NEW LIFE PHYSICAL THERAPY AND REHABILITATION, PC

PATIENT INFORMATION: (PLEASE PRINT CLEARLY)

Date:___________________________________ Clinic (location): ___________________________

Name: ____

Address: ____Apt#:_________________

City: ____State:________________Zip:________

Home Phone: ___________________________ Work Phone: ________________________________

Birthday: ________________________________ Social Security #:____________________________

Marital Status: M_______ S_______ W _______ Sex: Male_________ Female__________

How did you hear about New Life Physical Therapy and Rehabilitation?

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Have you been treated at New Life before? ____

EMPLOYMENT INFORMATION:

Employer / School: ____________________________________Occupation:____________________

Address: ____

City: _________________________________State: __________________________ Zip: ____________

ADDITIONAL INFORMATION:

Referring Physician:____

Address: ____

City: _________________________________State: __________________________ Zip: ____________

Date of Injury: ____

Is this an approved Workers Comp Injury?   Yes_____No _____

Is this an Auto Accident?   Yes_____No _____   Is this a Lawsuit?   Yes_____No _____

If you would like us to send copies of correspondence to your primary care physician, please complete the following section:

Name: ____Phone:__________________________

Address: ____

City: ____State:_______________Zip:________

INSURANCE INFORMATION:

Primary Insurance Company: ____

Name of Policy Holder: ______________________________Relationship:__________________

SSN: ____Date of Birth: _________________

Ins. Co. Phone: ___________________________ID #:_______________Group #:____________

Secondary Insurance Company: ____

Name of Policy Holder: ______________________________Relationship:__________________

SSN: ____Date of Birth: _________________

Ins. Co. Phone: ___________________________ID #:_______________Group #:____________

WORKMAN'S COMPENSATION:

Employers Name: ________________________________Phone:_________________________

Occupation: ____

Address: ________________________City:____________________State:________Zip:_______

Claims Adjustor Name: ________________________Phone:________________Claim#:_______

Claims adjustor Insurance Company Name: ____

Rehab Nurse Name: ______________________________Phone:_________________________

Nurse Case Management Co Name: _______________________________Phone:____________

NEW LIFE PHYSICAL THERAPY FINANCIAL POLICY:

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we will verify your insurance coverage and benefits, as well as file therapy claims for you, however we do not accept the responsibility for settling the claim with your carrier. (**Verification is only a quote**)
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require 24-HOUR NOTICE for any cancellation. A fee will be charged to your account for failure to comply.

TREATMENT AUTHORIZATION:

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization is required by a parent/legal guardian for all minors.

____ _______________

Patient Signature Date

____ _______________

Parent or Guardian Signature Date

HIPAA AUTHORIZATION:

In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

Name: ____ Relationship: _________________

Name: ____ Relationship: _________________

Name: ____ Relationship: _________________

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OUTPATIENT SCREENING FORM

Please answer the following questions to the best of your ability.

Patient Name: ____

Age: _________________ Height: __________________ Weight: _____________

What problem(s) are you being treated for today? _____________________________________

Have you received treatment for these symptoms before? Yes ___________ No _________

If yes, what type of treatment? ____

Have you received physical therapy within the last year? Yes ___________ No ____________

If yes, was it for your current problem? Yes ___________ No ____________

Approximately how many treatment sessions have you received this year? ________________

Are you currently working? Yes_________ No __________

What is your occupation? ____

Does your occupation consist of: Sitting ______ Standing ______Walking______Lifting _______

Are you currently taking any medications: Yes________ No _________

If yes, please list medication(s) ____

Do you have any drug allergies? Yes_________ No __________

Please list: ____

Have you had any surgeries or significant past medical history? Yes_________ No __________

If yes, please list:

____

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What kind of testing have you received for this problem? (Circle)

X-ray MRI CT Scan Bone Scan other

Please explain the results:

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Please place a **CHECK** next to any conditions that you have experienced in the **PAST**. **CIRCLE** any conditions that you have **CURRENTLY**.

Bone or joint disease	Thyroid problems	Lymphedema
Kidney problems	Sleep disorders	Chest pain
Numbness/tingling	Hypoglycemia	Blood clots
Breathing difficulties/asthma	High blood pressure	Low blood pressure
Pacemaker	Metal Implants	Are you pregnant?
Tendonitis/bursitis	Broken/fractured bones	Arthritis
Spasms/cramps	Low back, hip, leg pain	Sprains/strains
Jaw pain/TMJ	Neck, shoulder, arm pain	Diabetes
Headaches/head injuries	Seizures	Cancer/tumors
Heart condition	Athlete’s foot	Fatigue
Allergies/skin allergies		

If you checked/circled any of the above, please explain:

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During the past month, have you been bothered by feeling down, depressed, or hopeless?

Yes ____________ No _____________

During the past month, have you been bothered by having little interest or pleasure in doing things? Yes ____________ No _____________

Do you exercise regularly? Yes ____________ No _____________

If yes, what is your primary activity?

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____

____

Person to contact in case of emergency:

Name: ____________________________________ Phone: _____________________________

Relationship: ____

Patient Signature: ____ Date: __________

Signature of Parent/Guardian: _____________________________________Date:___________

NEW LIFE PHYSICAL THERAPY AND REHABILITATION, PC

NOTICE OF PRIVACY PRACTICES

In compliance with a newly enacted Federal Law, the **Health Insurance Portability and Accountability Act (HIPAA),** New Life Physical Therapy is informing you of your privacy rights. Please review the information below.

What is HIPAA? HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). *PHI is confidential information about a patient, including demographic information.*

What are my rights under HIPAA? Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

- You have a ***right to inspect and obtain a copy of your PHI.*** We will respond to your request within 30 days. In most cases your request will be honored and a copy of your PHI will be mailed to you.
- You have a ***right to request an amendment of PHI.*** If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.
- You have the ***right to know what disclosure(s) of your PHI have been made***. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/correctional facilities, or disclosures made prior to April 14, 2003.
- You have a ***right to request confidential communications of PHI***. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.
- You have a ***right to request restrictions on the use and disclosure of PHI.*** However we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.
- You have a ***right to receive a hard copy of this notice***. This notice can also be accessed on our website *www.nlptr.com*.

How will New Life Physical Therapy Use and Disclose PHI under HIPAA? HIPAA allows us to use and disclose your PHI for the purposes of ***Treatment, Payment and Healthcare Operations***. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of ***Treatment, Payment and Healthcare Operations***. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

• ***Disclosure to those Involved in the Individual's Care* –** when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.

• ***Uses and Disclosures Required by Law*** – as required by law we are required to use and disclose PHI for the following reasons:

Notice of Privacy Practice Continued:

•<u>Use and Disclose PHI for Public Health Activities</u> – Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
•<u>Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence</u>- Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse.
•<u>Uses and Disclosure of Health Oversight Activities</u> – we may use and release PHI to be used for audits, investigations, licensure issues, etc.
•<u>Disclosure for Judicial and Administrative Proceedings</u> – we may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.
•<u>Disclosure for Law Enforcement Purposes</u> – we may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
•<u>Uses and Disclosures Related to Decedents</u> – we may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
•<u>Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations</u> – we may use and release PHI in order to facilitate organ, eye or tissue donations.
•<u>Uses and Disclosures to Avert a Serious Threat to Health or Safety</u> – we may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
•<u>Uses and Disclosures for Specialized Government Functions</u> – we may use and release PHI for military/veterans activities and national security/intelligence activities.
•<u>Use and Disclosure of PHI in Emergency Situations</u> - in the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.
• **<u>Uses and Disclosures of PHI for Marketing Purposes</u>** – New Life Physical Therapy will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
•**<u>Uses and Disclosures of PHI for Research Purposes</u>** – we do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
•**<u>Uses and Disclosures requiring the Patients Authorization</u>** - we must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

What does HIPAA require of New Life Physical Therapy? New Life Physical Therapy must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

Receipt of Notice of Privacy Practices Form

Effective April 14, 2003, I, ____, hereby acknowledge receipt of New Life
Print Name
Physical Therapy's Notice of Privacy Practices. New Life Physical Therapy will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand New Life Physical Therapy has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any revised notice will be provided to me or made available at my next office visit.

I give my consent for New Life Physical Therapy to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to New Life Physical Therapy

Signed: ____Date: _____________________

If you are not the patient, please specify your relationship to the patient __________________________

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KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. Please be aware to give 24 hours notice if you are unable to attend your appointment or it will result in a cancellation charge.

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks. The patient and therapist have discussed the importance of frequency and duration.

THANK YOU FOR YOUR COOPERATION.

Patient Signature ____Date________________

Therapist Signature ____Date________________