Patient Registration Form Omega Physical Therapy

Name _____
First MI Last

Address _____
Street or PO Box

_____
City State

Is this your permanent address? If not, include your permanent address: _____

_____

Primary Phone _____

Secondary Phone _____

Emergency Contact: _____

Phone # _____

Are you a student? Yes / No If yes, full time / part time

SSN _____-____-_____ **DOB** ____/____/_____

Circle Correct Answers below:

Gender: Male Female
Race: American Indian Hispanic Arabic Other
Ethnicity: Caucasian Hispanic Other
Language Spoken: English Spanish _____

Single Married Widowed Divorced

Primary Care Physician: _____
Telephone # _____

Referring Physician: _____
Telephone # _____

Employer Info: _____
Work Phone _____

Primary Insurance

Name of Insurance: _____

ID# _____ **Group#**_____

Cardholder: _____

Cardholder DOB: _____/_____/_____

Cardholder SSN: _____-_____-_____

Relationship to patient: _____

Cardholder address if different from above:

_____

_____

Secondary Insurance

Name of Insurance: _____

ID#_____**Group#**_____

Cardholder: _____

Cardholder DOB: _____/_____/_____

Cardholder SSN: _____-_____-_____

Relationship to patient: _____

Cardholder address if different from above:

_____

_____

Responsible Party: _____
DOB:_____ **SSN** _____-_____-_____
Address: (if different than above)

_____

_____
Phone #: _____

Is this visit related to an Auto or Work Incident?___
If yes, please provide the following information:
Send Claims to: _____

_____

_____

Adjuster:_____
Phone:_____Fax _____
Email _____

Date of Loss/Injury: _____
Claim Number:_____

Is your Insurance coverage purchased by Marketplace Exchange/Affordable Care Act? _____

If purchased through an exchange, please indicate the state which you purchased coverage? _____

PLEASE NOTE: If your exchange plan is OUTSIDE the state of Michigan, your services will *NOT* be covered in our office.

Statements for patient responsibility/co insurance are sent monthly (every 30 days). **Effective June 1, 2015, there will be a Billing Fee of $5.00 on unpaid balances greater than 60 days.**

No Show charge of $25.00 per missed appointment

Omega Physical Therapy

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: _____ **Date of birth**: _____

Date of next visit with the referring doctor: _____

Allergies: List any medication (s) you are allergic to: _____

List any other allergies we should know about: _____

Circle Yes or No

Have you or any immediate family member ever been told you have:

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid Arthritis?	Yes	No	Yes	No
Circulation Problems?	Yes	No	Yes	No
Thyroid problems?	Yes	No	Yes	No
Multiple Sclerosis?	Yes	No	Yes	No
Blood Clots?	Yes	No	Yes	No

Other: _____

Do you or have you in the past smoked tobacco?

If yes, ____ packs/ day ____ years

Last tobacco use: ____

Do you drink alcoholic beverages?

If yes, how many drinks do you routinely have per week?

/ Week

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

Prescribed medications:

_____

Over the counter medications:

___Aspirin	___ Advil/ Aleve? Ibuprofen
___Tylenol	___ Laxatives
Decongestants	___ Vitamins/ Minerals
Antacids	Antihistamines

Other _____

Circle Yes or No

In the past 3 months have you had or do you experience:

Nausea/ Vomiting?	Yes	No
Fever/ Chills/ Sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or Tingling?	Yes	No
Change of appetite?	Yes	No
Difficulty Swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper Respiratory Infection?	Yes	No
Urinary Tract Infection?	Yes	No
Changes in Balance (falls)?	Yes	No
Fatigue/ Weakness?	Yes	No
Double Vision/ Loss of Vision?	Yes	No
Arm/ Leg Swelling?	Yes	No
Blood in Stool/ Urine?	Yes	No
Recent falls?	Yes	No
Difficulty Speaking?	Yes	No

Circle Yes or No

Do you have a history of:

Allergies/ Asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney Disease?	Yes	No
Rheumatic Fever?	Yes	No
Ulcers?	Yes	No
Seizures/ Tremors?	Yes	No
Hepatitis?	Yes	No
Tuberculosis?	Yes	No

Surgeries: (Date and Reason) _____

_____

_____

_____

Leisure Activities: _____

_____

_____

_____

Patient's Goals: _____

_____

_____

_____

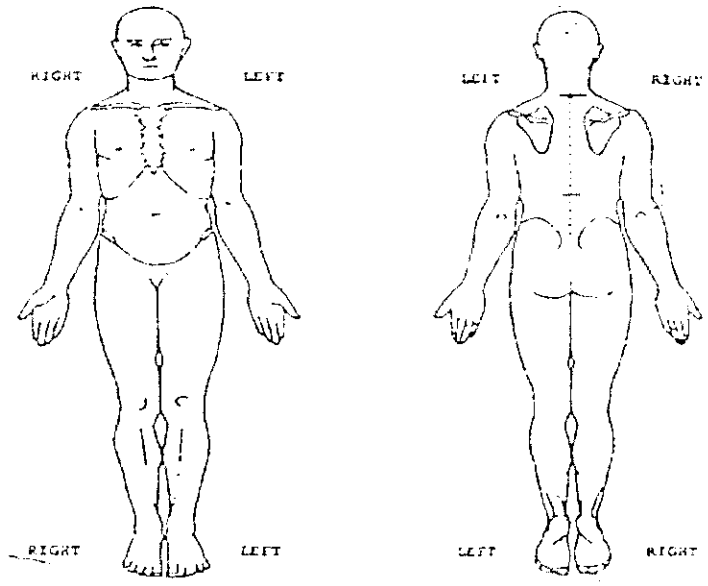
_____

Omega Physical Therapy
Pain Diagram and Pain Rating

Name:_____ _____ Date:_____ __ Date of Birth:_____

Please use the diagram below to indicate the symptoms you have experienced in the last 24 hours. Use the Key to indicate the type of symptoms.

Key: Pain: XXXXXXXXX Pins and Needles:0000000000



Please rate your **current level of pain** on the following scale: (circle one) 0- no pain, 10- worst imaginable pain

0 1 2 3 4 5 6 7 8 9 10

Please rate your **worst level of pain** this episode: (circle one) 0- no pain, 10 worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Please rate your **best level of pain** this episode: (circle one) 0- no pain, 10- worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Are your symptoms:

Getting Worse _ The Same _ Improving

How are you able to sleep at night:

Fine _ Moderate Difficulty Only with Medication

My symptoms **are worst** in the:

Morning _ Afternoon _ Evening Night ___ No Difference

My symptoms **are best** in the:

___ Morning Afternoon __ Evening ___ Night No Difference

Patient Signature __ ____ ___ Date __

Omega Physical Therapy
(Revised July 17, 2013)

Notice of Privacy Policy

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.

OUR OBLIGATIONS:

We are required by law to:
Maintain the privacy of protected health information
Give you this notice of our legal duties and privacy practices regarding health information about you
Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally

required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Medical Records. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Attn: Medical Records.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Attn: Financial

Coordinator.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Attn: Medical Records. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Attn: Medical Records. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request one with our front desk reception or ask to speak to someone in Medical Records.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Office Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Patient Signature _____ Date _____

THE FAMILY PRACTICE AND ORTHOPEDIC CARE CENTER, PC

RELEASE FOR CONSENT OF SHARED MEDICAL INFORMATION

Patient Name_____ DOB_____

If other than patient, name of person authorizing release _____
(Legally authorized representative)

Relationship to patient of person providing authorization _____

I hereby give permission for The Family Practice & Orthopedic Care Center, PC and its employees to provide medical information pertaining to the above named patient as requested by:

_____
(Please list all person(s) you wish to have access to the patient's medical information)

To further clarify, the above named person(s) may receive the medical information either by phone, fax, or in person. I understand this medical information may contain diagnoses, prognoses, treatment, and/or education related to drug and/or alcohol abuse; communicable and/or sexually transmitted diseases, including acquired immunodeficiency syndrome (AIDS) and results of tests for human immunodeficiency virus (HIV) or HTLV-III antibody, antigen, or nonantigenic products; psychiatric and other mental health services, diagnoses, prognoses, and/or treatment whether rendered prior to this authorization or hereafter; and genetic information and test results.

Exceptions to this disclosure:_____

_____
(Please list Information you wish NOT to be disclosed)

****

_____Date_____
(Signature of patient or legally authorized representative)

_____Date_____
(Relationship of legally authorized representative to patient)

_____Date_____
(Staff member/Practice representative)

This authorization shall remain valid from the signed date until such time as written revocation from the patient or patient representative is received in this office.