

**CONFIDENTIAL PATIENT INFORMATION**

Date \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS FRONT AND BACK. IF YOU NEED ASSISTANCE PLEASE ASK THE RECEPTIONIST. THANK YOU FOR THE OPPORTUNITY TO SERVE YOU.**

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ MARITAL STATUS M S W D NUMBER OF CHILDREN \_\_\_\_\_

CITY, STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ E-Mail Address \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_ SPOUSE OCCUPATION \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_

PATIENT'S NEAREST RELATIVE \_\_\_\_\_ PHONE \_\_\_\_\_

Whom may we thank for referring us to you \_\_\_\_\_

If a phone book, which one: SBC (Ameritech) \_\_\_\_\_ or Yellow book (McLeod) \_\_\_\_\_

BRIEFLY EXPLAIN YOUR CONDITION \_\_\_\_\_

OTHER DOCTORS SEEN FOR THIS CONDITON \_\_\_\_\_

**GENERAL HEALTH INFORMATION**

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

WHAT OPERATIONS HAVE YOU HAD? WHEN? \_\_\_\_\_

SERIOUS ILLNESS? WHEN? \_\_\_\_\_

SERIOUS ACCIDENT? When? \_\_\_\_\_

KNOWN DRUG ALLERGIES: \_\_\_\_\_

**HAVE YOU EVER SUFFERED FROM:**

Dizziness	Y N	Sinus Trouble	Y N
Backaches	Y N	Heart Trouble	Y N
Headaches	Y N	Nervousness	Y N
Numbness	Y N	Anemia	Y N
Leg Pain	Y N	Cancer	Y N
Arm/Shoulder Pain	Y N	Diabetes	Y N
Burning/Ringing in Ears	Y N	Asthma	Y N
Arthritis	Y N	Allergies	Y N
Digestive Disorders	Y N	Fatigue	Y N

Have you been treated for any medical condition by a physician in the past year? Y N

**Primary Insurance**

Company Name \_\_\_\_\_ Name of Policyholder \_\_\_\_\_

Policy Number \_\_\_\_\_

**Do you have any other medical insurance (are you covered on a spouses plan)?** \_\_\_YES \_\_\_NO

**If YES:**

Company Name \_\_\_\_\_ Name of Policyholder \_\_\_\_\_

Policy Number \_\_\_\_\_

**ASSIGNMENT AND RESPONSIBILITY STATEMENTS  
(Please read carefully)**

1. You may use your insurance coverage to pay a portion of your incurred medical expenses. However, you should be aware these insurance payments are not a substitute for your responsibility relative to incurred charges for service. It is your responsibility to pay for debts not covered by your insurance company, including deductibles and co-payments.
2. Our staff will file all of the necessary insurance claim forms and do everything in their power to insure smooth claim processing.
3. This form shall serve as an authorization for this office to:
  - A) Bill your insurance carrier for all services rendered,
  - B) Release any information necessary to process insurance claims,
  - C) Have any insurance benefits paid directly to this office.
  - D) Release any information necessary to other providers offices.
4. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE** until other financial arrangements are made. If care and treatment is suspended or terminated, any fees for professional services rendered will immediately due and payable in addition to any cost of collection, if applicable. Personal balances older than 30 days will have interest charges of 1.5% per month added.
5. **CONSENT FOR CARE** I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition (s). Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee our treatment will help the condition you are seeking treatment for. There is also a risk your treatment may cause pain or injury, or may aggravate previously existing conditions. Further, I authorize physical therapy treatments to be performed in an open bay area.

**Patient Signature** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Insured Signature** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Guardian Signature authorizing care** \_\_\_\_\_

# PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date \_\_\_\_\_

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## COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients



Describe the illness/injury for which you are being treated.

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How did the injury happen?

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Date of illness/injury \_\_\_\_\_

First date of treatment \_\_\_\_\_

Do you have any other medical insurance coverage? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes please provide name of insurance company and policy number.

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1. Is your treatment her due to one of the following:

Work related: YES \_\_\_\_\_ NO \_\_\_\_\_

Automobile accident YES \_\_\_\_\_ NO \_\_\_\_\_

If you said yes to either of the above question, the following information is required.

2. If this is a work related illness/injury:

a. Did the injury happen while you were working or did your job requirements aggravate your illness/injury? \_\_\_\_\_

b. Where did the illness/injury occur (name, address, city, state, zip and telephone number(s))

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3. If there was a motor vehicle accident, please answer questions c – g.

c. Were you the driver \_\_\_\_\_, passenger \_\_\_\_\_ or pedestrian \_\_\_\_\_.

d. Name of your automobile insurance company (include phone and claim/policy numbers)

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e. Name of other vehicle (S) automobile insurance company ( include phone and

claim or policy numbers).

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f. Name and address of other vehicle(s) owner (s).

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g. Name of the police department the accident was reported to

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4. Do you have an attorney in relation to this illness/injury (attorney name, address, and phone number) ?

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Your signature \_\_\_\_\_ Date \_\_\_\_\_

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

**AUTHORIZATION FORM**

**FOR**

**USE OF PATIENT'S SUCCESS STORY IN**

**PUBLIC RELATIONS AND MARKETING ACTIONS**

Your success story is fantastic! Thank you for writing it for us. It is always great to be acknowledged for doing what we do each and everyday, help people.

We have found that when patients tell their physician about how they were treated and the results they obtained in physical therapy, the impact is far greater that if we tell them through meetings and other documentation.

Our most successful campaign to grow our practice and help more people get well has been through these success stories. When a patient states in writing the results he or she has obtained and how they feel about it, the doctors who read it, **KNOW** that we are **REALLY** helping people.

We have found that many doctors who may never have referred a patient to us, still need to know of our results. We do this by sending out patient success stories to them as long as the patient authorizes us to do so. This authorization is obtained and kept on file.

The Success Story book that you looked at when you started physical therapy in our office, is another tool we use to reassure a new patient when they first come to us for care. A lot of patients are a little anxious about what to expect at first, and the Success Story book really helps them to not feel that way. We would need your authorization in order to place your success story in our book as well.

This is absolutely voluntary on your part. If you have any concerns about authorizing us to promote our clinic and our results, please let us know. If you prefer not to have us use your success story in any way, simply return the form unsigned.

**I authorize the clinic to utilize my success story in the following manner:**

Success story book that remains in the office at all times.

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

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

Any promotional mailing to any physician making the services know to them and the results obtained.

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

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