Welcome to MTS Physical Therapy. We are excited to be a part of your journey toward well-being. Whether you are new to our services or a returning patient, we would like to share some information that we feel will help get you started on the best path.

The forms within this new patient packet will provide valuable information to your therapist and care team. Please complete them accurately as this will help your therapist determine the ideal care plan for your time with us in our clinic and thereafter.

At any time, ask your therapist about our MTS Wellness Program. We offer many different services, including our fully equipped gyms, a wide variety of group exercise classes, and much more. We also offer special rates while you are in patient care. You can visit our website (mtsphysicaltherapy.com) for more information.

MTS has partnered with KEET Health because KEET feels the same way we do about your health. KEET Health allows us to engage with you through their software during your care in our clinic and throughout the time you begin following our recommendations at home. Keet Health will assign questionnaires to you that will help us understand how you are progressing during our time with you. Lastly, KEET allows us to share a large library of at home exercises that will be tailored to your needs.

Please take these next steps to fully participate in your care:

1. Download KEET Health app.
2. Please maintain access to your email address provided to ensure you get the latest updates to your care.

You can download KEET Health app by searching KEET Health in the Apple App Store, Google Play Store or by visiting their website directly at mts.keethealthapp.com/login.

Prior to your visit with us your insurance will be verified and if necessary, authorization obtained. An appointment reminder call will be made, and your financial responsibility will be reviewed with you at that time. You can anticipate these calls to come from our front office staff at your scheduled location.

Please see the below to know how to be prepared for your visit and the time spent with your Therapist:

- ☑ Script from your physician to evaluate and treat, unless faxed by physician.
- ☑ Your completed paperwork, if not already completed through email.
- ☑ Driver's license and/or parent or legal guardian.
- ☑ Your insurance cards.
- ☑ Any copays or monies owed by you for your visit.

It is required that you arrive or virtually sign in 15 minutes before your initial appointment time and have all the above listed items with you, or it will be necessary to reschedule your appointment.

If you have any questions or we can be of any assistance, please call your clinic office.

We look forward to seeing you and working with you to achieve your best self.

Sincerely,

Your MTS Team

MTS
PHYSICAL THERAPY
& WELLNESS

PATIENT INFO

Date of Birth: _____ Clinic Name: _____

Patient First & Last Name:_____Middle Initial: _____

Gender: M F Email address:_____

Mailing Address: _____

City:_____State: _____ Zip Code: _____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone Provider: _____

Social Security Number:_____

Marital Status: _____

Place of Employment: _____

Employment Address: _____

City:_____State:_____ Zip Code:_____

EMERGENCY CONTACT INFO

I designate the person stated below as my emergency contact in the instance that anything would happen during the in clinic or telehealth session that would require emergency communication. I authorize the release and distribution of information concerning my illness or injury and outpatient treatment by MTS Physical Therapy & Wellness to the below mentioned individual.

Emergency Contact Full Name: _____

Relationship: _____ Phone Number: _____

RESPONSIBLE PARTY/GUARDIAN INFO

First & Last Name: _____ Date of Birth: _____

Address:_____ Phone Number: _____

City:_____State: _____Zip Code: _____

Do you have an active membership with our MTS Wellness Program? Yes __ No __

Patients receive a Preferred Rate while in therapy

Patient/Responsible Party Initials: _____

PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand MTS-OLG Therapy Services LLC's Notice of Information Practices. I understand that MTS-OLG Therapy Services LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that MTS-OLG Therapy Services, LLC will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I hereby authorize the use and disclosure of my personal health information for purposes as noted in MTS-OLG Therapy Services LLC Notice of Information Practices. I understand that I retain the right to revoke this authorization by notifying the practice in writing, at any time.

PATIENT/RESPONSIBLE PARTY SIGNATURE:_____ **DATE:** _____

I hereby consent to the release and disclosure of my personal health information to MTS-OLG Therapy Services LLC. This authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of designing a plan of treatment. I understand that MTS-OLG Therapy Services LLC is permitted to send me unencrypted emails that contain personal health information if advised by me and I am aware of the risk.

PATIENT/RESPONSIBLE PARTY SIGNATURE:_____ **DATE:** _____

TELEHEALTH CONSENT

In order for MTS-OLG Therapy Services, LLC to effectively give the best possible treatment and care for our patients, we may choose to use audiovisual communication to enhance interventions. I agree to participation in intervention via audiovisual communication with the possibility of communication recording via a secure platform of communication. I understand if there are any recordings of information that it will be stored via HIPPA compliant means. I understand, if at any time I am uncomfortable with participating in Telehealth, I have the option to no longer participate and it will be acknowledged and addressed by MTS Physical Therapy & Wellness.

PATIENT/RESPONSIBLE PARTY SIGNATURE:_____ **DATE:** _____

NO SHOW POLICY

In order for MTS-OLG Therapy Services LLC to effectively give the best possible treatment and care for our patients, it is imperative that our patients attend their scheduled appointments as referred by their physicians. If you are unable to attend your scheduled appointment, as a courtesy to our office, please call 24 hours prior to your appointment time to cancel. If you consistently miss scheduled appointments our office will not be able to schedule your next appointment and will discontinue treatment. This will require you to obtain a new referral for treatment from your physician.

PATIENT/RESPONSIBLE PARTY SIGNATURE:_____ **DATE:** _____

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Preferred Physicians involved in your care:

Physician Name:_____ Specialty: _____

Physician Name:_____ Specialty: _____

Patient Name: _____ DOB: _____ Date: _____

What area of your body is your pain located?

_____

What side of your body is your pain located? (Circle one)

Left Right Both

When did your symptoms start (date)? _____

How did your symptoms start? _____

Describe your symptoms by circling all that apply:

Numbness Tingling Burning

Ache Stabbing Shooting

Have you had these symptoms before? (Circle one) Yes No

Symptoms are? (Circle One)

Constant Come and go Only with activity

Symptoms are? (Circle One)

Getting worse Not changing Getting better

What medical treatment have you had for this?

_____

What diagnostic testing you have had? (Circle one)

MRI CT Scan X-Rays None

Other: _____

What relieves your symptoms?

_____

Does your pain radiate/travel throughout your body? (Circle One)

Yes No

What do you have difficulties with?

_____

What activity do you have the most pain/difficulty performing?

_____

Use the scale below to rate your pain/difficulty for the next 2 questions:

|---|-----|------|------|-------|------|------|-----|------|------|

0 1 2 3 4 5 6 7 8 9 10

No Pain/Difficulty Slight Pain/Difficulty Max Pain/Difficulty

Pain at **WORST** with the above activity: _____

Pain at **BEST** with the above activity: _____

Occupation: _____

Work Status: _____

Is your condition related to: (Circle one)

Employment Accident Auto Accident Other

Home Accident None

List Assistive Devices you use (crutches, braces, shoe inserts):

_____

Medical History: (Circle Yes or No)

Cancer?	Yes	No
Diabetes?	Yes	No
High Blood Pressure?	Yes	No
Heart Disease?	Yes	No
Pacemaker?	Yes	No
COPD?	Yes	No
Osteoporosis?	Yes	No
Osteoarthritis?	Yes	No
Rheumatoid Arthritis?	Yes	No
Neurologic dz (MS, Parkinson's)?	Yes	No
Ulcers / GERD / Acid Reflux?	Yes	No
Kidney / Liver Disease?	Yes	No
Hepatitis A, B, C / HIV?	Yes	No

Other: _____

Any other current physical limitations?

_____

In the past 3 months have you had, or do you experience:

(Circle Yes or No)

Fever / chills / sweats?	Yes	No
Unexplained weight change (>10 lbs)?	Yes	No
Numbness or tingling?	Yes	No
Bowel / bladder incontinence?	Yes	No
Unexplained Falls/Decreased balance?	Yes	No
Are you currently pregnant?	Yes	No

Prior surgeries?

_____

_____

Please list your medications and what you are taking them for:

_____

_____

_____

MEDICAL EMERGENCY

If an emergency situation is identified during a telehealth visit, the clinician will contact the local emergency responder in the location from which the Telehealth communication is originated. If transportation is required, the patient may arrange own transportation and if unable to agrees to utilize ambulance services. The MTS Physical Therapy and Wellness staff will not be involved at any time in transporting patients. MTS Physical Therapy and Wellness staff will not be directly involved in any emergency assessment. For the purposes of this service, an emergency will be defined as:

- Loss of consciousness
- Fall with injury
- Observable distress or changes in cardiopulmonary status
- Observable distress or changes in neurological status

_____ _____

Patient/Member Signature **Date**

Unable to consent because:____Of minor age_____Other:_____

I therefore consent for the above.

_____ _____

Consenter's Signature Date

_____

Relationship

NOTICE OF PATIENT INFORMATION PRACTICES

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

MTS-OLG Therapy Services, LLC's LEGAL DUTY

MTS-OLG Therapy Services, LLC. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

MTS-OLG Therapy Services, LLC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, MTS-OLG Therapy Services, LLC. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

MTS-OLG Therapy Services, LLC. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, MTS-OLG Therapy Services, LLC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

MTS-OLG Therapy Services, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time.

You have the right to request that we correct any inaccurate or incomplete information in your records. A request for an amendment must be sent in writing to our office administrator and must include the reason for your amendment request. We will provide a decision in writing within 60 days.

You have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. MTS-OLG Therapy Services, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

If you have given someone health care power of attorney or if someone is your legal guardian under Louisiana law, that person can exercise your rights under this notice and make choices about your health information. However, we may choose not to treat a person as your representative if MTS-OLG Therapy Services, LLC or your physician reasonable believes that the person might endanger you in situation of domestic violence, abuse, or neglect.

You have the right to be notified following a breach of your unsecured health information. The notice of breach must be (1) in written form, (2) be provided without unreasonable delay (no later than 60 days following the discovery of the breach) and (3) to the extent possible, include a brief description of the breach, the types of information involved, the steps you should take to protect against potential harm, a brief description of what we are doing to investigate the breach, mitigate the harm to individuals and to protect against any further breaches, and contact procedures for you to ask questions.

CONCERNS AND COMPLAINTS

If you are concerned that MTS-OLG Therapy Services, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Compliance Officer at the address listed below. You may also file a complaint to the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 2020, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

For further information on MTS-OLG Therapy Services, LLC's health information practices or if you have a complaint, you can file your grievance in person, by mail, fax or phone with:

MTS: Compliance Officer, 111 Pasa Place, Lafayette, LA 70503, Phone: (337)571-1200, Fax: (337) 571-1204.

Or you can choose to call the Compliance Hotline: 1-877-547-2633