



YMCA OF GREATER DES MOINES

Acknowledgement of Receipt of Notice of Privacy Practices

The YMCA Healthy Living Center reserves the right to modify the privacy practices outlined in the notice provided for your review.

By signing, I acknowledge that I have been given a copy or the opportunity to read the Notice of Privacy Practices for the YMCA Healthy Living Center and have had any questions answered before signing.

Name (print): \_\_\_\_\_ DOB: \_\_\_\_\_

Signature of patient: \_\_\_\_\_

Signature of patient representative: \_\_\_\_\_
(required if the patient is a minor or adult who is unable to sign this form)

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
Guardian or conservator of an incompetent patient
Personal representative of patient unable to sign

Date: \_\_\_\_\_

Authorization to Release Information

I consent to the release of information and/or disclosure to the YMCA Healthy Living Center all or any part of my medical record to individuals acting in official capacities as my advocate, representing governmental or third party payers, governmental agencies, accrediting bodies or other health care providers involved in my care.

I hereby authorize the staff of the YMCA Healthy Living Center to disclose information related to my care to the following persons upon request:

Name and Relationship: \_\_\_\_\_

Name and Relationship: \_\_\_\_\_

Name and Relationship: \_\_\_\_\_

For office use only:

Form received by \_\_\_\_\_ Date \_\_\_\_\_

Acknowledgement refused:

Efforts to obtain:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Reason patient refused:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

## **2. Your Privacy Rights**

**Restrictions:** You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

**Confidential Communications:** You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

**Access to PHI:** You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

**Amendments:** You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

**Accounting of Disclosures:** After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

**Complaints:** If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

### **Our Duty to Protect Your Privacy**

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

### **Privacy Contact**

If you would like more information about our privacy practices or to file a complaint you may contact:

Name: Trina Radske-Suchan, MPT, CSCS  
Title: Medical Programs Director  
Phone: 515-645-3342



YMCA OF GREATER DES MOINES
YMCA Healthy Living Center

Patient Demographics Form

First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Employed at \_\_\_\_\_

Email Address \_\_\_\_\_ Marital Status Married Single Divorced Widowed Separated Child

Spouse's Name \_\_\_\_\_ Employed at \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Notification Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Policy Holder (if different than above) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Effective Date \_\_\_\_\_ Employed at \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy Holder (if different than above) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Effective Date \_\_\_\_\_ Employed at \_\_\_\_\_

Workers Compensation

Case Manager: \_\_\_\_\_ Contact # \_\_\_\_\_

Please note any additional Insurance Coverage: \_\_\_\_\_

Attorney: \_\_\_\_\_ Contact # \_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be made directly to the physician or supplier of services rendered. Our office cannot accept responsibility for collecting an insurance claim or for negotiating disputed claims. You are responsible for payment within ninety (90) days from date of service. Insurance reimbursement is a contract between you and your insurance company. In consideration of the services rendered to me by this physician, I am obligated to pay said office in accordance with the physician's credit and policy terms.

Patient's or Authorized Person's Signature

Date



**YMCA OF GREATER DES MOINES**  
**YMCA Healthy Living Center**

**Patient Intake Questionnaire**

Name: \_\_\_\_\_

Date: \_\_\_\_\_ DOB: \_\_\_\_\_

**Social History**

1. How did you hear about the YMCA Healthy Living Center?  
\_\_\_\_\_
2. Primary Care Physician: \_\_\_\_\_
3. Referring Physician: \_\_\_\_\_
4. Employment/Work
  - Working without restrictions
  - Working with restrictions
  - Unable to work due to dysfunction
  - Not employed
  - Student
  - Other
5. Occupation: \_\_\_\_\_
6. Please indicate your marital status: \_\_\_ M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_ Sep. \_\_\_ Child
7. Do you have any religious affiliations? \_\_\_\_\_

**General Health Status**

8. At the present time, would you say that your health is excellent, very good, fair, or poor?  
\_\_\_\_\_
9. Please rate your average level of stress: \_\_\_ Low \_\_\_ Moderate \_\_\_ High
10. Have you had any major life changes during the past year? \_\_\_ No \_\_\_ Yes  
If yes, please explain: \_\_\_\_\_

**Health Habits**

13. Do you currently smoke tobacco? \_\_\_ No \_\_\_ Yes # packs per day \_\_\_\_\_
14. Do you drink alcohol? \_\_\_ No \_\_\_ Yes How many drinks per average week? \_\_\_\_\_
15. Do you exercise beyond normal daily activities and chores? \_\_\_ No \_\_\_ Yes  
Include type, days per week, and duration of exercise: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. Do you have any questions or concerns regarding your nutrition?  
\_\_\_\_\_

**Medical/Surgical History**

17. Have you ever had or do you presently have any of these conditions? (Check if yes)

- |                       |                          |                      |                          |                       |                          |
|-----------------------|--------------------------|----------------------|--------------------------|-----------------------|--------------------------|
| Rheumatic Fever       | <input type="checkbox"/> | Surgery              | <input type="checkbox"/> | Edema                 | <input type="checkbox"/> |
| High Blood Pressure   | <input type="checkbox"/> | Muscular Injury      | <input type="checkbox"/> | Heat/Cold Sensitivity | <input type="checkbox"/> |
| Low Blood Pressure    | <input type="checkbox"/> | Back Pain            | <input type="checkbox"/> | Seizures/Epilepsy     | <input type="checkbox"/> |
| High Cholesterol      | <input type="checkbox"/> | Broken Bone/Fracture | <input type="checkbox"/> | Liver/Kidney Disease  | <input type="checkbox"/> |
| Lung Disease          | <input type="checkbox"/> | Diabetes             | <input type="checkbox"/> | Fainting              | <input type="checkbox"/> |
| Chest Pain            | <input type="checkbox"/> | Arthritis/Gout       | <input type="checkbox"/> | Stomach/Intestinal    | <input type="checkbox"/> |
| Stroke                | <input type="checkbox"/> | Hernia               | <input type="checkbox"/> | Osteoporosis          | <input type="checkbox"/> |
| High Cholesterol      | <input type="checkbox"/> | Circulation/Vascular | <input type="checkbox"/> | Infection             | <input type="checkbox"/> |
| Pacemaker             | <input type="checkbox"/> | Depression           | <input type="checkbox"/> | Infectious Disease    | <input type="checkbox"/> |
| Heart Disease         | <input type="checkbox"/> | Anxiety              | <input type="checkbox"/> | Head Injury           | <input type="checkbox"/> |
| Peripheral Neuropathy | <input type="checkbox"/> | Thyroid Problems     | <input type="checkbox"/> | Neurological Disorder | <input type="checkbox"/> |

Explain below checked items with appropriate dates of occurrence.

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18. Within the past year, have you had any of the following symptoms:

- |                        |                          |                       |                          |                      |                          |
|------------------------|--------------------------|-----------------------|--------------------------|----------------------|--------------------------|
| Joint pain or swelling | <input type="checkbox"/> | Difficulty sleeping   | <input type="checkbox"/> | Cough                | <input type="checkbox"/> |
| Pain at night          | <input type="checkbox"/> | Chest pain            | <input type="checkbox"/> | Hearing problems     | <input type="checkbox"/> |
| Headaches              | <input type="checkbox"/> | Bowel/bladder prob.   | <input type="checkbox"/> | Traumatic event(s)   | <input type="checkbox"/> |
| Weakness in arm/leg    | <input type="checkbox"/> | Shortness of breath   | <input type="checkbox"/> | Nausea/Vomiting      | <input type="checkbox"/> |
| Loss of balance        | <input type="checkbox"/> | Dizziness or fainting | <input type="checkbox"/> | Numbness or tingling | <input type="checkbox"/> |
| Difficulty walking     | <input type="checkbox"/> | Weight loss or gain   | <input type="checkbox"/> | Visual disturbances  | <input type="checkbox"/> |

19. Have you ever had surgery? \_\_\_ No \_\_\_ Yes If yes, please describe and when:

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20. Are you or could you be pregnant? \_\_\_ No \_\_\_ Yes

**Medications**

21. Do you take any prescription or nonprescription medications? \_\_\_ No \_\_\_ Yes

Prescription:

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Non-prescription:

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**Contraindications for Aquatic Therapy**

22. Please indicate if you have experienced any of the following:

- Uncontrolled hypertension or severe hypotension
- Diminished respiratory capacity
- Recent radiation treatment (last 3 months)
- Epilepsy
- Fever higher than 100 F
- Bladder or vaginal infections
- Infectious diseases
- Open wounds
- Known allergies to pool chemicals
- Unpredictable bowel or bladder incontinence

**Current Condition/ Chief Complaint (s)**

23. Please describe the problem (s) for which you seek aquatherapy?

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We look forward to serving your physical and wellness needs here at the YMCA Healthy Living Center. Please let us know of any way we can better meet those needs.



## YMCA OF GREATER DES MOINES YMCA Healthy Living Center

### Patient Rights

The YMCA Healthy Living Center is dedicated to providing you with the best in therapy services, both in terms of treatment and patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care.

#### Patients' Rights

The YMCA Healthy Living Center is committed to providing you with respectful care as we meet your healthcare needs. For this reason, we provide the following summary of your rights as a patient:

- You have a right to considerate and respectful care given by competent personnel.
- You have the right to participate in the development and implementation of your plan of care.
- You have the right to know the names and professional titles of your physical therapists and all other persons directly participating in your care.
- You have the right to every consideration of privacy concerning your rehabilitation program and to receive care in a safe environment.
- The confidentiality of your clinical and personal records will be maintained.
- You will not be denied access to care due to race, creed, color, national origin, sex, age, sexual orientation, disability or source of payment.
- You have the right to information about your diagnosis, condition and treatment in terms that you can understand.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the possible consequences of the refusal.
- You have the right to appropriate assessment and management of pain.
- You are entitled to information about rules and regulations affecting your care or conduct.
- You have the right to expect emergency procedures to be implemented without unnecessary delay.
- You have the right to see your medical record within the limits of the law.
- You have the right to an explanation of all items on your bill.
- You are entitled to be free from all forms of abuse or harassment.
- You have the right to make or have a representative of your choice make informed decisions about your care.
- You have the right to formulate advance directives and have them followed.
- You are entitled to be free from any forms of restraint or seclusion as a means of convenience, discipline, coercion or retaliation.
- Seclusion and restraint for behavior management can only be used in emergency situations.
- Supervised healthcare providers in training may become involved in your care and treatment. You have the right to ask if any of your healthcare providers are in training. Students at the high school or college level may become involved in your care through

observation or job shadowing opportunities. You have the right to consent or refuse their participation in your care.

- You may consent or refuse to participate in experimental treatment or research.
- You can request a change of provider or second opinion if you choose.
- You have the right to a prompt and reasonable response to any request for services within the capacity of the Healthy Living Center.
- You have the right to expect upon discharge information regarding continuing rehabilitation requirements and the means for meeting them.
- You have the right to express concerns or grievances regarding your care to the Medical Programs Director or Associate Executive Director of the Healthy Living Center.

### **Patients' Responsibilities**

This is a summary of your responsibilities as a patient of the YMCA Healthy Living Center.

- It is your responsibility to provide accurate and complete information about all matters pertaining to your health, including medications and past or present medical problems.
- You are responsible for following the instructions and advice of your healthcare provider. If you refuse treatment or do not follow the instructions or advice, you must accept the consequences of your actions.
- It is your responsibility to notify your physical therapist if you do not understand information about your care and treatment.
- You are responsible for reporting changes in your condition or symptoms, including pain, to your physical therapist.
- It is your responsibility to act in a considerate and cooperative manner and to respect the rights and property of others.
- You are responsible for following the rules and regulations of the YMCA Healthy Living Center.
- You are expected to keep your scheduled appointments or to cancel them in advance if at all possible.
- It is your responsibility to pay your bills or make some arrangement with the facility to meet your financial obligations.
- Be honest about your financial needs so we may connect you with appropriate resources.

### **Questions or Concerns**

You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your physical therapist. If you have concerns that are not resolved, please contact the Medical Programs Director, Trina Radske-Suchan at 515-645-3342.

Should you continue to remain concerned after contacting the Medical Programs Director, you may contact the District Executive Director, Kim Stewart at 515-645-3344.





**YMCA OF GREATER DES MOINES**  
**YMCA Healthy Living Center**

**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.

1. **Uses and Disclosures:** We will use your protected health information (PHI) for the purpose of treatment, payment, and health care operations.

**Treatment** includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

**Payment** includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

**Health Care Operations** includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

**Other Special Uses:** Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

**Uses and Disclosures Required by Law**

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.



**YMCA OF GREATER DES MOINES  
YMCA Healthy Living Center**

**Consent for Purposes of Treatment, Payment,  
and Healthcare Operations**

I consent to the use or disclosure of my protected health information by the YMCA Healthy Living Center for the purpose of providing my treatment, obtaining payment for my health care bills, or to conduct health care operations. I understand that my treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment, or other healthcare operations of the facility. The YMCA Healthy Living Center is not required to agree to the restrictions that I may request. However, if the YMCA Healthy Living Center agrees to a restriction that I request, the restriction is binding on the YMCA Healthy Living Center and my physical therapist.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physical therapist and the YMCA Healthy Living Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physical therapist, another health care provider, a medical programs instructor, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the YMCA Healthy Living Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations. The Notice of Privacy Practices is provided to each new patient. This Notice of Privacy Practices also describes my rights and the YMCA Healthy Living Center's duties with respect to my protected health care information.

The YMCA Healthy Living Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

You may be contacted by the YMCA Healthy Living Center to remind you of appointments and other health services that may be of interest to you.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(or personal representative)  
Name of Patient: \_\_\_\_\_



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YMCA Healthy Living Center**

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