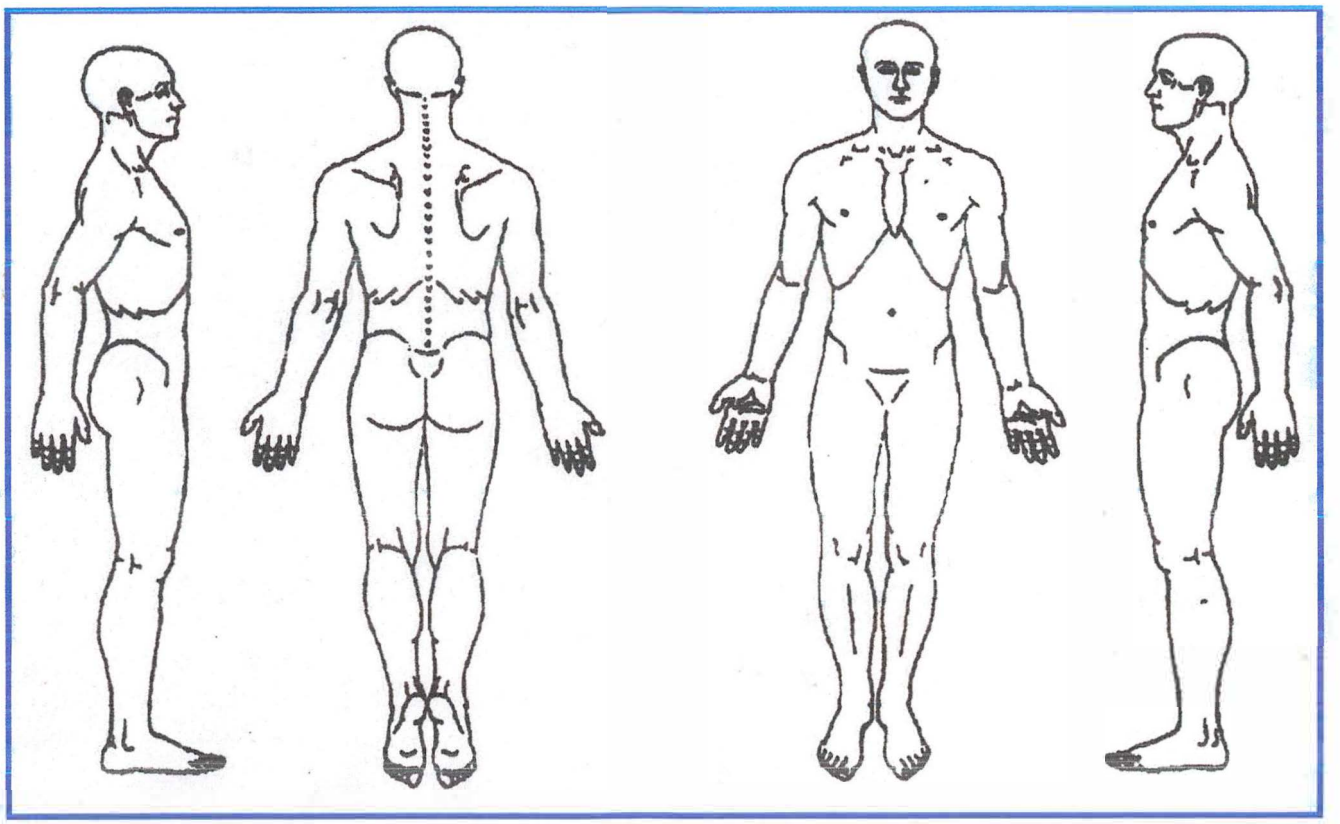
Name: _____ Date _____

Choose the number that best corresponds to your pain:

At best:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 (Excruciating Pain)**
Currently:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 (Excruciating Pain)**
At worst:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 (Excruciating Pain)**

☐ X-ray ☐ MRI ☐ CAT Scan ☐ Other _____

Shade in areas of pain on body diagrams. If you are filling this form out on a computer, print the form after completion and mark the diagram with a pen.



FOR OFFICE USE ONLY

Blood Pressure: _____

Pulse: _____

Oxygen: _____ Height: _____

Falls Assessment: _____ Weight: _____

Outcome Measure: _____ BMI: _____

TAOS PHYSICAL THERAPY INC
SPORTS REHABILITATION

414 Sipapu Street | Taos, New Mexico 87571 | 575.758.8761

Attendance Contract

- **Your attendance is imperative to getting better faster and returning to the activities you enjoy.**
- **The number of visits per week that your therapist has planned for you is important to reduce your symptoms and help you have a quicker recovery.**
- **Our therapist's time is valuable. They have blocked time for you on their schedule. Giving a 24 hour notice when you cannot make an appointment will allow them to schedule someone else during that time.**

____ I understand the importance of regular/consistent attendance to my therapy appointments.

____ I respect my therapist's time and the importance of providing 24 hour notice when I am unable to make my appointments.

____ I understand that should I have 3 consecutive cancellations with less than 24 hours notice, 2 consecutive no-show appointments, or a combination of both equaling 3, I will be discharged from therapy and Taos PT will notify my doctor of my non-compliance.

_____ _____

Print Patient's Name Date

_____

Patient's Signature

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements to 45 CFR § 164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Taos Physical Therapy, Inc. (the "Practice") for the purpose of treating me, obtaining payment for treatment of me , and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing the Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request to the office of the Practice at the following address: 414 Sipapu St. Taos NM 87571. Attention: Compliance Officer.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out the treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

PLEASE SIGN ON BACK

By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgment and a copy of the Practice's Privacy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and healthcare operations.

_____

Signature of Patient or Representative Date

_____

Patient's Name

_____

Date of Birth

_____

Social Security Number

_____

Name of Personal Representative(If applicable) Relationship to Patient

To Be Completed by the Practice

The requested revisions on the use and/or disclosure of the patient's health information set forth are:

_____Accepted _____Denied _____Not Applicable

_____Other (explain)_____

_____

Signature of Authorized Practice Representative Date