Medicare approved amounts or those contracted fees from other payers. Patients will not be required to pay amounts which can be promptly refunded to the party making the payment. All patients will be subject to the same collection policies and procedures which will comply with local, state, and federal law and are processed by my insurance, as a private payment arrangement and/ or personal injury claims.
- I am also ultimately responsible for any outstanding balance on my account after claims are processed by my insurance, as a private payment arrangement and/or personal injury claims.
- I understand that I must be seen within 30 days of the referral date or within 30 days of the last appointment I attended. After the 30 day mark I must get a new referral from my doctor.

_____ _____

Patient's Name Date

_____ _____

Patient/Parent/Guardian Signature Date