PATIENT HEALTH HISTORY

Name_____ Age _____ Date of Birth _____
FIRST NAME MIDDLE INITIAL LAST NAME

Referring Physician _____ Date of Last Appt _____ Date of Next Appt _____

Family or Other Physician _____ Date of Last Appt _____ Date of Next Appt _____

Date of onset of current condition _____ Have you had surgery for this condition? ___ Y ___ N When? _____

Have you received PHYSICAL or OCCUPATIONAL THERAPY in the past? ___ Y ___ N When? _____

_____

Please list medications: _____

_____

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
High Blood Pressure	☐	☐	AIDS or HIV Infection	☐	☐	Rheumatoid Arthritis	☐	☐
Heart Attack	☐	☐	Hepatitis A B C	☐	☐	Joint Replacement	☐	☐
Low Blood Pressure	☐	☐	Heart Disease	☐	☐	Stomach Disorder/Ulcer	☐	☐
Rheumatic Fever	☐	☐	Cardiac Pacemaker	☐	☐	Thyroid Problem	☐	☐
Swollen Ankles	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Fractures	☐	☐	Chest Pain	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Liver Disease	☐	☐
Epilepsy/Seizures	☐	☐	Osteoporosis	☐	☐	Diabetes	☐	☐
Fibromyalgia	☐	☐	Emphysema	☐	☐	High Cholesterol	☐	☐
Incontinence	☐	☐	Cancer / Leukemia	☐	☐	Other - specify: _____		
Kidney Diseases	☐	☐	Osteoarthritis	☐	☐	_____		

WOMEN: Are you pregnant or think you may be pregnant? ___Yes ___No Are you postmenopausal? ___ Yes ___ No

Please list any surgeries and the approximate dates these occurred.

_____

_____

Are you allergic to or have you had any reactions to the following?

	Y	**N**		**Y**	**N**
Local Anesthetics (e.g. Novocaine)	☐	☐	Bee Stings	☐	☐
Iodine	☐	☐	Medications	☐	☐
Latex Rubber	☐	☐	Please specify: _____		

Date _____

PATIENT INFORMATION (CONFIDENTIAL)

Soc Sec #_____

Name_____ Phone_____ Email_____
FIRST NAME MIDDLE INITIAL LAST NAME

Address_____ City_____ State_____ Zip_____

Circle Gender: Male Female Circle Marital Status: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Person To Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____ SS# _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. **Co-Pay in full at each visit**.

___ CASH ___ Personal Check Credit Card: ___ VISA ___MasterCard ___I wish to discuss the office payment policy.

INSURANCE INFORMATION *(We request your insurance card(s) to make a copy for your file.)*

Name of Insured _____ Relationship to Patient _____

Birthdate _____Social Security # _____ Date Employed _____

Name of Employer _____ Policy# _____ Work Phone _____

Address of Employer _____ City_____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___ YES ___ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____Policy# _____Work Phone _____

Address of Employer _____ City_____ State _____ Zip _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Clinton Physical Therapy Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Clinton Physical Therapy Center insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have been provided with the **Insurance and Financial Policy** and agree to the terms as stated.

_____ _____

Signature of patient (or parent if minor) Date

CLINTON PHYSICAL THERAPY CENTER

PATIENT INFORMATION CONSENT FORM

Federal Regulations prohibit healthcare providers from giving any kind of information to any person other than you, the patient, without your prior permission. This includes not giving information to your spouse, parent, other household members, relatives, etc. even when they call or come in to Clinton Physical Therapy Center on your behalf or at your request unless you have given us permission to talk to them.

Please tell us how we may contact you and to whom we may disclose your health information.

Home Phone # _____ Work Phone# _____

Cell Phone # _____ Alternative Phone # _____

_____ I do not want information release to anyone other than myself, including my spouse.

_____ No restrictions – speak with whom ever necessary on my behalf.

_____ Leave message on home answering machine.

_____ You may speak with anyone who answers my Home Phone.

_____ You may speak with _____my spouse, _____my parents, _____persons I listed below.
_____, _____, _____
about my medical condition(s) and treatment.

I have read and fully understand Clinton Physical Therapy Center's Notice of Information Practices. I understand that Clinton Physical Therapy Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Clinton Physical Therapy Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Clinton Physical Therapy Center's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Print Patient Name or Legal Representative

_____
Signature

_____
Date

CLINTON PHYSICAL THERAPY CENTER

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

CLINTON PHYSICAL THERAPY CENTER'S LEGAL DUTY

Clinton Physical Therapy Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Clinton Physical Therapy Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Clinton Physical Therapy Center may use your personal health information for the following purposes:

- **We will use your health information for treatment**
  For example: Information obtained will be recorded in your records and use to determine the course of treatment that should work best for you. We will also provide your referring physician or appropriate health care provider with copies of reports/summaries that should assist him or her in assessing your plan of care.

- **We will use your health information for payment**
  For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

- **We will use your health information for regular health operations**
  For example: Members of our organization may use information in your health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

OTHER FORMS OF DISCLOSURES

- **Business Associates**: There are some services provided in our organization that utilize outside agencies. These include medical supply companies and other forms of business associates that provide us a service. To protect your health information we require each of our business associates to sign a contract with our organization stating they will safeguard your information.

- **Notification**: We may use or disclose information to notify or assist in notifying a family member, personal representatives or another person responsible for your care, location and general condition.

- **Communication with Family**: We may disclose to a family member, other relative, close personal friend, coach or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

- **Marketing**: We may contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

- **Federal and State Agencies**: As required by law we may disclose health information to public health or legal authorities charged with preventing or controlling diseases, injury or disability.

- **Law Enforcement**: As required by law we may disclose health information for law enforcement purposes as required by law or in response to valid subpoena.

In any other situation, Clinton Physical Therapy Center's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Clinton Physical Therapy Center may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and/or patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Clinton Physical Therapy Center will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Clinton Physical Therapy Center may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Clinton Physical Therapy Center's health information practices or if you have a complaint, please contact the following person:

Clinton Physical Therapy Center
Joyce S. Klee, PT, Privacy Officer
1921 N. Charles Seivers Blvd P.O. Box 916 Clinton, TN 37717-0916
Telephone: (865) 457-1649 Fax: (865) 463-7825

Revised: 03/01/11