[redacted]

Purpose of Disclosure:	Type of Access:	Delivery Method: (If left blank, a paper copy will be provided)
☒ Continuation of Care	☒ Copies of Record	☐ Fax (Physician Only)
☐ Insurance Purposes	☐ Review of Record	☐ Mailed – Paper Copy
☐ Legal Reason	☐ Discussion of Record	☐ Pick Up – Paper Copy
☒ Personal Use		☐ Email (Patient Only/Abstract Only)
☐ Other (Specify)		☐ Encrypted ☐ Unencrypted
		☒ USB Flash Drive (Patient Only)

Thank you
Otto

Section B: Description of Information to be used or disclosed

Description:		Date(s) of Service:	Location:	
☐ Admission Documentation	☐ Nursing Notes		☐ Brooks Rehab Hospital	☐ Brooks Home Health
☐ History & Physical	☐ Clinical Tests		☒ Outpatient Rehab Clinic	☐ Behavioral Health
☐ Physician orders	☐ Evaluations/Assessments		☐ Bartram Crossing	☐ Bartram ALF
☐ Progress Notes	☐ Medications		☐ University Crossing	☐ Brooks Medical Group
☐ Consultation Reports	☐ Transfer forms			
☐ Discharge Summary	☐ Billing Records			
☐ Therapy Notes	☒ Other: Please include	All PT reports		

I acknowledge, and hereby consent to such, that the released information may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions. OS *(Initials)*

I understand that:

1. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
2. I may revoke this authorization at any time in writing. I understand the revocation will not apply to information already released in response to this authorization.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by state or federal privacy regulations.
4. Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization.
5. Upon request, I may receive a copy of this form after I sign it.
6. If I fail to specify expiration date or condition as set forth below, this authorization is valid for 6 months from the signature date.
7. Patient information provided on a USB flash drive is for patient requests only and requires decryption with a provided password.
8. I understand there are risks for obtaining my records through unencrypted email and accept responsibility for those risks. Risks include, but are not limited to, interception of email by a third party, read or accessed by unintended recipient, or sent to the wrong recipient.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:	Signature of Witness:
Otto E Snow	03/23/2021	
Print Name of Patient/Guardian/Patient Representative:	**Relationship to Patient:**	
Otto E Snow		

Authorization expires 6 months from the date signed unless otherwise specified below:
Expiration Date/Event:

From: Otto Snow [redacted]
Sent: Tuesday, March 23, 2021 3:19 PM
To: Brooks ROI
Subject: Re: Brooks Medical Records Release

[External Email: Do not click on any links or open attachments unless you trust the sender and know the content is safe.]

Hi Rachel, my name is Otto E Snow, 01/15/1956 and if you would mail me the USB flash drive with full records.

Greatly appreciated.

Have a wonderful day, Otto

On Mar 23, 2021, at 3:13 PM, Brooks ROI <Brooks.ROI@Brooksrehab.org> wrote:

Good Afternoon Mr. Snow,

Per our phone conversation please provide your name, date of birth, and the information needed to finish processing your request. Should you have any questions do not hesitate to reach out to our office at (904) 345-7235.

Thank you,
Rachel
<image001.jpg>
Brooks Rehabilitation
HIM – Medical Records Department
3901 University Blvd S.
Jacksonville, FL 32216
Phone (904) 345-7235 | Fax (904) 345-7213
Email: Brooks.ROI@Brooksrehab.org

SNOW, OTTO Subscriber

MEMBER ID VMAH17946641
DOB Jan 15, 1956
GENDER Male
PLAN / COVERAGE DATE Mar 01, 2015 - Dec 31, 9999
DATE OF SERVICE Nov 12, 2015

Either the patient's ID, name, date of birth, or address in the response does not match the information sent in the request. The response reflects the correct information. To avoid future errors in submission, please update this information in your computer system

Subscriber Information

9177 JENA RD
SPRING HILL, FL 34608-4765
MEMBER ID [redacted]

PRIOR ID NUMBER [redacted]
GROUP NUMBER 99999
PLAN SPONSOR NAME QHP INDIVIDUAL UNDER65
PLAN DATE Jan 01, 2015 - Dec 31, 2015

Plan / Product Information

ACTIVE COVERAGE

INSURANCE TYPE Preferred Provider Organization (PPO)
PLAN / PRODUCT EVERYDAY HEALTH PLAN 1431C-R1

Service Types
Health Benefit Plan Coverage
Physical Therapy

Payer Details

PAYER FLORIDA BLUE
PAYER ID BCBSF
CONTACT INFORMATION

Blue Cross Blue Shield of Florida
P: 800-727-2227

PAYER CONTACT BLUEOPTIONS 1431C

PO BOX 1798
JACKSONVILLE, FL 32231-0014
SERVICE TYPES
Health Benefit Plan Coverage
Physical Therapy

Other or Additional Payers

LAST UPDATE DATE Nov 03, 2015

- MEMBER HAS VERIFIED ONLY BCBSF COVERAGE

Provider Details

REQUESTING PROVIDER

NAME Genesis Health Development, Inc
NPI 1821030115
SUBMITTER ID H4566

Pre-existing Information

STATUS Pre-existing Condition
LEVEL Individual
SERVICE TYPE Plan Waiting Period

- PRE-EXISTING IS WAIVED

Benefit Disclaimer

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

Coverage and Benefits Information

Physical Therapy - PT

ACTIVE COVERAGE

INSURANCE TYPE Preferred Provider Organization (PPO)
PLAN / PRODUCT EVERYDAY HEALTH PLAN 1431C-R1

Contact Information - Physical Therapy

NAME BLUEOPTIONS 1431C
TYPE Payer

PO BOX 1798
JACKSONVILLE, FL 32231-0014

Co-Payment - Physical Therapy

IN NETWORK | INDIVIDUAL

$0.00 Service Year
3 Visits

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION

- NO AUTHORIZATION REQUIRED
- COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$0.00 Remaining
3 Visits

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION

- NO AUTHORIZATION REQUIRED
- COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$4.00 Visit

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION
PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED

IN NETWORK | INDIVIDUAL

$0.00 Service Year
3 Visits

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN, COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$0.00 Remaining
3 Visits

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN, COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$4.00 Visit

PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN

IN NETWORK | INDIVIDUAL

$10.00 Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- PHYSICIAN BENEFIT

IN NETWORK | INDIVIDUAL

$10.00 Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- SPECIALIST

Co-Insurance - Physical Therapy

IN NETWORK | INDIVIDUAL — 0 % Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- FACILITY BENEFIT

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION
PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- FACILITY BENEFIT

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- PHYSICIAN BENEFIT

Limitations - Physical Therapy

IN NETWORK — 35 Visits

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

IN NETWORK — 24 Visits / Remaining

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

OUT OF NETWORK — 35 Visits

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT- PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

OUT OF NETWORK — 24 Visits / Remaining

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT- PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

PLACE OF SERVICE Outpatient Hospital — 35 Visits

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED FACILITY THERAPY MAXIMUM INCLUDES PT - HOSPITAL, OT, PT - PHYSICIAN, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

PLACE OF SERVICE Outpatient Hospital — 24 Visits / Remaining

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED FACILITY THERAPY MAXIMUM INCLUDES PT - HOSPITAL, OT, PT - PHYSICIAN, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

PLACE OF SERVICE Outpatient Hospital — 4 Number of Services or Procedures

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- THERAPY MODALITIES - PHYSICIAN BENEFIT
- for Day

PLACE OF SERVICE Outpatient Hospital — 35 Visits

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT(OUTSIDE OF HOSPITAL ONLY) - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

PLACE OF SERVICE Outpatient Hospital — 24 Visits / Remaining

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT(OUTSIDE OF HOSPITAL ONLY) - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

Health Benefit Plan Coverage - 30

ACTIVE COVERAGE

INSURANCE TYPE Preferred Provider Organization (PPO)
PLAN / PRODUCT EVERYDAY HEALTH PLAN 1431C-R1

Contact Information - Health Benefit Plan Coverage

NAME BLUEOPTIONS 1431C
TYPE Payer

PO BOX 1798
JACKSONVILLE, FL 32231-0014

Deductible - Health Benefit Plan Coverage

IN NETWORK | INDIVIDUAL
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$600.00 Calendar Year
- $600.00 Year to Date
$0.00 Remaining

IN NETWORK | FAMILY
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$1,200.00 Calendar Year
- $600.00 Year to Date
$600.00 Remaining

OUT OF NETWORK | INDIVIDUAL
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$10,000.00 Calendar Year
- $559.14 Year to Date
$9,440.86 Remaining

OUT OF NETWORK | FAMILY
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$20,000.00 Calendar Year
- $559.14 Year to Date
$19,440.86 Remaining

Out of Pocket (Stop Loss) - Health Benefit Plan Coverage

IN NETWORK | INDIVIDUAL

$2,250.00 Calendar Year
- $755.93 Year to Date
$1,494.07 Remaining

IN NETWORK | FAMILY

$4,500.00 Calendar Year
- $755.93 Year to Date
$3,744.07 Remaining

OUT OF NETWORK | INDIVIDUAL

$12,800.00 Calendar Year
- $559.14 Year to Date
$12,240.86 Remaining

OUT OF NETWORK | FAMILY

$25,000.00 Calendar Year
- $559.14 Year to Date
$24,440.86 Remaining

Medical Care - 1

Co-Insurance - Medical Care

IN NETWORK | INDIVIDUAL — 0 % Visit

- NO AUTHORIZATION REQUIRED
- INDEPENDENT THERAPY FACILITY

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

- NO AUTHORIZATION REQUIRED
- INDEPENDENT THERAPY FACILITY

Professional (Physician) - 96

Co-Payment - Professional (Physician)

IN NETWORK | INDIVIDUAL — $10.00 Visit

PLACE OF SERVICE Ambulatory Surgical Center

- NON-RAP SPECIALIST SERVICES

NEW AGE MEDICAL CENTER
DAVID MORENO, M.D.
12142 CORTEZ BOULEVARD
BROOKSVILLE, FL 34613

(352) 596-9095 TEL.
(352) 596-9271 FAX

DEA # BM 7356276
LIC. # ME83919
NPI # 1225045156

BATCH # MDI150303026015910 18

NAME Otto Snow DOB

ADDRESS DATE 8/24/15

TAMPER-RESISTANT FEATURES INCLUDE: SAFETY-BLUE ERASE-RESISTANT BACKGROUND, "ILLEGAL" PANTOGRAPH, WATERMARK ON BACK, QUANTITY CHECK-OFF BOXES, REFILL INDICATOR AND VENDOR ID W/ FORM BATCH NUMBER

℞

Physical Therapy

Dx: low back pain

- ☐ 1-24
- ☐ 25-49
- ☐ 50-74
- ☐ 75-100
- ☐ 101-150
- ☐ 151 and over

_____ Units

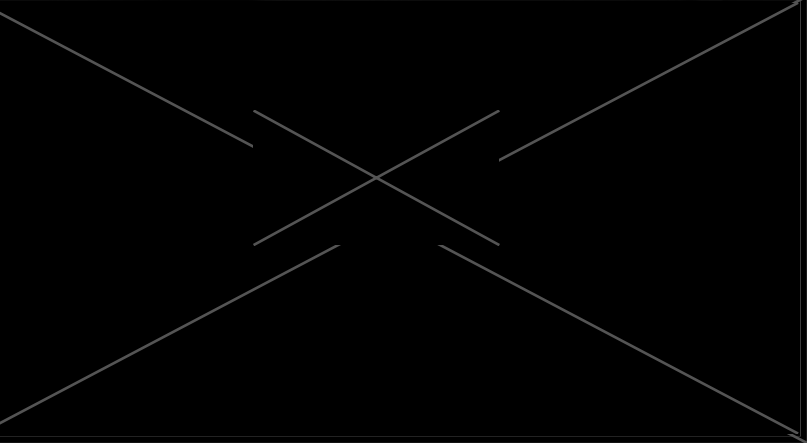
Label

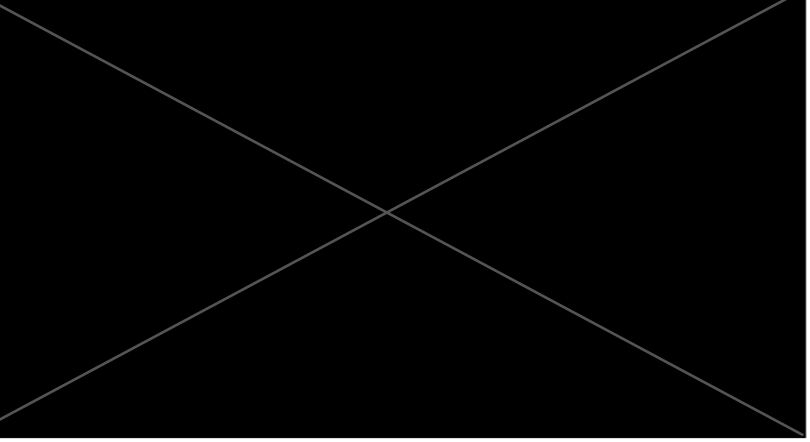
Refill NR 1 2 3 4 5

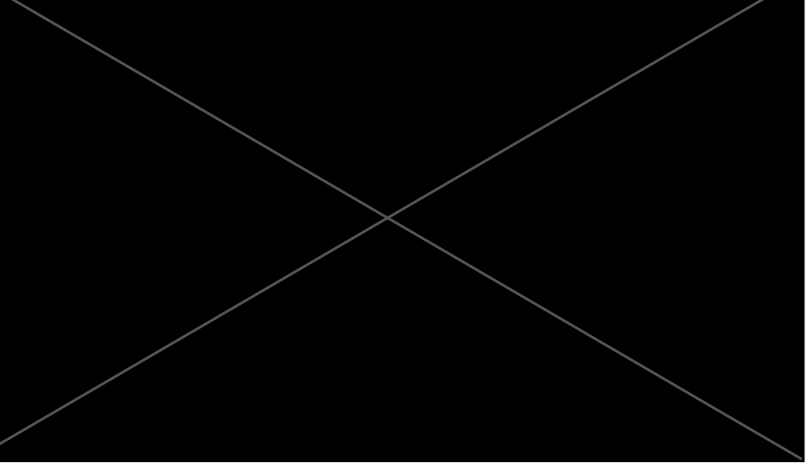
(Signature)

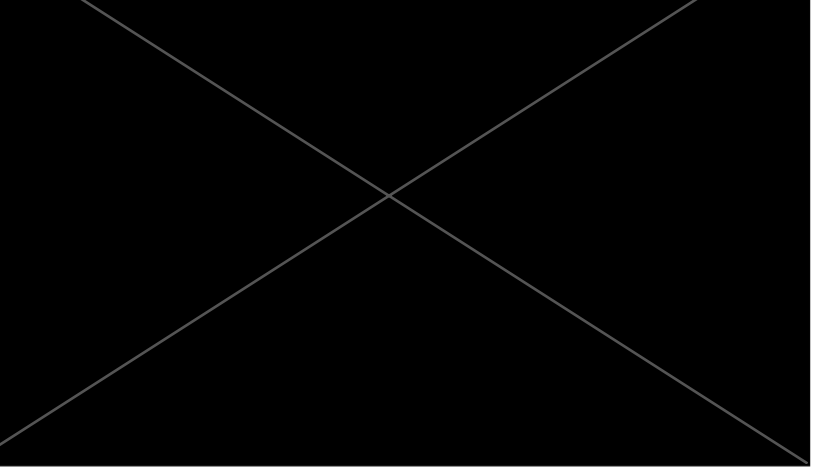
In order for the brand name product to be dispensed, the prescriber must write 'Medically Necessary' on the front of this prescription.

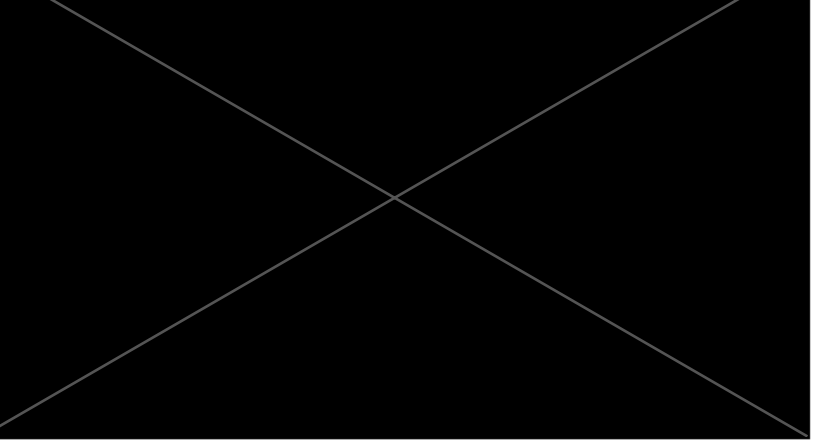
003057 5CIM0260159

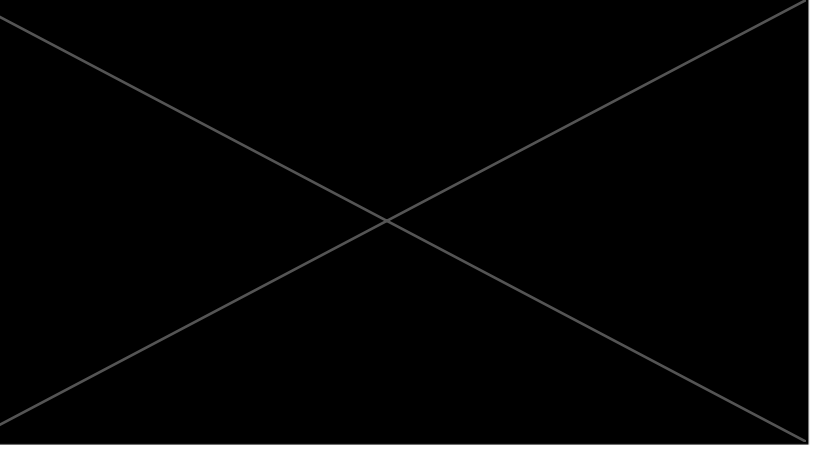












&9# 88665
F1212268
10371954 /OP

Section A: ***(All Sections must be complete to be valid)***

Patient Name: Otto Snow **Date of Birth:** [redacted] **Social Security #:** [redacted]

I hereby authorize Brooks Health System to Release my Confidential Health Information To:

Name/Facility: Otto Snow **Phone Number:** [redacted]

Address: 9177 Jena Rd **City:** Spring Hill **State:** Fl **Zip:** 34608

Purpose of disclosure:

FORMCHECKBOX Continuation of Care ✓
FORMCHECKBOX Insurance Purposes
FORMCHECKBOX Legal reasons
FORMCHECKBOX Personal Use ✓
FORMCHECKBOX Other (Specify)

Type of Access:

FORMCHECKBOX Copies of Record ✓
FORMCHECKBOX Review of Record

Section B: **Description of information to be used or disclosed**

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
All	NOV DEC JAN 2015 - 2016				
FORMCHECKBOX Admission Documentation		FORMCHECKBOX Consultation Reports		FORMCHECKBOX Medication Information	
FORMCHECKBOX History & Physical		FORMCHECKBOX Therapy Notes		FORMCHECKBOX Transfer forms	
FORMCHECKBOX Physician orders		FORMCHECKBOX Nursing Notes		FORMCHECKBOX Diagnosis	
FORMCHECKBOX Progress Notes		FORMCHECKBOX Clinical Tests		FORMCHECKBOX Billing Records	
FORMCHECKBOX Discharge Summary		FORMCHECKBOX Evaluations/ Assessments		FORMCHECKBOX Other: _____	

I acknowledge, and hereby consent to such, that the released information may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions. *(Initial here)* OS

1031508-03

I understand that:

I may refuse to sign this authorization and that it is strictly voluntary.

My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.

I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations.

I understand that if I ask, I may see and obtain a copy of the information to be used pr disclosed pursuant to this authorization.

I get a copy of this form after I sign it, if requested.

If I fail to specify an expiration date or condition as set forth below, this authorization is valid for six months from the signature date.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/ Patient Representative: Otto E Snow **Date:** 2/11/16 **Signature of Witness:** Scott Kellogg

Print Name of Patient/Guardian/Patient Representative:

Relationship to Patient:

This authorization **will expire six months from the date signed** unless otherwise specified below:

Expiration Date/Event:

Thank you! Otto

From: "Ali, Sabrina" <Sabrina.Ali@Brooksrehab.org>
Subject: **RE: Hi Sabrina - Otto**
Date: February 25, 2016 10:40:12 AM EST
To: 'NAX' <ottosnow@tampabay.rr.com>

Hey Otto, can you go ahead and refax the release form and attention it to Ronald. I'm currently out of the office but he'll take care of it today.

From: NAX [mailto:ottosnow@tampabay.rr.com]
Sent: Wednesday, February 24, 2016 3:36 PM
To: Ali, Sabrina
Subject: Re: Hi Sabrina - Otto

Attn: Ronald

Hi Sabrina, Wish you a wonderful day.
I faxed you the release for my records on 2/12/16.
I have not received them as of yet.
If there is a fee for your services or you need me to resend the release, please let me know.
Thank you, Otto Snow

On Feb 11, 2016, at 10:16 AM, Ali, Sabrina wrote:

Our fax number is 904-345-7213

From: NAX [mailto:ottosnow@tampabay.rr.com]
Sent: Thursday, February 11, 2016 9:34 AM
To: Ali, Sabrina
Subject: Hi Sabrina - Otto - Where do I fax to? - Thank you

Hi Sabrina, Wish you an excellent day. Could you send me the number where I should fax release.
Thank you, Otto Snow

On Feb 11, 2016, at 9:28 AM, Ali, Sabrina wrote:

<~WRD000.jpg>

<~WRD000.jpg> **This is a secure, encrypted message.**

<~WRD000.jpg> **Desktop Users:**
Open the attachment (message.zdm.html) and follow the instructions

<~WRD000.jpg> **Mobile Users:**
Get the mobile application.

Need Help?

Disclaimer: This email and any attachments are confidential and for the sole use of the recipients. If you have received this email in error please notify the sender

Email Security Powered by Voltage IBE™
Copyright 2002-2013 Voltage Security, Inc. All rights reserved

<message_zdm.html>

THE HOGAN LAW FIRM®

We mean business℠

MAY 1 1 2017

Spring Hill Office
11031 Spring Hill Drive
Spring Hill, FL 34608
Phone: (352) 686-0334
Facsimile: (352) 686-1633
Please reply to this address

Brooksville Office
20 South Broad Street
Brooksville, FL 34601
Phone: (352) 799-8423
www.hoganlawfirm.com
JNapolitano@HoganLawFirm.com

MAY 1 2 2017

May 11, 2017

Sent by fax only: 904.345.7213

Brooks Rehabilitation
P.O. Box 47230
Jacksonville, FL 32247
Attn: Billing Department

R# 99386 PGS
UNIT # 1212268
ACCT 371854 CLINIC D/C 12/24/15 BAY

Your Patient/Our Client: Otto Snow
Account Number: F00010371954
Date of Birth: [redacted]
Date of Loss: October 29, 2015

Dear Sir/Madam:

Please allow this correspondence to serve as our request for a copy of the billing ledger, (showing charges, payments and any balance remaining), for Mr. Otto Snow. We have included a medical authorization herein. Please send the billing statement to us as soon as possible by fax to 352-686-1633.

Thank you for your assistance with this matter. Should you have any questions, please do not hesitate to contact this office.

Sincerely,

Luanne Ashton
Legal Assistant for
John E. Napolitano, Esq.
Of Counsel

JEN/lsa

00657451

1031508-03

Patient's Name: 164.508(c)(1)(ii) Otto E. Snow	Date of Birth: [redacted]	Social Security Number: [redacted]
Provider's Name and Address: Brooks Rehabilitation P.O. Box 47230 Jacksonville, FL. 32247	Recipient's Name and Address: 164.508(c)(1)(iii) John E. Napolitano Esq. *Of Counsel for* The Hogan Law Firm 11031 Spring Hill Drive Spring Hill, Florida 34608	

Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event: 164.508(c)(1)(v)
Date: N/A **Event:** Conclusion of Personal Injury Claim

Purpose of Disclosure: 164.508(c)(1)(iv)
Personal Injury Claim

Is this request for psychotherapy notes?
___ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. 164.508(b)(3)(ii)
_x_ No, then you may check as many items below as you need. 164.508(c)(1)(i)

Description:	Date of Service:
_x_ ~~All PHI in Medical Record~~	
_x_ All Medical Bills	10/29/15 - present

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid. 164.508(c)(1)(vi)
2. I understand that protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 164.508(c)(2)(ii)
4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of privacy Practices. 164.508(c)(2)(i)
5. If the requester or receiver is not a health plan or heal care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 164.508(c)(2)(iii)
6. There may be a reasonable fee to obtain a copy of the information being requested on this form. 164.524(c)(4)
7. I get a copy of this form after I sign it. 164.508(c)(4)

Required Signatures: 164.508(c)(1)(vi)
I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/or Personal Representative: Otto E Snow	Date Signed: 11/13/15

Printed Name of Patient/Guardian/or Personal Representative:
Otto E. Snow

00518743

SNOW, OTTO Subscriber

MEMBER ID VMAH17946641
DOB [redacted]
GENDER Male
PLAN / COVERAGE DATE Mar 01, 2015 - Dec 31, 9999
DATE OF SERVICE Sep 02, 2015

Florida Blue

Subscriber Information

9177 JENA RD
SPRING HILL, FL 34608-4765
MEMBER ID VMAH17946641

GROUP NUMBER 99999
PLAN SPONSOR NAME QHP INDIVIDUAL UNDER65
PLAN DATE Jan 01, 2015 - Dec 31, 2015

Plan / Product Information

ACTIVE COVERAGE

INSURANCE TYPE Preferred Provider Organization (PPO)
PLAN / PRODUCT EVERYDAY HEALTH PLAN 1431C-R1

Service Types

Health Benefit Plan Coverage
Physical Therapy

Payer Details

PAYER FLORIDA BLUE
PAYER ID BCBSF
CONTACT INFORMATION

Blue Cross Blue Shield of Florida
P: 800-727-2227

PAYER CONTACT BLUEOPTIONS 1431C

PO BOX 1798
JACKSONVILLE, FL 32231-0014
SERVICE TYPES
Health Benefit Plan Coverage
Physical Therapy

Other or Additional Payers

LAST UPDATE DATE Apr 05, 2015

- MEMBER HAS VERIFIED ONLY BCBSF COVERAGE

Provider Details

REQUESTING PROVIDER

NPI 1821030115
SUBMITTER ID H4566

Pre-existing Information

STATUS Pre-existing Condition
LEVEL Individual
SERVICE TYPE Plan Waiting Period

- PRE-EXISTING IS WAIVED

Benefit Disclaimer

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

Coverage and Benefits Information

Physical Therapy - PT

ACTIVE COVERAGE

INSURANCE TYPE Preferred Provider Organization (PPO)
PLAN / PRODUCT EVERYDAY HEALTH PLAN 1431C-R1

Contact Information - Physical Therapy

NAME BLUEOPTIONS 1431C
TYPE Payer

PO BOX 1798
JACKSONVILLE, FL 32231-0014

Co-Payment - Physical Therapy

IN NETWORK | INDIVIDUAL

$0.00 Service Year
3 Visits

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION

- NO AUTHORIZATION REQUIRED
- COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$0.00 Remaining
3 Visits

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION

- NO AUTHORIZATION REQUIRED
- COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$4.00 Visit

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION
PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED

IN NETWORK | INDIVIDUAL

$0.00 Service Year
3 Visits

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN, COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$0.00 Remaining
3 Visits

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN, COMBINED THERAPY VISIT INCLUDES, OTHER DIAGNOSTIC, PHYSICIAN OFFICE, SUBSTANCE ABUSE, MENTAL NERVOUS, MATERNITY

IN NETWORK | INDIVIDUAL

$4.00 Visit

PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN

IN NETWORK | INDIVIDUAL

$10.00 Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- PHYSICIAN BENEFIT

IN NETWORK | INDIVIDUAL

$10.00 Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- SPECIALIST

Co-Insurance - Physical Therapy

IN NETWORK | INDIVIDUAL — 0 % Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- FACILITY BENEFIT

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLAN / PRODUCT BLUE PHYSICIAN RECOGNITION
PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLACE OF SERVICE Office

- NO AUTHORIZATION REQUIRED
- FAMILY PHYSICIAN

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- FACILITY BENEFIT

OUT OF NETWORK | INDIVIDUAL — 50 % Visit

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- PHYSICIAN BENEFIT

Deductible - Physical Therapy

IN NETWORK | INDIVIDUAL

PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$600.00 Calendar Year
- $600.00 Year to Date

$0.00 Remaining

IN NETWORK | FAMILY

PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$1,200.00 Calendar Year
- $600.00 Year to Date

$600.00 Remaining

OUT OF NETWORK | INDIVIDUAL

PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$10,000.00 Calendar Year
- $559.14 Year to Date

$9,440.86 Remaining

OUT OF NETWORK | FAMILY

PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$20,000.00 Calendar Year
- $559.14 Year to Date

$19,440.86 Remaining

Out of Pocket (Stop Loss) - Physical Therapy

IN NETWORK | INDIVIDUAL

$2,250.00 Calendar Year
- $719.93 Year to Date

$1,530.07 Remaining

IN NETWORK | FAMILY

$4,500.00 Calendar Year
- $719.93 Year to Date

$3,780.07 Remaining

OUT OF NETWORK | INDIVIDUAL

$12,800.00 Calendar Year
- $559.14 Year to Date

$12,240.86 Remaining

OUT OF NETWORK | FAMILY

$25,000.00 Calendar Year
- $559.14 Year to Date

$24,440.86 Remaining

Limitations - Physical Therapy

IN NETWORK — 35 Visits

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

IN NETWORK — 24 Visits / Remaining

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

OUT OF NETWORK

35 Visits

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT- PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

OUT OF NETWORK

24 Visits / Remaining

PLACE OF SERVICE Outpatient Hospital

- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT- PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

PLACE OF SERVICE Outpatient Hospital — 35 Visits

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED FACILITY THERAPY MAXIMUM INCLUDES PT - HOSPITAL, OT, PT - PHYSICIAN, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

PLACE OF SERVICE Outpatient Hospital — 24 Visits / Remaining

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED FACILITY THERAPY MAXIMUM INCLUDES PT - HOSPITAL, OT, PT - PHYSICIAN, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

PLACE OF SERVICE Outpatient Hospital — 4 Number of Services or Procedures

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- THERAPY MODALITIES - PHYSICIAN BENEFIT
- for Day

PLACE OF SERVICE Outpatient Hospital — 35 Visits

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT(OUTSIDE OF HOSPITAL ONLY) - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
- for Calendar Year

PLACE OF SERVICE Outpatient Hospital — 24 Visits / Remaining

- NETWORK NOT APPLICABLE
- NO AUTHORIZATION REQUIRED
- COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT(OUTSIDE OF HOSPITAL ONLY) - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

Health Benefit Plan Coverage - 30

ACTIVE COVERAGE

INSURANCE TYPE Preferred Provider Organization (PPO)
PLAN / PRODUCT EVERYDAY HEALTH PLAN 1431C-R1

Contact Information - Health Benefit Plan Coverage

NAME BLUEOPTIONS 1431C
TYPE Payer

PO BOX 1798
JACKSONVILLE, FL 32231-0014

Deductible - Health Benefit Plan Coverage

IN NETWORK | INDIVIDUAL
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$600.00 Calendar Year
- $600.00 Year to Date
$0.00 Remaining

IN NETWORK | FAMILY
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$1,200.00 Calendar Year
- $600.00 Year to Date
$600.00 Remaining

OUT OF NETWORK | INDIVIDUAL
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$10,000.00 Calendar Year
- $559.14 Year to Date
$9,440.86 Remaining

OUT OF NETWORK | FAMILY
PLAN / COVERAGE DATE Jan 01, 2015 - Dec 31, 2015

$20,000.00 Calendar Year
- $559.14 Year to Date
$19,440.86 Remaining

Out of Pocket (Stop Loss) - Health Benefit Plan Coverage

IN NETWORK | INDIVIDUAL

$2,250.00 Calendar Year
- $719.93 Year to Date
$1,530.07 Remaining

IN NETWORK | FAMILY

$4,500.00 Calendar Year
- $719.93 Year to Date
$3,780.07 Remaining

OUT OF NETWORK | INDIVIDUAL

$12,800.00 Calendar Year
- $559.14 Year to Date
$12,240.86 Remaining

OUT OF NETWORK | FAMILY

$25,000.00 Calendar Year
- $559.14 Year to Date
$24,440.86 Remaining

BROOKS[SM] Rehabilitation

Patient Information & Consent

Referring MD: Moreno,David
Clinic: Hudson/Bayonet

General Information:

Patient Name/ID: Snow,Otto / 1031508-03
Address: 9177 Jena Rd
Spring Hill, FL 34608
Home Phone : [redacted]
Guarantor:
Primary Care Physician: Dr. Moreno

Patient's Email Address:

Date of Birth: [redacted]
SSN: [redacted]
Sex: M
Marital Status: Single
Guarantor Relationship:
Patient's Cell Phone:

Employer Information:

Employment Status: Self
Employer Name:
Employer Phone:

Emergency Information:

Spouse: Phone Number:
Other Contact: Phone Number:
Relationship:

Injury Information:

Date of Injury: 10-29-15 Employment Related: No Auto Related: No Other Injury: No

Attorney Information: (related to current injury)

Legal Case Pending? Yes / No Attorney Name: Phone Number:

Consent For Care and Treatment

I agree and consent to receive services according to the applicable standards of care used for evaluating or treating my medical condition. In the event of an unexpected emergency, the therapy staff will initiate basic life support measures. The Fire Rescue Department will be called to provide additional support measures and to transfer the patient to an Emergency Room if indicated. The patient's referring physician will be notified to any emergencies that may arise. In addition, I hereby release Brooks Health System (& Affiliates) of any responsibility for my personal property, which I choose to bring to therapy.

Consent For Release of Information

I understand that my health information is confidential but may be used or released in accordance with Federal & State laws for purposes of treatment, payment or health care operations; such as for outcomes assessment, quality assurance, business planning/improvement activities, service providers on my evaluation and/or treatment team, other treating healthcare providers involved in my care, utilization review organizations or agencies that provide managed care services for my insurance benefits. I know and agree that my health information may be disclosed to worker's compensation agencies, insurance companies, or employers for purposes of workers' compensation and work site safety laws. I authorize *Brooks Health System (& Affiliates)* to furnish my health or medical information to my treating physician(s), insurance carriers, and other payers as necessary to process claims, and obtain reimbursement or payment. In addition, I direct my insurance carriers and other payers to accept a photocopy of this assignment in lieu of the original. I assume all responsibility for the confidentiality of medical record documentation released directly to me by Brooks as the patient or legal guardian of the patient. I understand that medical record documentation after release is no longer protected by Federal & State Privacy Regulations.

In addition, I authorize Brooks to discuss billing, treatment and medical conditions with the following friends, family or others involved in my care: _____. I understand that **this consent does not authorize Brooks to release copies of medical records to the people listed above**, without written consent. I understand that I can revoke this consent by sending a written letter to the Medical Records Dept. @ 3901 University Blvd.S, Jacksonville, FL 32216.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I agree that I have received a copy of the Notice of Privacy Practices from *Brooks Health System (& Affiliates)* dated: July 1, 2013.

Missed Appointments

When you miss an appointment specifically reserved for you, other patients in need of medical care cannot be seen.
We ask that you give us 24-hour notice if it becomes necessary to change an appointment.
After 3 consecutive missed visits we reserve the right to remove any remaining scheduled appointments.
Non-compliance with treatment may result in discharge.

Initial: OS

I acknowledge that the information listed above is accurate to the best of my knowledge and that all of my medical insurance information has been presented.

Patient/Guardian Signature: Otto E Snow **Date:** 11/13/15

Witness: Monique Acosta **Date:** 11/13/15

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Evaluation,

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Otto Snow	Otto E Snow	11/13/15
Name *(PRINT or TYPE)*	**Signature**	**Date**

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand)*:

Connie Gaines		11/13/15
Name *(PRINT or TYPE)*	**Signature**	**Date**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

BROOKS Rehabilitation

Medical History/Summary

Patient Name: Snow,Otto

Patient ID: 1031508-03

Are there any personal, cultural, spiritual beliefs or wishes that might affect your care? ☒ No ☐ Yes (please list)

_____

_____

_____

Language:
- ☐ English
- ☐ Interpreter needed
- ☐ Language you speak most often _____?

Whom do you live with: (check all that apply)
- ☒ Alone
- ☐ Significant other
- ☐ Children: Number ____; Ages _____
- ☐ Other relatives
- ☐ Personal care attendant
- ☐ Other: _____

Where do you live?
- ☒ Private home
- ☐ Private apartment
- ☐ Homeless
- ☐ Assisted living / group home
- ☐ Long-term care facility
- ☐ Other _____

Employment/Work/School: (check all that apply)
- ☒ Working (☐ full time ☐ part time)
- ☐ Student (☐ full time ☐ part time)
- ☐ Homemaker
- ☐ Retired
- ☐ Unemployed

Does your home have: (check all that apply)
- ☐ Stairs, no railing
- ☐ Stairs, railing
- ☐ Ramps
- ☐ Elevator
- ☐ Uneven terrain
- ☐ Assistive devices (e.g. grab bars) _____
- ☐ Any obstacles: _____

Do you use: (check all that apply)
- ☐ Cane
- ☐ Crutches
- ☐ Walker or rollator
- ☐ Manual wheelchair
- ☐ Motorized wheelchair / scooter
- ☐ Other: _____

SOCIAL/HEALTH HABIT

a) Currently smoke? ☐ No ☒ Yes Too Long
Packs per day 1 How long _____

b) Smoked in past? ☐ No ☐ Yes
Years quit _____

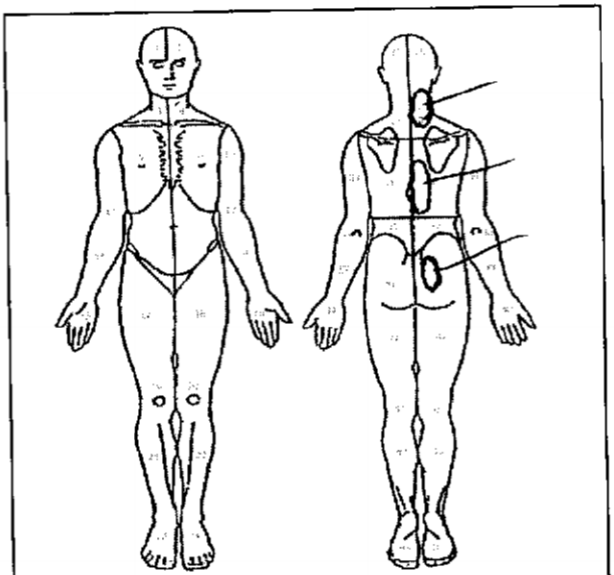
c) How many alcoholic beverages do you have per week?
☒ 0 ☐ 1-2 ☐ 3-4 ☐ >4

d) Do you generally eat 3 meals per day?
☐ No ☒ Yes

e) Would you rate your nutrition habits as
☐ Poor ☒ Fair ☐ Good

f) Do you exercise beyond normal daily activities and chores? ☐ No ☒ Yes (i-iii below)
- i) Average number of days per week 3
- ii) Average number of minutes of exercise 60
- iii) Does your exercise make you breath heavy? ☐ No ☒ Yes
- iv) type of exercise Stretches, bands, tredmill

g) Do you routinely get 6-8 hours of uninterrupted sleep? ☒ No ☐ Yes



Please mark the areas you have symptoms on the diagram above.

Thinking about the **LAST WEEK (7 days)**, please rate the following on a 0 to 10 scale: **(0 = no pain; 10 = worst pain imaginable)**

WORST pain 7 /10 **LEAST** pain 3 /10

CURRENT pain 4 /10

SCREENING QUESTIONS

a) Have you fallen in the last 12 months? ☒ No ☐ Yes

b) During the last 3 months, have you leaked urine? (even a small amount) ☒ No ☐ Yes

c) Do you have pelvic pain? Right ☐ No ☒ Yes

d) **FOR WOMEN:** Are you, or do you think you may be pregnant? NA ☐ No ☐ Yes

e) Please list all medications and supplements that you are currently taking.

☐ Not taking any medications ☐ See attached list

Medication / Reason for Taking / Dose/Frequency

Multi vitamins, muscle relaxers,
Lorazepam

BROOKS Rehabilitation

Medical History/Summary

Patient Name: Snow,Otto

Patient ID: 1031508-03

MEDICAL/SURGICAL HISTORY

a) Please check if you ever had

- ☐ Arthritis
- ☐ Broken bones
- ☐ Osteoporosis
- ☐ Blood disorders
- ☐ Hepatitis C
- ☐ HIV
- ☐ Circulation/ Vascular problems
- ☐ Heart problems
- ☒ High blood pressure
- ☐ Lung problems
- ☐ Diabetes/High blood sugar
- ☐ Hypoglycemia/Low blood sugar
- ☐ Head injury
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Parkinson disease
- ☐ Seizures/Epilepsy
- ☐ Developmental or growth problems
- ☒ Allergies everything
- ☐ Cancer
- ☐ Kidney problems
- ☐ Ulcers/Stomach problems
- ☐ Repeated infections
- ☐ MRSA
- ☒ Depression
- ☐ Fibrillator/Pacemaker
- ☐ Other: _____

b) Within the **past year**, have you had any of the following symptoms? (Check all that apply)

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Dizziness or blackouts
- ☐ Coordination problems
- ☐ Weakness in arms/legs
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Joint pain or swelling
- ☐ Pain at night
- ☐ Other: _____
- ☒ Difficulty sleeping
- ☒ Loss of appetite
- ☐ Nausea/vomiting
- ☐ Difficulty swallowing
- ☒ Bowel problems
- ☐ Weight loss/gain
- ☐ Urinary problems
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Pneumonia

c) Have you ever had surgery?

- ☐ No
- ☒ Yes (please list and include year)
- ☐ (see attached sheet) 2012 2 hernias 1 Gallbladder

CURRENT CONDITION

a) Describe the problem(s) for which you seek therapy: RT SIDE Back pain from SI to head

b) When did the problem begin: 10/29/15

c) Are you currently seeing, or have you seen, anyone else for the problem? (Check all that apply)

- ☐ Acupuncturists
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Family practitioner
- ☐ Internist
- ☒ Massage therapist
- ☐ Neurologist
- ☐ Personal Trainer
- ☐ Occupational therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Primary care physician
- ☐ Rheumatologist
- ☐ Ob/Gyn
- ☐ Other: _____

Date of next appt: _____

d) Within the **past year**, have you had any of the following tests? (Check all that apply)

- ☐ Angiogram
- ☐ Arthrogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☒ Blood test
- ☐ Bone scan
- ☐ Bronchoscopy
- ☒ CT scan
- ☐ Doppler ultrasound
- ☐ Mammogram
- ☐ Modified barium swallow study
- ☒ ECG/EKG (Echocardiogram / electrocardiogram)
- ☐ EEG (electroencephalogram)
- ☐ EMG (electromyogram)
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve conduction
- ☐ Pap smear
- ☐ Pulmonary function
- ☐ Spinal tap
- ☒ Stool test
- ☐ Stress test (e.g. Treadmill)
- ☐ Urine test
- ☒ X-ray
- ☐ Other: _____

Results: Low Potassium.

Patient Signature: Otto E Snow	Clinician Signature: PT, DPT 11/18/15
Date: 10/13/15	

MHX

Dizziness Handicap Inventory

Date: 11/13/15 Patient: Otto E. Snow Age: 59

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question. *Answer each question as it pertains to your dizziness or unsteadiness only.*

ITEM	QUESTION		Y	N	S
1*	Does looking up increase your problem?	P	✓		
2	Because of your problem, do you feel frustrated?	E	✓		
3	Because of your problem, do you restrict your travel for business or recreation?	F	✓		
4	Does walking down the aisle of a supermarket increase your problem?	P	✓		
5*	Because of your problem, do you have difficulty getting into or out of bed?	F	✓		
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	F	✓		
7	Because of your problem, do you have difficulty reading?	F	✓		
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P	✓		
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E	✓	✓	
10	Because of your problem, are you embarrassed in front of others?	E		✓	
11	Do quick movements of your head increase your problem?	P	✓		
12	Because of your problem, do you avoid heights?	F	✓		
13*	Does turning over in bed increase your problem?	P	✓		
14	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E		✓	
16	Because of your problem, is it difficult for you to walk by yourself?	F		✓	
17	Does walking down a sidewalk increase your problem?	P		✓	
18	Because of your problem, is it difficult for you to concentrate?	E	✓		
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F	✓		
20	Because of your problem, are you afraid to stay at home alone?	E		✓	
21	Because of your problem, do you feel handicapped?	E		✓	
22	Has your problem placed stress on your relationships with members of your family or friends?	E		✓	
23	Because of your problem, are you depressed?	E		✓	
24	Does your problem interfere with your job or household responsibilities?	F	✓		
25*	Does bending over increase your problem?	P	✓		
			x4	x0	x2
		=	64		
		TOTAL		64	

P _____ E _____ F _____

☐100-70 = severe perception of having a handicap, ☒69-40 = moderate perception of handicap, ☐ 39-0 = low perception of handicap.

Name Otto E. Snow Date 11/13/15

Modified Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much you low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section **one circle** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the circle that most closely describes your problem.**

Section 1 - Pain Intensity

- O The pain comes and goes and is very mild.
- O The pain is mild and does not vary much.
- O The pain comes and goes and is moderate.
- O The pain is moderate and does not vary much.
- ⊘ The pain comes and goes and is severe.
- O The pain is severe and does not vary much.

4

Section 2 - Personal Care

- O I do not have to change my way of washing or dressing to avoid pain.
- ⊘ I do not normally change my way of washing or dressing even though it causes me pain.
- O Washing and dressing increase the pain, but I manage not to change my way of doing it.
- O Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- O Because of the pain I am unable to do some washing and dressing without help.
- O Because of the pain I am unable to do any washing and dressing without help.

Section 3 - Lifting (skip if you have not attempted lifting since the onset of your low back pain)

- O I can lift heavy weights without extra low back pain.
- O I can lift heavy weights but it causes extra pain.
- O Pain prevents me lifting heavy weights off the floor.
- O Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned; e.g. on a table.
- O Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- O I can only lift light weights at the most.

Section 4 - Walking

- O I have no pain walking.
- O I have some pain on walking, but I can still walk my required to normal distances.
- ⊘ Pain prevents me from walking long distances.
- O Pain prevents me from walking intermediate distances.
- O Pain prevents me from walking even short distances.
- O Pain prevents me from walking at all.

2

Section 5 - Sitting

- O Sitting does not cause me any pain.
- O I can sit as long as I need provided I have my choice of sitting surfaces.
- ⊘ Pain prevents me from sitting more than 1 hour.
- O Pain prevents me from sitting more than 1/2 hour.
- O Pain prevents me from sitting more than 10 minutes.
- O Pain prevents me from sitting at all.

2

Section 6 - Standing

- O I can stand as long as I want without pain.
- O I have some pain while standing, but it does not increase with time.
- O I cannot stand for longer than 1 hour without increasing pain.
- X I cannot stand for longer than 1/2 hour without increasing pain. 3
- O I cannot stand for longer than 10 minutes without increasing pain.
- O I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

- O I have no pain while in bed.
- O I have pain in bed, but it does not prevent me from sleeping well.
- X Because of pain I sleep only 3/4 of normal time.
- O Because of pain I sleep only 1/2 of normal time. 2
- O Because of pain I sleep only 1/4 of normal time.
- O Pain prevents me from sleeping at all.

Section 8 - Social Life

- O My social life is normal and gives me no pain.
- O My social life in normal, but increases the degree of pain.
- X Pain prevents me from participating in more energetic activities e.g. sports, dancing.
- O Pain prevents me from going out very often. 2
- O Pain has restricted my social life to my home.
- O I hardly have any social life because of pain.

Section 9 - Traveling

- O I get no pain while traveling.
- O I get some pain while traveling, but none of my usual forms of travel make it any worse.
- O I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
- X I get extra pain while traveling that requires me to seek alternative forms of travel. 3
- O Pain restricts all forms of travel.
- O Pain prevents all forms of travel except that done lying down.

Section 10 - Employment/Homemaking

- O My normal job/homemaking duties do not cause pain.
- O My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- O I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
- X Pain prevents me from doing anything but light duties. 3
- O Pain prevents me from doing even light duties.
- O Pain prevents me from performing any job or homemaking chore.

SCORE 22/45 49%

Section 7: Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☒ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

3

Section 8: Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☒ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all

3

Section 9: Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless)
- ☒ My sleep is greatly disturbed (3-5 hrs sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs sleepless)

4

Section 10: Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in all my recreation activities, with some pain in my neck
- ☒ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all

2

Score: ___/50 **Transform to percentage score x 100 = %points**

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)
45 (total possible score) x 100 = 35.5%

21/45

46% dis

Minimum Detectable Change (90% confidence): 5 points or 10 %points

NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Office Use Only
Name Snow, Otto
Date 11/13/15

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☒ The pain is moderate at the moment 2
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☒ I can look after myself normally but it causes extra pain 1
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting Don't lift

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck 3
- ☐ I can read as much as I want with moderate pain in my neck
- ☒ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Section 5: Headaches

- ☐ I have no headaches at all
- ☒ I have slight headaches, which come infrequently 1
- ☐ I have moderate headaches, which come infrequently
- ☐ I have moderate headaches, which come frequently
- ☐ I have severe headaches, which come frequently
- ☐ I have headaches almost all the time

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty 2
- ☒ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

BROOKS Rehabilitation

Patient Name: Snow,Otto

Patient ID: 1031508-03

FINANCIAL RESPONSIBILITY AGREEMENT

The copay/coinsurance and/or deductible amounts listed below are based on information we have received from your insurance carrier and may change when processed by your insurance carrier. I understand that I am responsible for the charges for treatment received and I agree to pay any outstanding balance, subject to applicable laws. I understand that my final balance will result after all claims for rendered services have been submitted to all the provided payers. If my account has to be referred to a collection agency, I will pay all costs of the collection, including reasonable attorney's fees.

I understand that if I fail to notify Brooks of any insurance coverage changes I will be responsible for charges not covered by insurance. OS (Initial)

Primary Insurance: Liberty Mutual

Co-pay Per Visit	$ 0		
Co-insurance	0 %		
Deductible	$ 0	Met	Balance
OOP (Out of Pocket)	$	Met	Balance
HRA (Health Reimbursement Account)	$	Used	Balance
Authorization Information			

Secondary Insurance: BCBS

Co-pay Per Visit	$ 0		
Co-insurance	0 %		
Deductible	$ 600.00	Met 600.00	Balance 0
OOP (Out of Pocket)	$	Met	Balance
HRA (Health Reimbursement Account)	$	Used	Balance

☐ (patient initial) No Secondary Insurance.

Payment Plan – Remaining Deductible

- ☐ $1 - $500 = $50.00 / visit*
- ☐ $501 - $1000 = $80.00 / visit*
- ☐ $1001 + above = $100.00 / visit*

*Visit = all services received in 1 day.

Payment Plan - Co-Insurance

- ☐ 10% Co-insurance = $10.00 / visit*
- ☐ 20% Co-insurance = $15.00 / visit* (Auto = Collect $30/visit)
- ☐ 30% Co-insurance = $25.00 / visit*
- ☐ Other:

YOUR DEDUCTIBLE & COINSURANCE PAYMENTS WILL HELP LOWER YOUR BALANCE DUE. YOU WILL RECEIVE A BILL AT THE CONCLUSION OF TREATMENT FOR YOUR REMAINING BALANCE.

****PAYMENT DUE AT EACH APPOINTMENT :** $ 0

This payment will reduce the balance due from you at the conclusion of your treatment. The insurance information listed above is based on verbal confirmation of benefits and is NOT A GUARANTEE. We recommend that you contact your Insurance Carrier.

I, the undersigned, have read and understand the conditions listed above with respect to financial responsibility.

Otto E Snow — Patient/Legal Guardian Signature — 11/24/15 Date

Witness — 11/20/15 Date

***** COPY PROVIDED TO PATIENT/LEGAL GUARDIAN*****

Revised: 7/22/14

Dizziness Handicap Inventory

Date: 12/29/15 Patient: Otto E Snow Age: 59

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question. *Answer each question as it pertains to your dizziness or unsteadiness only.*

ITEM	QUESTION		Y	N	S
1*	Does looking up increase your problem?	P		X	X
2	Because of your problem, do you feel frustrated?	E		X	
3	Because of your problem, do you restrict your travel for business or recreation?	F		X	
4	Does walking down the aisle of a supermarket increase your problem?	P		X	
5*	Because of your problem, do you have difficulty getting into or out of bed?	F		X	
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties? NA	F			
7	Because of your problem, do you have difficulty reading?	F			X
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			X
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E		X	
10	Because of your problem, are you embarrassed in front of others?	E		X	
11	Do quick movements of your head increase your problem?	P	X		
12	Because of your problem, do you avoid heights?	F	X		
13*	Does turning over in bed increase your problem?	P		X	
14	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	F	X		
15	Because of your problem, are you afraid people may think you are intoxicated?	E		X	
16	Because of your problem, is it difficult for you to walk by yourself?	F		X	
17	Does walking down a sidewalk increase your problem?	P		X	
18	Because of your problem, is it difficult for you to concentrate?	E			X
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F		X	
20	Because of your problem, are you afraid to stay at home alone?	E		X	
21	Because of your problem, do you feel handicapped?	E		X	
22	Has your problem placed stress on your relationships with members of your family or friends?	E		X	
23	Because of your problem, are you depressed?	E			X
24	Does your problem interfere with your job or household responsibilities?	F		X	
25*	Does bending over increase your problem?	P	X		
			x4	x0	x2
		=	16		10
		TOTAL	26		

P _____ E _____ F _____

☐100-70 = severe perception of having a handicap, ☐ 69-40 = moderate perception of handicap, ☐ 39-0 = low perception of handicap.

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Office Use Only
Name Snow, Otto
Date 12-29-15

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☑ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- ☑ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☑ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☑ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Section 5: Headaches

- ☐ I have no headaches at all
- ☑ I have slight headaches, which come infrequently
- ☐ I have moderate headaches, which come infrequently
- ☐ I have moderate headaches, which come frequently
- ☐ I have severe headaches, which come frequently
- ☐ I have headaches almost all the time

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☑ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

Section 7: Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☒ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

Section 8: Driving

- ☒ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all

15

Section 9: Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☒ My sleep is moderately disturbed (2-3 hrs sleepless)
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation NA

- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in all my recreation activities, with some pain in my neck
- ☒ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all

Score: ___/50 **Transform to percentage score x 100 = %points**

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)
45 (total possible score) x 100 = 35.5%

34%

Minimum Detectable Change (90% confidence): 5 points or 10 %points

---

NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415

Name Otto E. Snow Date 12/29/15

Modified Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much you low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section **one circle** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the circle that most closely describes your problem.**

Section 1 - Pain Intensity

- O The pain comes and goes and is very mild.
- O The pain is mild and does not vary much.
- ⊗ The pain comes and goes and is moderate.
- O The pain is moderate and does not vary much.
- O The pain comes and goes and is severe.
- O The pain is severe and does not vary much.

Section 2 - Personal Care

- ⊗ I do not have to change my way of washing or dressing to avoid pain.
- O I do not normally change my way of washing or dressing even though it causes me pain.
- O Washing and dressing increase the pain, but I manage not to change my way of doing it.
- O Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- O Because of the pain I am unable to do some washing and dressing without help.
- O Because of the pain I am unable to do any washing and dressing without help.

Section 3 - Lifting (skip if you have not attempted lifting since the onset of your low back pain)

- O I can lift heavy weights without extra low back pain.
- O I can lift heavy weights but it causes extra pain.
- O Pain prevents me lifting heavy weights off the floor.
- O Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned; e.g. on a table.
- O Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- O I can only lift light weights at the most.

Section 4 - Walking

- O I have no pain walking.
- O I have some pain on walking, but I can still walk my required to normal distances.
- ⊗ Pain prevents me from walking long distances.
- O Pain prevents me from walking intermediate distances.
- O Pain prevents me from walking even short distances.
- O Pain prevents me from walking at all.

Section 5 - Sitting

- O Sitting does not cause me any pain.
- ⊗ I can sit as long as I need provided I have my choice of sitting surfaces.
- O Pain prevents me from sitting more than 1 hour.
- O Pain prevents me from sitting more than 1/2 hour.
- O Pain prevents me from sitting more than 10 minutes.
- O Pain prevents me from sitting at all.

Section 6 - Standing

- O I can stand as long as I want without pain.
- O I have some pain while standing, but it does not increase with time.
- O I cannot stand for longer than 1 hour without increasing pain.
- ✗ I cannot stand for longer than 1/2 hour without increasing pain.
- O I cannot stand for longer than 10 minutes without increasing pain.
- O I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

- O I have no pain while in bed.
- O I have pain in bed, but it does not prevent me from sleeping well.
- ✗ Because of pain I sleep only 3/4 of normal time.
- O Because of pain I sleep only 1/2 of normal time.
- O Because of pain I sleep only 1/4 of normal time.
- O Pain prevents me from sleeping at all.

Section 8 - Social Life NA

- O My social life is normal and gives me no pain.
- O My social life in normal, but increases the degree of pain.
- ✗ Pain prevents me from participating in more energetic activities e.g. sports, dancing.
- O Pain prevents me from going out very often.
- O Pain has restricted my social life to my home.
- O I hardly have any social life because of pain.

Section 9 - Traveling NA

- O I get no pain while traveling.
- ✗ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- O I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
- O I get extra pain while traveling that requires me to seek alternative forms of travel.
- O Pain restricts all forms of travel.
- O Pain prevents all forms of travel except that done lying down.

Section 10 - Employment/Homemaking

- O My normal job/homemaking duties do not cause pain.
- ✗ My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- O I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
- O Pain prevents me from doing anything but light duties.
- O Pain prevents me from doing even light duties.
- O Pain prevents me from performing any job or homemaking chore.

SCORE 38%

BROOKS℠
Rehabilitation

PATIENT VISIT LOG

**This log is to be signed by the patient and a witness
WHEN SERVICES ARE RENDERED.

Patient Name: **Otto Snow**

Account Number: **1031508-03**

Auto Carrier: Liberty Mutual

Claim Number: 032823693

Date of Service	Time In	Time Out	Patient Signature	Witness
11/13/15	9:25 AM	11:00	Otto E Snow	Maryann Arruda
11-17-15	9:00	10:00	Otto E Snow	Jessica Perella
11 2015	10:00	11:00	Otto E Snow	Maryann Arruda
11-23-15	9:00	10:00	Otto E Snow	Jessica Perella
11-25-15	9:00	10:25	Otto E Snow	Jessica Perella
12-2-15	12:00	1:00	Otto E Snow	Maryann Arruda
12-4-15	10:00	11:00	Otto E Snow	Maryann Arruda
12-8-15	10:00	11:00	Otto E Snow	Kathryn Burns
12-17-15	10:00	11:00	Otto E Snow	Maryann Arruda
12-29-15	1:55	2:00	Otto E Snow	Maryann Arruda

**According to Senate Bill CS/SB 32A, patients filing Personal Injury claims must sign a " Disclosure and Acknowledgement form" at the initial visit to the rendering provider and must also sign a daily log at all subsequent visits.

This log is to protect the patient' rights in the fight against insurance fraud.

pg. 258

ROI #7123
#371954 12/29/15 HUD
#352670 6/3/15 HUD
341855 1/20/15 HUD

BROOKS Rehabilitation

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Medical Record # | Account #

Section A: (This section must be complete to be valid)

Patient Name: Otto E Snow | Date of Birth: [redacted] | Social Security No.: [redacted]

I hereby authorize Brooks Health System to Release my confidential health information to:

Recipient's Name/Facility: Otto E Snow | Recipient's Phone: [redacted] | Recipient's Fax:

Address: 64 Leighton St. | City: Bangor | State: ME | Zip: 04401

Email Address (Use ALL CAPS): [redacted]

Purpose of Disclosure:
- [x] Continuation of Care
- [ ] Insurance Purposes
- [ ] Legal Reason
- [ ] Personal Use
- [ ] Other (Specify)

Type:
- [x] Copies of Record
- [ ] Review of Record
- [ ] Discussion of Record

Delivery Method: (If left blank, a paper copy will be provided)
- [ ] Fax (Physician Only)
- [x] Mailed Paper Copy
- [ ] Pick Up Paper Copy
- [x] Email (Patient Only/Abstract Only)
  - [ ] Encrypted [ ] Unencrypted

USB FedEx Next Day

Section B: Description of Information to be used or disclosed

Description:	Description:	Description:	Date(s) of Service:	Location
[x] Admission Documentation [x] History & Physical [x] Physician orders [x] Progress Notes [x] Discharge Summary	[x] Consultation Reports [x] Therapy Notes [x] Nursing Notes [x] Clinical Tests [x] Evaluations/Assessments	[ ] Medications [ ] Transfer forms [x] Diagnosis [ ] Billing Records [ ] **Other:** _____	All	[ ] Bartram Crossing [ ] Brooks Rehab Hospital [ ] Brooks Americare Home Health [ ] Brooks Medical Group [x] Outpatient Rehab [ ] University Crossing

I acknowledge, and hereby consent to such, that the released information may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions. OS ***(Initials)***

I understand that:
1. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
2. I may revoke this authorization at any time in writing. I understand the revocation will not apply to information already released in response to this authorization.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by state or federal privacy regulations.
4. Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization.
5. Upon request, I may receive a copy of this form after I sign it.
6. If I fail to specify expiration date or condition as set forth below, this authorization is valid for 6 months from the signature date.
7. Patient information provided on a USB flash drive is for patient requests only and requires decryption with a provided password.
8. I understand there are risks for obtaining my records through unencrypted email and accept responsibility for those risks. Risks include, but are not limited to, interception of email by a third party, read or accessed by unintended recipient, or sent to the wrong recipient.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

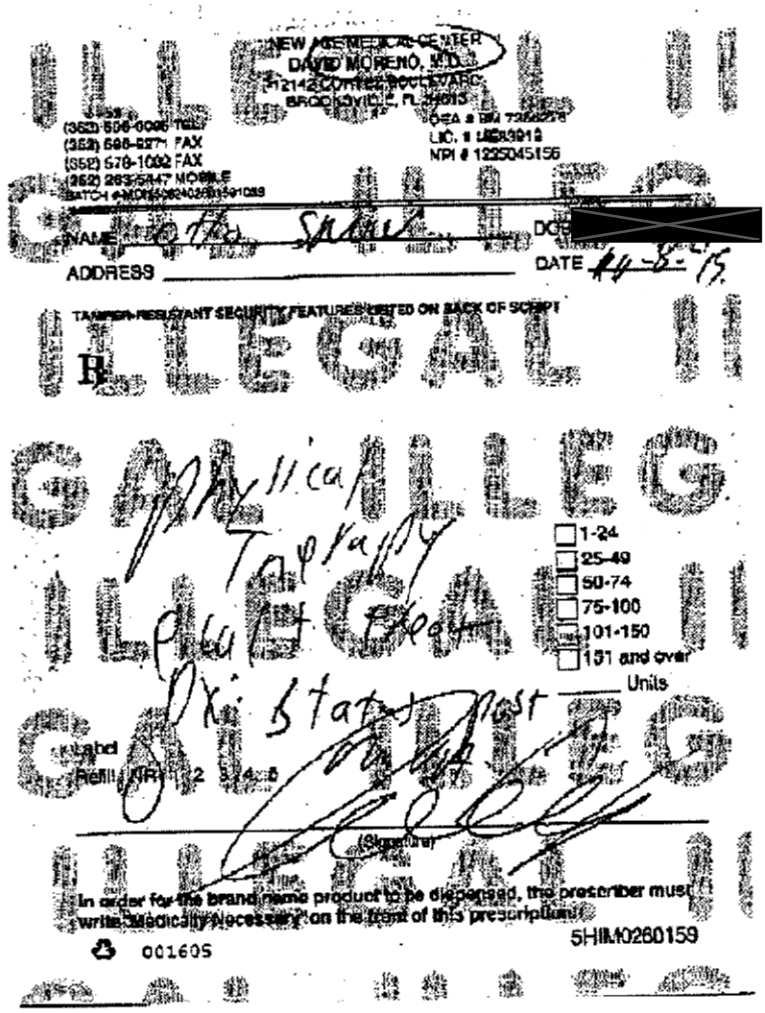
Signature of Patient/Guardian/Patient Representative:	Date:	Signature of Witness:
Otto E Snow	10/18/18	
Print Name of Patient/Guardian/Patient Representative:	**Relationship to Patient:**	
Otto E Snow	self	

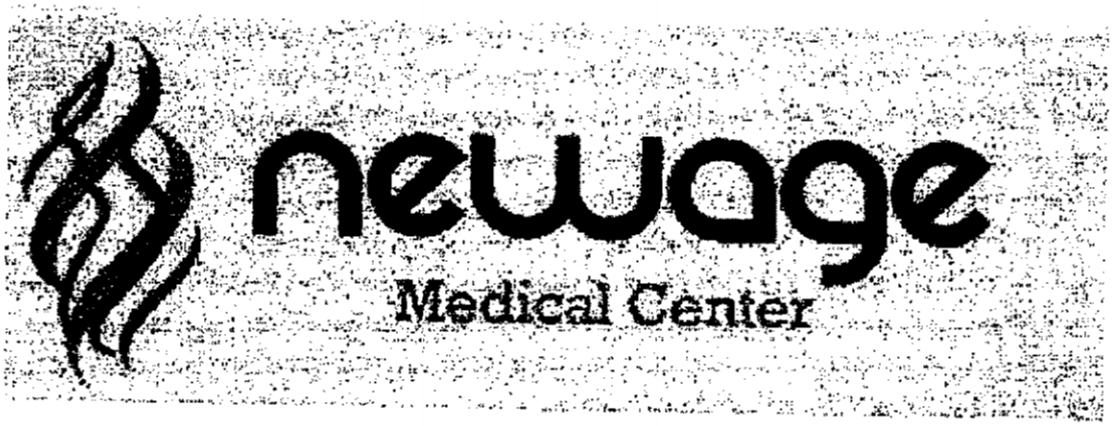
Authorization **expires 6 months from the date signed** unless otherwise specified below:
Expiration Date/Event:

Updated. December 2016

[ ] ID Verification

TV #: 1021508-03





12142 Cortez Blvd
Brooksville Fl. 34613

352-596-9095 Phone
352-596-9271/
352-578-1032 Fax

TO: Dr. Brooks Rehabilitation **From:** Dr. Moreno

Date: 11/9/15 **Pages:**

RE: Referral for physical therapy. **CC:**

BROOKS Rehabilitation

Physical Therapy Evaluation
Evaluation Date: 11-13-2015

Patient: **Snow,Otto / Patient ID # 1031508-03** ***(Meditech Acct# F00010371954 /U#F1212268)***
DOB: [redacted]
Referring MD: David Moreno *(Insurance: Liberty Mutual WC)*

I. HISTORY AND SYSTEMS REVIEW:

Otto Snow is a 59 year old male who is seen today with chief complaint of low back pain, SIJ pain, neck pain, and dizziness. Otto states chief complaint began after motor vehicle accident on 10/29/15. The MVA was a T-bone to the driver side door and the patient report jolting to the right due to the impact. Since the accident tha patient reports R sided back pain from his SIJ to his head. Patient also reports an increase in pressure in the head, but states that all CTs, MRIs, and Xrays were negative for all injuries. The patient reports the chief complaint has gotten worse since the accident warranting evaluation.

Contributing past medical history: high blood pressure, PTSD, anxiety, depression, bowel issues, and difficulty sleeping.

See Medical History Form for:
Medical/Surgical History, Review of Systems, Social/Occupational History, Diagnostic Testing, Medications and Prior Treatment obtained.

II. CLINICAL IMPRESSION:

Examination revealed findings consistent with a diagnosis of: BPPV L posterior canalithiasis. The patient is also reporting cervical/lumbar symptoms secondary to post-MVA however, limited assessment during evaluation other than self reporting outcome measures due to patient unable to tolerate physical assessment secondary to symptoms from BPPV. Will plan to assess completely his spinal issues at next follow up visit.

The patient's activity and participation limitations (described in the table below) are related to the following impairments: R sided pain from SIJ through head, decreased toelrance to positions due to onset of dizziness, and decreased level of functional mobility.

Contextual factors affecting the patient's plan of care include: mental status, pain report in back and neck, CLOF, and PLOF

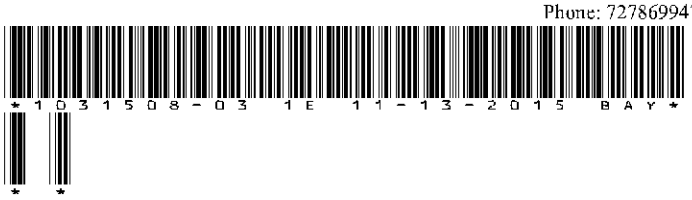
PROGNOSIS:
Good for stated goals based on PLOF, CLOF, and mental and medical status.

PLAN OF CARE:
Therapy for this patient will begin with canal repositioning and will progress to the assessment of the neck, low back, and SIJ.

III. DESCRIPTION OF PAIN/SYMPTOMS:

- Location: R side of the spine, from SIJ up through the head.
- Description: ranges from a soreness to a sharp pain depending on the movement or activity
- Frequency/Duration: pain is constant; changes due to activity
- Aggravating Factors: bending over, turns and transitions, repetitive movements, standing for an extended period of time, and walking for an extended period of time.
- Relieving Factors: laying down, sleeping, and special lotion he reports he uses
- 24 hr Behavior: worst in the morning and at the end of the day

Average pain in the last week is reported as 4 /10.



IV. PRIOR LEVEL OF FUNCTION:

Prior to onset of the patient's chief complaint, the patient was able to perform activities and participation listed below with no pain, dizziness, and with less difficulty

V. GOALS:	Description	Type	Due Date
1.	Long Term Goals to Be Completed in 5 Weeks	Long-term	
2.	The patient will be independent with a self-management and/or HEP program directed towards VOR, lumbar stabilization, and SIJ correction.		
3.	Patient will present with a negative L hallpike for both nystagmus and report in dizziness.		
4.	Patient will report an oswestry score 16.7% lower in order to demonstrate a decrease in pain and overall increase in function from improvement in the low back.		
5.	Patient will report a NDI score 5 points lower in order to demonstrate a decrease in pain and an overall increase in function related to the patient's neck.		
6.	Patient will report a DHI score 17% lower in order to demonstrate a decreased perception of handicap related to dizziness and an increase in function.		

VII. The Treatments may include, but not limited to:

1. Evaluation - PT (97001 U)
2. Re-Evaluation - PT (97002 U)
3. PhysPerfTest/Measure FCE(97750) NO Aetna
4. E Stim -Unattend (97014 U)
5. EStm-U Mcr/Unt/ACN/BC/Auto/Tri/AMd G0283
6. Manual Therapy(97140)NO progressive auto
7. Therapeutic Exercise (97110)
8. Therapeutic Activities (97530)
9. Neuromuscular Re-education (97112)
10. SelfCare/Home Management(97535)NO AvMed
11. Gait Training (97116)

Frequency/Duration: **2x** time(s) per **Week** for **5 weeks**

The patient agrees with the findings, goals and plan as written: **Yes**

Certification Dates: **11-13-2015** to **02-13-15**

Thank you for the opportunity to assist you with the care of this patient.

Connie Garces PT, DPT

11-13-2015

Connie Garces PT

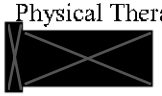
If you concur with the treatment plan for this patient, please indicate by signing and dating this letter and faxing it back to our office at **7278617135**.

_____/_____

Referring Physician Signature **Date**

David Moreno

I have examined and approve of this Plan of Care and treatment which is established and reviewed by the physician periodically. I Order the treatments and concur with the frequency and duration as documented in this Plan of Care.



VII. OBJECTIVE FINDINGS:

Test	Test Descriptions	Results	Comments
Systems Review	***CARDIOPULMONARY***	.	
	Resting Blood Pressure	155/102 mmHg	
	Resting Heart Rate	79 bpm	
	NEUROMUSCULAR	.	
	Coordination	not assessed, assess at a later date	
	Balance	not assessed, assess at a later date	
	Cognition	intact, alert and oriented	
Neurologic Exam	***MYOTOMES***	.	
	C1 (craniocervical flexion)	not assessed due to report of dizziness, assess at a later date	
	C2 (craniocervical extension)	not assessed due to report of dizziness, assess at a later date	
	C3 (cervical lateral flexion)	not assessed due to report of dizziness, assess at a later date	
	C4 (shoulder shrug)	not assessed due to report of dizziness, assess at a later date	
	C5 (shoulder abduction)	not assessed due to report of dizziness, assess at a later date	
	C6 (elbow flexion/wrist ext)	not assessed due to report of dizziness, assess at a later date	
	C7 (elbow ext/wrist flexion)	not assessed due to report of dizziness, assess at a later date	
	C8 (thumb adduction)	not assessed due to report of dizziness, assess at a later date	
	T1 (finger abduction)	not assessed due to report of dizziness, assess at a later date	
	L1/2 (hip flexion)	not assessed due to report of dizziness, assess at a later date	
	L3 (knee extension)	not assessed due to report of dizziness, assess at a later date	
	L4 (ankle dorsi flexion)	not assessed due to report of dizziness, assess at a later date	
	L5 (great toe ext/ankle eversion)	not assessed due to report of dizziness, assess at a later date	
	S1 (heel raise)	not assessed due to report of dizziness, assess at a later date	
	S2 (knee flexion)	not assessed due to report of dizziness, assess at a later date	
Functional Reporting - Entire Spine	*** SELF-REPORT MEASURES ***	.	
	Average Pain in Last Week	5/10	
	---Worst Pain in Last Week	7/10	
	---Least Pain in Last Week	3/10	
	---Current Pain	4/10	
	Neck Disability Index	21/45; 46% disability	
	Oswestry Disability Index (0=best, 50=worst)	22/45; 49% disability	
	*** ACTIVITY LIMITATIONS ***	.	
	Bed Mobility (BADL)	requires more time to complete, reports an increase in symptoms when	
	Transfers (BADL)	completed, and experiences dizziness with all bed mobility; PLOF patient had no	
	Ambulation (BADL)	difficulty	
	Household Chores	patient requires BUEs to remain steady; PLOF patient completed with no UEs	
	Job or School	patient cannot complete quick turns or transitions due to increase in dizziness	
	Recreational Activities	patient reports difficulty completing activies in the kitchen due to head turns and	
	*** SELF REPORT ***	quick movements	

	DIzziness Handicap Inventory (DHI)	patient cannot read for an e[illegible] of time or stare at a computer screen due to onset of headache and dizziness patient is unable to hike due to pain and onset of dizziness when looking up and down . 64%; moderate perception of handicap	
Observation & Palpation - Entire Spine	*** OBSERVATIONS *** Standing Posture Sitting Posture Movement Quality Breathing Pattern Gait Without Assistive Device *** PALPATION *** Cervical Muscle Turgor Thoracic Muscle Turgor Lumbar Muscle Turgor Pelvic Muscle Turgor *** TENDERNESS *** Cervical Tenderness Thoracic Tenderness Lumbar Tenderness Pelvic Tenderness	. flexed posture, forward head, and rounded shoulders flexed posture, forward head, and rounded shoulders moves with hesitancy and guarding elevated rate due to reported anxiety patient demonstrates minimal arm swing, pelvic rotation, and trunk rotation. . not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date . not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date	
ROM & Resisted Testing - Entire Spine	*** CERVICAL AROM *** Cervical Flexion (AROM) Cervical Extension (AROM) Cervical Left Rotation (AROM) Cervical Right Rotation (AROM) Cervical Left Lateral Flexion (AROM) Cervical RIght Lateral Flexion (AROM) *** CERVICAL PROM *** Cervical Flexion (PROM) Cervical Extension (PROM) Cervical Left Rotation (PROM) Cervical Right Rotation (PROM) Cervical Left Lateral Flexion (PROM) Cervical Right Lateral Flexion (PROM) *** CERVICAL RESISTED TESTING *** Cervical Flexion Cervical Extension Cervical Left Rotation Cervical Right Rotation Cervical Left Lateral Flexion Cervical Right Lateral Flexion *** THORACIC AROM ***	. not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date . not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date . not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date .	

	Thoracic Flexion (AROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Extension (AROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Left Rotation (AROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Right Rotation (AROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Left Lateral Flexion (AROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Right Lateral Flexion (AROM)	not assessed due to report of dizziness, assess at a later date	
	*** THORACIC PROM ***	.	
	Thoracic Flexion (PROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Extension (PROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Left Roation (PROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Right Rotation (PROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Left Lateral Flexion (PROM)	not assessed due to report of dizziness, assess at a later date	
	Thoracic Right Lateral Flexion (PROM)	not assessed due to report of dizziness, assess at a later date	
	*** THORACIC RESISTED TESTING ***	.	
	Thoracic Flexion	not assessed due to report of dizziness, assess at a later date	
	Thoracic Extension	not assessed due to report of dizziness, assess at a later date	
	Thoracic Left Rotation	not assessed due to report of dizziness, assess at a later date	
	Thoracic Right Rotation	not assessed due to report of dizziness, assess at a later date	
	Thoracic Left Lateral Flexion	not assessed due to report of dizziness, assess at a later date	
	Thoracic Right Lateral Flexion	not assessed due to report of dizziness, assess at a later date	
	*** LUMBAR AROM ***	.	
	Lumbar Flexion (AROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Extension (AROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Left Rotation (AROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Right Rotation (AROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Left Lateral Flexion (AROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Right Lateral Flexion (AROM)	not assessed due to report of dizziness, assess at a later date	
	*** LUMBAR PROM ***	.	
	Lumbar Flexion (PROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Extension (PROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Left Rotation (PROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Right Rotation (PROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Left Lateral Flexion (PROM)	not assessed due to report of dizziness, assess at a later date	
	Lumbar Right Lateral Flexion (PROM)	not assessed due to report of dizziness, assess at a later date	
	*** LUMBAR RESISTED TESTING ***	.	
	Lumbar Flexion	not assessed due to report of dizziness, assess at a later date	
	Lumbar Extension	not assessed due to report of dizziness, assess at a later date	
	Lumbar Left Rotation	not assessed due to report of dizziness, assess at a later date	
	Lumbar Right Rotation	not assessed due to report of dizziness, assess at a later date	
	Lumbar Left Lateral Flexion	not assessed due to report of dizziness, assess at a later date	
	Lumbar Right Lateral Flexion	not assessed due to report of dizziness, assess at a later date	
Joint Mobility - Entire Spine	OA	not assessed due to report of dizziness, assess at a later date	
	AA	not assessed due to report of dizziness, assess at a later date	
	C2/3	not assessed due to report of dizziness, assess at a later date	

	C3/4	not assessed due to report of dizziness, assess at a later date	
	C4/5	not assessed due to report of dizziness, assess at a later date	
	C5/6	not assessed due to report of dizziness, assess at a later date	
	C6/7	not assessed due to report of dizziness, assess at a later date	
	C7/T1	not assessed due to report of dizziness, assess at a later date	
	T1/2	not assessed due to report of dizziness, assess at a later date	
	T2/3	not assessed due to report of dizziness, assess at a later date	
	T3/4	not assessed due to report of dizziness, assess at a later date	
	T4/5	not assessed due to report of dizziness, assess at a later date	
	T5/6	not assessed due to report of dizziness, assess at a later date	
	T6/7	not assessed due to report of dizziness, assess at a later date	
	T7/8	not assessed due to report of dizziness, assess at a later date	
	T8/9	not assessed due to report of dizziness, assess at a later date	
	T9/10	not assessed due to report of dizziness, assess at a later date	
	T10/11	not assessed due to report of dizziness, assess at a later date	
	T11/12	not assessed due to report of dizziness, assess at a later date	
	T12/L1	not assessed due to report of dizziness, assess at a later date	
	L1/2	not assessed due to report of dizziness, assess at a later date	
	L2/3	not assessed due to report of dizziness, assess at a later date	
	L3/4	not assessed due to report of dizziness, assess at a later date	
	L4/5	not assessed due to report of dizziness, assess at a later date	
	L5/S1	not assessed due to report of dizziness, assess at a later date	
	Left SIJ	not assessed due to report of dizziness, assess at a later date	
	Right SIJ	not assessed due to report of dizziness, assess at a later date	
Special Tests - Entire Spine	*** CERVICOGENIC HEADACHE ***	.	
	Flexion-Rotation Test	not assessed due to report of dizziness, assess at a later date	
	C1-C2 PA Pressure	not assessed due to report of dizziness, assess at a later date	
	*** CERVICAL FACET PAIN PROVOCATION ***	. not assessed due to report of dizziness, assess at a later date	
	Quadrant Test	.	
	*** CERVICAL SEGMENTAL PAIN PROVOCATION ***	not assessed due to report of dizziness, assess at a later date not assessed due to report of dizziness, assess at a later date	
	PA Springing	.	
	UPA Springing	not assessed due to report of dizziness, assess at a later date	
	*** LUMBAR FACET PAIN PROVOCATION ***	. not assessed due to report of dizziness, assess at a later date	
	Lumbar Quadrant Test	not assessed due to report of dizziness, assess at a later date	
	*** LUMBAR DISC PAIN PROVOCATION ***	not assessed due to report of dizziness, assess at a later date .	
	Repeated Flexion	not assessed due to report of dizziness, assess at a later date	
	Repeated Extension	not assessed due to report of dizziness, assess at a later date	
	Repeated Lateral Flexion	not assessed due to report of dizziness, assess at a later date	
	*** SIJ PAIN PROVOCATION ***	not assessed due to report of dizziness, assess at a later date	
	Thigh Thrust Test	not assessed due to report of dizziness, assess at a later date	

	SIJ Gapping SIJ Compression Gaenslen's Test Sacral Thrust FABER Test Single Leg Stance *** PUBIC SYMPHYSIS DYSFUNCTION *** Pubic Symphysis Palpation	not assessed due to report of dizziness; assess at a later date not assessed due to report of dizziness; assess at a later date . not assessed due to report of dizziness; assess at a later date	
Oculomotor in Room Light	Smooth Pursuits Convergence Saccades VOR-Cancellation R Hallpike L Hallpike R Roll Test L Roll Test	report of dizziness report of dizziness report of dizziness with observed nystagmus R = +, L = - negative positive for nystagmus and dizziness negative negative	

BROOKS Rehabilitation

Physical Therapy
Daily Treatment/Activity Note

Date: **11-13-2015**
Patient: **Snow,Otto / Patient ID # 1031508-03** ***(Meditech Acct# F00010371954 /U#F1212268)***
Referring MD: David Moreno *(Insurance:Liberty Mutual WC)*
Diagnosis: M54.2 Cervicalgia
H81.10 Benign paroxysmal vertigo, unspecified ear
M54.5 Low back pain

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
Evaluation - PT (97001 U)	1/	25
Re-Evaluation - PT (97002 U)		
PhysPerfTest/Measure FCE(97750) NO Aetna		
E Stim -Unattend (97014 U)		
EStm-U Mcr/Unt/ACN/BC/Auto/Tri/AMd G0283		
Manual Therapy(97140)NO progressive auto		
Therapeutic Exercise (97110)		
Therapeutic Activities (97530)	2/	35
Neuromuscular Re-education (97112)		
SelfCare/Home Management(97535)NO AvMed	----- not billable ------	
Gait Training (97116)		
*** DIAGNOSIS***	L posterior canalithiasis; low back and neck will be assessed at a later date	
*** PRECAUTIONS ***	dizziness and falls	
*** PLAN ***	canal repositioning	
*** VISIT COUNT ***	1/10	
*** NEXT PROGRESS/STATUS NOTE DUE ***	10	
*** OUTCOME MEASURES TO TRACK ***	DHI, oswestry, NDI	
*** PATIENT/CAREGIVER EDUCATION ***	HEP	
Current condition		
Self-management		
*** MANUAL THERAPY ***		
*** THER EX / NEURO RE-ED ***		
Mobility/Symptom Reduction/Tissue Health		
Motor Control / Coordination		
Endurance/Strengthening		
Power		
*** THERAPEUTIC ACTIVITIES ***		
Functional Performance Training		
left posterior canal repositioning	3x	
VOR x 1	HEP	
Balance Activities		
Equilibrium Training		
*** GAIT TRAINING ***		
	Total Minutes	60

Services provided are distinct because they occurred during a separate encounter ensuring optimal outcomes

PAIN LEVEL: 4

SUBJECTIVE:

OBJECTIVE:

Test	Test Description	Results	Comments

ASSESSMENT:

PLAN:

GOALS

Goal Description	Outcome
1.	

ADDITIONAL GOALS

Goal	Goal Length	Due Date
1.		

PT, DPT

11-13-2015

Amanda Akana PTS

Connie Garces PT