Physical Therapy Services of Morristown, LLC

Patient Information Form (PLEASE PRINT CLEARLY)

Patient Information

Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Employer	Employer Address			Work Phone
Email Address				Cell Phone

Other Information

Referring Doctor (Name, Location)			
Family Doctor (Name, Location)			
Emergency Contact	Relationship to patient	Home Phone	Work Phone

Primary Health Insurance

Primary Carrier Name	Mailing Address			
ID No.	Group No.		Employer	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Secondary Health Insurance

Secondary Carrier Name	Mailing Address			
ID No.	Group No.		Employer	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Tertiary Health Insurance

Tertiary Carrier Name	Mailing Address			
ID No.	Group No.		Employer	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Workman's Compensation

Carrier Name	Mailing Address	
Claim No.	Date of Accident	Adjuster's Name / Phone No.

Automobile Accident

Carrier Name	Mailing Address	
Claim No.	Date of Accident	Adjuster's Name / Phone No.

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Physical Therapy Services of Morristown, LLC

1. Consent for Care

I, the undersigned, do consent to physical therapy treatment administered by Physical Therapy Services of Morristown, LLC (PTSM).

2. Privacy Practices

We encourage you to read our Notice of Privacy Practices carefully and completely before signing this authorization. The Notice provides a description of our treatment, payment, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

My signature below indicates I have received, read, and understand the Notice of Privacy Practices. I understand that PTSM has the right to change its Notice of Privacy Practices and that I may contact the office at any time to obtain a current copy of the Notice. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

We reserve the right to change the privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

3. Electronic Mail Consent

By providing PTSM with my email address I have agreed to receive information of a non-sensitive nature, including, but not limited to: paperwork, schedules, and/or surveys about patient satisfaction. I understand that I have the option to unsubscribe from the list at any time by notifying PTSM.

4. Appointment Policy

I understand that twenty-four (24) hours notice is required to cancel an appointment. There will be a $25.00 charge for canceling the day of the appointment and a $40.00 charge for any no-shows. I understand that if I am fifteen (15) minutes late for my visit, I may not be seen.

5. Financial Agreement

I hereby assign my insurance benefits to be paid directly to PTSM. I authorize the filing of insurance and the release of information necessary to the completion of said claims. I understand that I am ultimately responsible for all charges incurred while undergoing care at PTSM, and that processing of insurance claims is a service and does not relieve me of my financial obligation. I understand that I am solely responsible for knowing all conditions, benefits, and limitations of my policy with my insurer. I understand that, should it become necessary to appeal claim decisions to my insurer, I am to pay the balance due on my account until the appeal is complete. I agree PTSM may impose reasonable interest, late charges, costs and/or attorney's fees should my account become delinquent.

I, the undersigned, do agree to all aforementioned terms. I understand that my signature on this document holds me financially responsible for all charges for the patient.

____ ________________________

Signature of Patient or Guardian Date

(Please fill out the information below. If self, check self and leave the rest blank)

Guarantor /Guardian Name ☐ SELF	Sex	Relation to Patient	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Employer	Employer Address			Work Phone

Physical Therapy Services of Morristown, LLC

Name:________________________________ **Age**:________ **Acct. #**:___________

In order for us to provide a thorough evaluation, please answer the following questions regarding your medical history. Place a check the box to the left of the item. Your therapist will assist you if you have any difficulty.

Please check any of the following conditions you may have or had:

	Anemia		Epilepsy or Seizure		Multiple Sclerosis
	Arthritis / Osteoporosis		Fractures		Neurological Condition
	Asthma		Heart Condition		Prostate problems
	Cancer		Hepatitis		Rheumatoid Arthritis
	Chemical Dependency		High Blood Pressure		Skin Conditions
	Circulation Problems		High Cholesterol		Stroke
	Complicated Pregnancy		Kidney Disease		Thyroid Condition
	Diabetes		Low Blood Sugar		Tuberculosis
	Emphysema / Bronchitis		Lymes Disease		Ulcers/Stomach Problems
	Endometriosis		Mental Illness / Depression		Visual Impairments

Other/Comments:

Has anyone in your immediate family ever been diagnosed with any of the following?

	Arthritis / Osteoporosis		Heart Condition		Mental Illness
	Cancer		High Blood Pressure		Stroke
	Chemical Dependency		High Cholesterol		
	Diabetes		Kidney Disease		

Other/Comments:

Within the past year, have you had any of the following tests?

	Angiogram		CT Scan		MRI
	Biopsy		Doppler Ultrasound		Stress Test
	Blood Test		Echocardiogram		Urine Test
	Bone Scan		Mammogram		X Rays

Other/Comments:

Have you recently noted?

	Fatigue		Numbness / Tingling		Weight Gain
	Fever, Chills, Sweats		Weakness		Weight Loss

Other/Comments:

Please check any of the following healthcare providers who are currently providing you care, or have provided you care in the past six (6) months:

	Acupuncturist		Homeopath		Physical Therapist
	Chiropractor		Massage Therapist		Psychiatrist / Psychologist
	Dentist		Medical Doctor		

Other/Comments:

Physical Therapy Services of Morristown, LLC

Name:________________________________ **Age**:________ **Acct. #**:___________

List and describe any surgeries or hospitalizations that you have had:

List any injuries that you have had which required medical attention:

List all prescription and non-prescription medications you are currently taking:

Are you, or do you think that you may be pregnant? YES NO
Do you have any religious beliefs that might affect your care? YES NO
If you were to lose consciousness under our care,
would you object to lifesaving measures being performed
to resuscitate you? (I.e. CPR) YES NO
Are you allergic or sensitive to latex? YES NO
Are you allergic to shellfish or iodine? YES NO

Other Allergies:

Do you smoke cigarettes now? YES NO
Quantify:___________(packs p/day) How long have you been smoking?___________________

Have you smoked in the past? YES NO
When did you quit?______________ How long had you been smoking?____________________

Do you drink alcohol? YES NO
Quantify:___________(drinks p/day)

Do you drink caffeine? YES NO
Quantify:___________(drinks p/day)

Have you recently been feeling depressed, down or helpless? YES NO
Have you recently had little interest or pleasure in doing things? YES NO
Do you feel unsafe at home or is someone trying to injure you? YES NO

____ ________________
Signature of Patient or Guarantor Date

____ ________________
Signature of Therapist Date

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.

I. Our Privacy Obligations.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

II. About This Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care 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. "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. Copies of this Notice of Privacy Practices can be obtained on our website at http://www.morristownpt.com, by calling the office and requesting that a copy be sent to you in the mail or at the time of your next appointment.

III. Use and Disclosures With Your Consent.

We may use or disclose your Protected Health Information only when your written authorization is obtained on a form that complies with the Health Insurance Portability and Accountability Act of 1996; or when there is an exception as described in Section IV. You may revoke your authorization at any time by delivering a written statement to the Privacy Officer.

IV. Use and Disclosures Without Your Consent

The following are examples of the types of uses and disclosures of your protected health information that our office is permitted to make without your consent. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. In addition, we may disclose your protected health information to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your therapist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your therapist.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, 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, and conducting or arranging for other business activities.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our office to request that these materials not be sent to you.

We may also use or disclose your protected health information in the following situations without your consent or authorization.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Public Health: We may disclose your protected health information for the following public health activities:(1) for the purpose of controlling disease, injury or disability; (2) if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority; (3) if authorized by law, for controlling exposure to a communicable disease; (4) to a public health authority that is authorized by law to receive reports of child abuse or neglect; (5) to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner as authorized by law. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Military Activity and National Security: We may use or disclose protected health information of individuals who are Armed

Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your protected health information if your therapist or another therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and our office determines that such disclosure is necessary.

V. Your Rights.

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to Inspect Protected Health Information: You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your therapist and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Official if you have questions about access to your medical record.

Right to Request Restriction of Protected Health Information: You have the right to request a restriction of your protected health information. This means 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 as described in this Notice. 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 request. If the therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist. Your request for

a restriction must be made in writing to the Privacy Official.

Right to Request Alternative Methods of Contact: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Official.

Amendment of Protected Health Information: You may have the right to have your therapist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Official if you have questions about amending your medical record.

Right to Accounting of Disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after January 1, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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 electronically.

VI. Complaints.

You may complain to us or to 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 Official of your complaint. We will not retaliate against you for filing a complaint.

Privacy Official:

David A. Patiño
101 Madison Ave, Suite 205
Morristown NJ 07960
(973) 292-1101
dpatino@morristownpt.com

This notice was published and becomes effective on January 1, 2003.

(Revised May 29, 2003)