Atlantic Rehabiliation - Patient Information Sheet

GENERAL INFORMATION:

First Name:____________________________ MI:_____ Last Name:___________________________

DOB: ______________________ Age: _____ Gender: Male: ____ Female: ____

Address:____ Apt. #______________

City:__________________________________ State:____________ Zip:_____________

Home #: ______________________________ Work: ______________________________

Cell #: ________________________________

SS# ___________________________________ Driver's License#:_________________________________

Marital Status: Married: ___ Single: ___ Divorced: ___ Widowed: ___

Emergency Contact:_____________________________ Emergency Phone#:____________________

DATE OF INJURY/ONSET:____________________ (MM/DD/YYYY) Ins. Co. needs specific date

Was this work related or due to an injury: Work: ___ Auto: ___ Other: ____

How did this injury occur? ____

How were you referred to us? Physician Case Mgr. Yellow Pgs. Ins. Co Friend Other___________

EMPLOYER INFORMATION:

Employer Name:______________________________ Occupation/Job Title:_____________________

Employer Address:____

City:__________________________________ State:____________ Zip:_____________

INSURED/GUARANTOR/RESPONSIBLE PARTY:

Relationship to Insured: Self Spouse Child Other

First Name:____________________________ MI:_____ Last Name:___________________________

Address:____ Apt. #______________

City:__________________________________ State:____________ Zip:_____________

Sex: M F Birth Date:_____________ Age:_________ SS#:______________________

Home#:_______________________ Cell#:______________________ Work#:____________________

WORKERS' COMPENSATION / AUTO ACCIDENT INFORMATION:

Case Manager:_______________________________ Phone#:______________________________

Company Name:______________________________ Fax#:_________________________________

Address:______________________ City:______________________ State:_____ Zip:_________

Attorney Name:______________________ Phone#:__________________________________

Address:______________________ City:______________________ State:_____ Zip:_________

ADMISSION CONSENT / ATTENDANCE POLICY / INSURANCE / SCRIPTS

CONSENT TO TREATMENT: I consent to rehabilitation and incidental medical services at Atlantic Rehabilitation, Inc.

LIABILITY: I know and agree that Atlantic Rehabilitation, Inc. is not responsible for loss or damage to personal valuables.

ATTENDANCE POLICY: You have been referred to physical therapy due to a physical problem or disability. The maximal benefits of therapy can only be achieved if you are serious about your rehabilitation and follow the instruction you are give.

Attendance at therapy is mandatory unless severe circumstances (illness, etc.) prevent you from making your appointment. In the event that you must cancel, please call our office 24 hours in advance and we will reschedule the appointment. If you do not show for a scheduled appointment it is your responsibility to reschedule the appointment at your next visit or by telephone. **If you miss more than 3 consecutive appointments, you will be charged a fee for missed appointments.**

INSURANCE: As a courtesy we verify your insurance: However, it is prudent to verify yourself because we have been provided with incorrect information before. We will do our best to notify you when benefits have been exhausted and/pr your script has expired but ultimately it is your responsibility to keep track.

SCRIPTS: It is your responsibility to notify us of your next doctor appointment and please do so a couple days before so we can provide the doctor with updated notes. As a courtesy we keep track of scripts expiration dates but it is your responsibility to obtain a new on once expired.

I HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT SIGNATURE: ______________________________ DATE: ______________

PARENT/LEGAL GUARDIAN: ______________________________ DATE: ______________
(if the patient is a minor, or legally incapacitated please obtain the signature of a parent or legal guardian.)

CLINIC REPRESENTATIVE: ______________________________ DATE: ______________

Health History

All Information is Strictly Confidential.

Please check any symptoms or conditions that you have or have had in the past.

- ☐ Dizziness/Fainting
- ☐ Headache
- ☐ Migraine Headaches
- ☐ Unexplained weight loss
- ☐ Epilepsy/Seizures
- ☐ Stroke
- ☐ Mini-Stroke/TIA
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular/Rapid Heart Beat
- ☐ Arthritis Type?_______________
- ☐ Asthma
- ☐ Cancer _______________________
- ☐ HIV Positive/AIDS
- ☐ Diabetes
- ☐ Emphysema
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Vision loss
- ☐ Hearing loss

Please describe any serious illness or operations you have had

____

Medications/Allergies

Please list all medications you are currently taking____

____

List allergies to medications or substances_________________________

____

Health Habits

What is your occupation?_____________________

Does your work expose you to:

- ☐ Stress
- ☐ Heavy lifting
- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Prolonged walking
- ☐ Computer work

List your hobbies or interests_______________

____

List any activities that you are unable to participate in due to this injury or problem_______________

____

Are you receiving home health services?_______

Have you had physical therapy services this Year? _____________

Signatures

To the best of my knowledge, the above information is complete and correct. I will inform my physical therapist or my doctor if I ever have a change in health.

______________________________________ ____________________

Signature of Patient, Parent or Guardian Date

ATLANTIC REHABILITATION, INC.
INITIAL PATIENT QUESTIONNAIRE

PRESENTING MEDICAL PROBLEM

Mechanism of Onset (When and how did this injury occur)

____

____

____

Pain Rating (Rate your pain on a scale of 0-10. 0= No Pain 10+ Max pain and you need to go the emergency room)

__ / 10 With Medication __ / 10 Without Medication

Pain Descriptions (please put a "X" on the following lines that explain your pain.)

Frequency	Time of Day	Activity	Description	Relief of Pain
__ Constant	__ Morning	__ At Rest	__ Dull	__ Medication
__ Intermittent	__ Afternoon	__ During Activity	__ Shooting	__ Heat
	__ Night	__ After Activity	__ Ache	__ Cold/Ice
		__ At Work	__ Throbbing	__ Rest
		__ After Work	__ Numbness	__ Activity
		__ Standing	__ Tingling	__ ________
		__ Sitting	__ Burning	
		__ Walking	__ Stabbing	
		__ Bending	__ Radiating	
		__ Kneeling	__ ________	
		__ ________		

Sleep Disturbances (Please check the flowing that apply)

__ Difficulty Falling asleep
__ Difficulty Finding Comfortable Position
__ Awakened by Pain

Work Status (Below describe if you are working, what type of work you do, and how your injury is affecting you at work)

____

____

____

Atlantic Rehabilitation, Inc.
5026-B North Federal Highway, Lighthouse Point, FL 33064
954-426-8884 Fax:954-426-8885

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay health care bills, to support the operation of the physical therapy practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for physical therapy services may require that your relevant protected health information be disclosed to the health plan to obtain approval for the services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical / therapy school students that interact with patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physical therapist or physician is ready to provide care to you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Disease: Health: Abuse or Neglect food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroner, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that you physical therapist or the physical therapy practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, you may not inspect or copy the flowing records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, civil criminal, or administrative action or proceeding, and protected health information that is subject to law that is subject to law that prohibits access to protected health information.

Your physical therapist is not required to agree to a restriction that you may request. If a physical therapist believes it is in your best interest to permit use and disclosure of you protected health information, your protected health information will not be restricted. You then have a right to select another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physical therapist amend your protected health information. If we deny your request for amendment, you may have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for fining a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individual with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 1-866-636-2905.

Signature below is only acknowledgement that you received this Notice of our Privacy Practices:

____________________________ ____________________

Patient Name Date

____________________________ ____________________

Signature of Responsible Party Relationship