Patient Information Form

Contact Information

Patient Name_____

Patient Address_____

Patient City_____

Patient State_____

Patient Zip_____

Patient Phone, Home (_____) _____-_____

Patient Phone, Cell (_____) _____-_____

Patient Phone, Work (_____) _____-_____

Patient Email _____

Best way to remind you about appointment

Text-Cell ___ Call-Cell ___ Call-Home ___

Emergency Contact _____

Relation to Patient_____

Emergency Phone_____

Patient Gender_____

Marital Status_____

Student? _____

SSN _____

Date of Birth _____

Injury Details

Body Part_____

Injury Onset Date_____

Is condition related to Workers Comp / Auto

Surgery Date _____

Referral Source

Referring MD _____

Referring Phone _____

PCP Name _____

Primary Ins. Or Workers Comp or Auto Ins.

Insurance _____

ID# / Claim# _____

Phone (_____) _____-_____

Group # _____

Case Worker_____

Caseworker Phone (_____) _____-_____

Employer_____

Insurance Subscriber

Name_____

Date of Birth _____

Gender_____

Relationship to Patient_____

Secondary Insurance

Insurance _____

ID# / Claim# _____

Phone (_____) _____-_____

Group # _____

Case Worker_____

Caseworker Phone (_____) _____-_____

Employer_____

Insurance Subscriber

Name_____

Date of Birth _____

Gender_____

Relationship to Patient_____

Third Insurance

Insurance_____

ID# / Claim# _____

Phone (_____) _____-_____

Case Worker_____

Caseworker Phone (_____) _____-_____

Employer_____

*Have you previously have physical therapy? _____ If yes what for? _____ And where and when? _____

** If you want someone besides yourself to be able to access your medical information and/ or billing please talk to the receptionist.

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, 2017

Southern Tier Physical Therapy Associates

240 Riverside Drive, Johnson City, NY 13790
(607) 217-4341
Fax (607) 217-5749

200 Front Street, Vestal, NY 13850
(607) 754-1776
Fax (607) 748-5465

17 Charles Street, Binghamton, NY 13905
(607) 771-8181
Fax (607) 772-2899

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KUMARI RIEGLE, PT

I hereby agree and give consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand I am responsible to inform this practice of any changes that occur in my medical coverage. I authorize release of payment directly to this practice, regardless of participation in or out of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred. Also, by signing below, I acknowledge that I have read the "Notice of Privacy Practices". I understand that I may ask Questions about the "Notice of Privacy Practices" at any time.

Patient, Parent or Guardian Signature: _____ Date: _____

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, New York 13850.

Sign: _____ Date: _____

If your insurance denies payment for any reason (i.e. hit Medicare cap, Insurance Authorization is denied etc.) and you continue to come to physical therapy you will be held responsible for payment.

Sign: _____ Date: _____