Southern Tier Physical Therapy Patient Information Form

Patient Name First ____________________ Last ___________________________ DOB _____/_____/_____ SS #________-______-

Address ____City ________________________ State ______________Zip

Male _____ Female _____ Single_____ Married _____ Divorced _____ Other _____ Home Phone # ________-________-

Employer ____ Work Phone # ________-________-

Email address ____ Cell Phone # ________-________-

Student Yes ____ No ____ School

Ref DR ____ Phone # _______-_______-___________

Primary MD if different than Ref MD ____ Phone # _______-_______-___________

Injured body part _____________________ Date of injury _____/_____/_______ Surgery if yes date _____/_____/

Is condition related to Work _____ Auto Accident _____ Other Accident

<u>Have you had physical therapy for this injury</u>? Yes _____ No _____ If yes when and where?**

Primary Insurance **____ Phone # _______-______-**

Subscribers Name ______________________________ DOB _____/_____/______ SS # ______-______-__________

Male ___ Female ___ Subscribers Relationship to patient ___________________ Subscribers employer

Insurance group # __________________ Insurance ID #

Secondary Insurance **_____________________________________ Phone # ______-______-__________**

Subscribers Name ______________________________ DOB____/_____/______ SS #______-_____-

Male___ Female___ Subscribers Relationship to patient ________________ Subscribers employer

Insurance group # ___________________ Insurance ID # ____

Worker Comp or No Fault Insurance **____________________________________ Claim # _____________________________**

Address ____________________________________ City ______________________ State ________________ Zip____________

Adjuster / Caseworker _____________________________ Phone # _______-______-

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Content:
I authorize the release of medical information including evaluation and treatment notes from Southern Tier Physical Therapy necessary to process any claim. I authorize payment for any physical therapy services, including supplies. I understand that if I receive any services / supplies (i.e. ionto pads) that are denied or not covered by my insurance that I will be responsible for the bill.

I was offered / have read a copy of the STPTA Notice of Privacy Practices.

It is Patient's responsibility, and we strongly encourage each patient to verify their physical therapy benefits for the year with their individual insurance carriers. The patient is responsible for payment in the event they've exhausted their benefits, do not provide proper referral, or authorization etc.

Patient is responsible for any copays at the time of service

Patient Signature or Guardian ____ Date ______/______/

**** There will be a $15.00 Service charge for all returned checks****

200 Front Street Vestal, New York 13850-1548 (607) 754-1776 Fax (607) 748-5465

Medical History Screening Form

Have you or any immediate family member ever been told you/they have:
(Please circle yes or no)

	SELF	FAMILY
Cancer	YES / NO	YES / NO
If yes what type____________________________		
Diabetes	YES / NO	YES / NO
High Blood Pressure	YES / NO	YES / NO
Heart Disease	YES / NO	YES / NO
Angina / Chest Pain	YES / NO	YES / NO
Stroke	YES / NO	YES / NO
Osteoporosis	YES / NO	YES / NO
Osteoarthritis	YES / NO	YES / NO
Rheumatoid Arthritis	YES / NO	YES / NO

In the last 3 months have you had or experienced:

A change in your health? YES / NO
If yes, what changes? _____________________
Nausea / Vomiting? YES / NO
Fever/ Chills / Sweats? YES / NO
Unexplained weight loss? YES / NO
Numbness / Tingling? YES / NO
Change in appetite? YES / NO
Difficulty swallowing? YES / NO
Changes bowel / bladder function? YES / NO
Shortness of breath? YES / NO
Dizziness? YES / NO
Upper Respiratory Infection? YES / NO

Are you currently:
Pregnant? YES / NO
Depressed? YES / NO
Under stress? YES / NO

Do you have a pacemaker? YES / NO

I currently have difficulty:
(Check all that apply)
____ Driving ____ Getting up from a chair
____ Walking ____ Bending from the waist
____ Standing ____Lifting

If you are accustomed to regular exercise, check the ones that give you difficulty now:
____ Playing Sports ____Running ____ Calisthenics

Are your symptoms related to a motor vehicle accident? YES / NO
If yes, date of accident: ______________________

Do you have a history of:
(Please circle yes or no)
Allergies? YES / NO
If yes, please list them:
____
____
____
____

Latex allergy YES / NO
Asthma? YES / NO
Headaches? YES / NO
Bronchitis? YES / NO
Kidney Disease? YES / NO
Rheumatic Fever? YES / NO
Ulcers? YES / NO
Seizures? YES / NO

Are your symptoms:
(Please check one)
____ Getting worse ____ Same ____ Improving

Does your current pain effect how you sleep: YES / NO
If yes, is it: ___ Mild ___ Moderate
___ Only with medication

(Please check what applies to the following questions)
Do you have a problem with:
___Hearing ___Vision ___ Speech ___Communication

How do you learn the best by:
___Seeing ___Doing ___ Hearing

Do you now or have you in the past:
Smoke? YES / NO
If yes, how much_________ When________

Drink Alcoholic beverage? YES / NO
If yes, how many per week _______________

Date of your last physical exam: _________________
List any current medications:
____
____
____
____
____

List of Surgical History:
____
____
____
____
____
____

SOUTHERN TIER PHYSICAL THERAPY ASSOCIATES, PC
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect the privacy of your personal health information and are committed to maintaining the confidentiality of your information. This Notice applies to all information and records related to your care that our facility has received or created. It extends to information received or created by our employees, staff, volunteers and physicians. This Notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and our obligations regarding your personal health information.

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your personal health information; and
- Abide the terms of the Notice that are currently in effect

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail you a revised notice.

WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

We have described uses and disclosure of information of treatment, payment, and health care operations below and provide examples of the types of uses and disclosures we may make in each of these categories.

For Treatment: We will use and disclose your personal health information in providing you with treatment and services. We may disclose your personal health information to facility and non-facility personnel who may be involved in your care, such as physicians, nurses, nurse's aides, and physical therapists. For example, a nurse caring for you will report any change in your condition to your physician. We also may disclose personal health information to individuals who will be involved in your care after you leave the facility.

For Payment: We may use and disclose your personal health information so that we can bill and receive payment for treatment and services you receive at the facility. For billing and payment purposes, we may disclose your personal health information to your representative, insurance or managed care company, Medicare, or another third party payer. For example, we may contact Medicare or your health plan to confirm your coverage or to request coverage information for a proposed treatment or service.

For Health Care Operations: We may use and disclose your personal health information for facility operations. These uses and disclosures are necessary to manage the facility and to monitor our quality of care. For example, we may use personal health information to evaluate our facility services, including the performance of our staff.

WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your personal health information to a family member or close personal friend, including clergy, who is involved in your care.

Public Health Activities; we may disclose your personal health information for public health activities. These activities may include, for example:

- Reporting to a public health or other government authority for preventing or controlling disease, injury or disability, or reporting abuse or neglect;
- Reporting to the federal Food and Drug Administration (FDA) concerning adverse events or problems with products for tracking products in certain circumstances, to enable product recalls or to comply with other FDA requirements;
- To notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition or
- For certain purposes involving workplace illness or injuries.

Reporting Victims of Abuse, Neglect, or Domestic Violence: If we believe that you have been a victim of abuse, neglect, or domestic violence, we may use and disclose your personal health information to notify a government authority if required or authorized by law, or if you agree to the report.

Right to Receive Confidential Communication: If you are dissatisfied with the manner or location in which you are receiving communications related to your health information, you may request that we provide you with such information by alternative means or at an alternative location.

Right of Access to Health Information: You have the right to request, either orally or in writing, your medical or billing records

or other written information that may be used to make decisions about your care. If you request copies of the records, we must provide you with copies within two business days of that request. We may charge a reasonable fee for our costs in copying and mailing your requested information.

Right to Receive an Accounting of Disclosures of Health Information: You have the right to request that we provide you with a written accounting of all disclosures of your health information that we have made during a time period you specify (not to exceed 6 years). Please understand that such an accounting will not include information on disclosures;

1. For treatment, payment, or health care operations;
2. To you or your legal representative, or any other individual involved with your care
3. Incident to a use or disclosure permitted or required by the federal Privacy Rule;
4. Based on your authorization to release information;
5. For nation security or intelligence purposes
6. As part of a limited data set for research, public health or health care operations; and
7. To a health oversight agency or law enforcement official for the period of time that the agency or official asked to have the information not disclosed.

Right to Notice of Privacy Practices: You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with the facility or with the Office of Civil Rights in the U.S. Department of Health and Human Services.

To file a complaint with the facility, contact Kris Secord, Office Manager.

We will not retaliate against you if you file a complaint.

CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual right, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provision effective for all personal health information already received and maintained by the facility as well as for all personal health information we receive in the future. We will post a copy of the current Notice in the facility. In addition, we will provide a copy of the revised Notice to all patients via U.S. mail or our in-house mail system.

FOR FURTHER INFORMATION

If you have any questions about this Notice, please contact - Kris Secord, Office Manager.

EFFECTIVE DATE: January 1, 2016

Patient Name: ________________________________

I have read a copy of the Southern Tier Physical Therapy Associates Notice of Privacy Practice.

________________ ____

Date Patient Signature/Responsible Party Signature

Consent Form for Medical Records Release of Information

I,_____________________ request medical records, MRI reports and any X-rays available to be released to Southern Tier Physical Therapy Associates from (doctor and or medical facility) ________________________.

I understand that all the information contained in these reports will be kept confidential and only will be provided to my physical therapist. And I also understand that the information will be faxed or mailed to 200 Front Street Vestal, NY 13850.

Sign:____ Date:________________________________

Patient Signature/Responsible Party Signature