PATIENT INFORMATION

First Name: ______________________ Last Name: _______________________ Middle Initial: __________

Address: _______________________________________ Apt#: _____________

City: _________________ State: ________ ZIP_______

Birth date: _____/_____/_______ Age: ___________ Female Male S.S. #. _________________

Height: ________ Weight: __________ Right Handed: _____ Left Handed: _____

Home Phone: (_____)_________-______________ Alternative Phone: (_____)_________-_____________

How did you hear about us?

Doctor Friend Family Website Insurance Former Patient

PATIENT QUESTIONNAIRE

Primary Care Doctor: ___________________________ Referring Doctor: ____________________________

Date of Injury: ___________________________ Date of Surgery (if applicable): _______________________

SOCIAL HISTORY

Do you smoke? Yes No If yes, how much per day? ______________________

Do you drink alcohol? Yes No If yes, how much per day? ______________________

Marital Status: Single Married Divorced Separated Widowed

If female, are you pregnant? Yes No

WORK INFORMATION

Employer: ____ Work Phone: (______)______-________

Occupation: ___________________________________

Are you currently working? Yes No

Employment Status: Full Time Part Time Retired Not Employed Disabled

Signature: _______________________________ Date: _____________________

EMERGENCY CONTACT

Name: ________________________________ Phone: (_____)_________-______________

Relationship to Patient: Spouse Child Friend Other (please list relationship) _______________

INSURANCE INFORMATION

Primary Insurance Name: ______________________________

Subscriber's Name: ______________________________ Birth Date: _____/_____/_______

ID. #: __________________________________ Group/Policy #_____________________

Patient's Relationship to Subscriber: Self Spouse Child Other

Name of Secondary Insurance if applicable: ______________________________

Subscriber's Name: ______________________________ Birth Date: _____/_____/_______

ID. #: __________________________________ Group/Policy #_____________________

Patient's Relationship to Subscriber: Self Spouse Child Other

DOCTOR INFORMATION

Referring Doctor Name: __________________

Referring Doctor Ph #: (_____)_______-_________

ATTORNEY INFORMATION

Name: ________________________ Law Firm: ______________________________ Phone:(____)_____-______

Address: __________________________________ City: __________________ State: ________ ZIP_______

Case Manager: _______________________________

WORKER'S COMP INFORMATION

Company: __________________________________ Claim #: _______________________

Adjuster: ______________________________ Phone: (_____)______-________

Signature: _________________________________ Date: ______________________

PHYSICAL THERAPY

PAIN AND SYMPTOM STATUS REPORT / PAST MEDICAL HISTORY

Chief Compliant (what hurts): ____

How were you injured?

Car Accident   Slip and Fall   Lifting   Work Related   Post-Operative   Unknown

If other, please specify: ____

Have you been treated for this injury before?   Yes   No

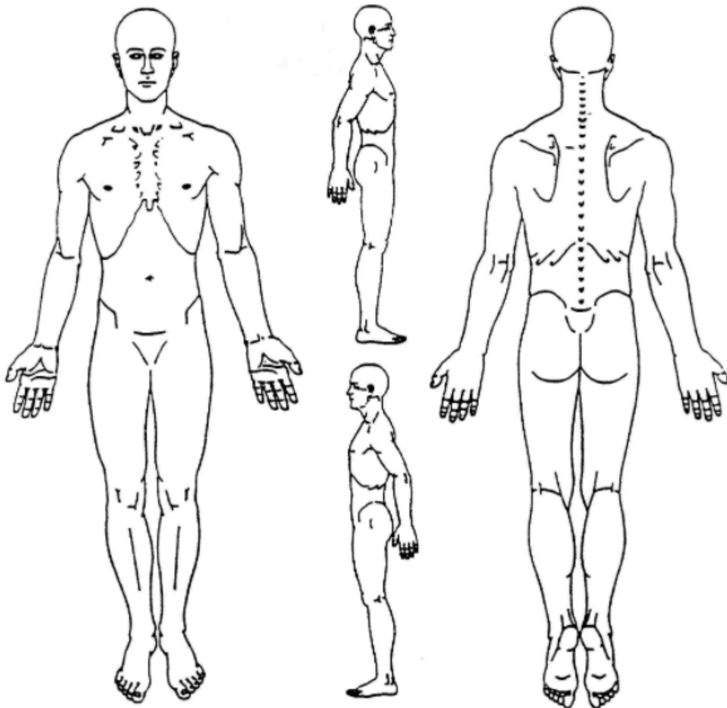
If yes, where have you been treated? _________________________   Are you still being treated? Yes No

FOR MEDICARE PATIENTS: Are you currently receiving home health?   Yes   No

Current Medications: ____

Please check of the following that apply to you:

______Alcoholism	______ Allergies	______ Asthma	______Arthritis
______ Diabetes	______ Hepatitis	______ Heart Trouble	______ Hypertension
______ Thyroid	______ Mental Disease	______ STD	



Please indicate how you would rate your pain?

(LOW) 1 2 3 4 5 6 7 8 9 10 (HIGH)

What sensation or pain are you currently feeling?

____ Ache
____ Burning
____ Radiating Pain
____ Dull Pain
____ Numbness
____ Stabbing
____ Pins and Needles
____ Other

Please use the diagram to the left and shade areas of pain

FINANCIAL POLICY

We are committed to providing you with the best care possible. In order to achieve this, we need your assistance and understanding of our financial policy. If you have medical insurance, we are happy to help you with your claims. We will verify your insurance benefits/coverage before your initial visit. However, this is not a guarantee of payment from your insurance.

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. Please initial the following:

_______ 1. I authorize the release of my medical records to my referring physician and to my insurance company if applicable.

_______ 2. I authorize and request that insurance payments be made directly to MML Physical Therapy, should they elect to receive such payments. However, you will be responsible for your deductible, co-pays, or percentage not covered by your insurance.

_______ 3. This office understands special needs. It may be necessary to set up a payment plan for a patient. If this situation is necessary for you, please ask to speak with our office manager.

_______ 4. I understand that I am financially responsible for services rendered my MML Physical Therapy, unless my treatment pertains to an accepted worker's compensation claim.

_______ 5. I agree to pay 40% of the additional cost incurred by collections and responsible attorney fees in the event that default of payment occurs, unless charges pertain to an accepted worker's compensation claim.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE FINANCIAL POLICY OF THIS OFFICE.

Signature: ________________________________ Date: ______________________

NOTICE OF PRIVACY PRACTICES (HIPPA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.
This notice of privacy practiced describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, which is information about you, including demographic information that may identify you and relates to your past or present physical or mental health or condition and related healthcare services.

USES AND DISCLOSURES OF PROTECTED OF PROTECTED HEALTH INFORMATION Your protected health information may be used and disclosed by your therapist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the therapist's practice, and any other use required by law.

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

PAYMENT Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, your protected health information may be disclosed to the health plan in order to obtain approval for continued treatment.

HEALTHCARE OPERATIONS We may use or disclose your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your name. We may also call you by name in the waiting room when your therapist is ready to see 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: public health issues, communicable diseases, health oversight, abuse or neglect, legal proceedings, law enforcement, coroners, funeral directors, organ donation research, criminal activity, military activity, workers' compensation, required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

YOU HAVE THE RIGHT TO INSPECT AND REQUEST A COPY YOUR HEALTH INFORMATION Under federal law, however, you may not inspect or copy the following records, information compiled in reasonable anticipation of, or in use in, a civil, criminal, or administrative action or proceeding and health information that is subject to law that prohibits access to protected health information.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If the therapist believes it is in your best interest to permit use and disclosure of your protected health information.

YOU HAVE THE RIGHT TO HAVE YOUR THERAPIST AMEND YOUR PROTECTED HEALTH INFORMATION If we deny your request for amendment, you 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.

COMPLAINTS You may complain to us or to the Secretary of Health and Services if you believe your privacy rights have been violated by us.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE READ AND RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES.

Name: ______________________ Signature: ______________________ Date: ______________

MEDICAL RECORDS RELEASE AUTHORIZATION

Name: ____ Date: ______________

_________ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information This information may be released to:

- [____] Spouse: Name_________________________________
- [____] Child (ren): Name/s______________________________
- [____] Other: _______________________________________
- [____] My information is not to be released to anyone

<u>This Release of Information will remain in effect until terminated by me in writing.</u>

Please call My Home (_____)_________-_________ My Cell (_____)_________-_________

If unable to reach me:

- [____] You may leave a detailed message
- [____] Leave a message asking me to return your call
- [____] _____________________________________

The best time of day to reach me is (day)_______________________ between (time) _________________

Signature: ______________________________ Date: ____________________