Northern Rhode Island Physical Therapy

One Garnett Lane nGreenville, Rhode Island 02828 n Phone 401-949-0380 n Fax 401-949-5581

652 George Washington Highway n Lincoln, Rhode Island 02828 n Phone 401-333-3211n Fax 401-333-5581

Patient Information Sheet

Patient Last Name	First Name	MI

Home Address	CITY / STATE / ZIP
Home Telephone Number	**Other Contact Number(s)**
Occupation	**Employer**
Work Address	**Work Phone Number**
Social Security Number	**Date of Birth** / **Gender**
Referring Physician	**Diagnosis**

Latex Allergy: YES NO	***EMERGENCY CONTACT INFORMATION***
Pace Maker: YES NO	EMERGENCY CONTACT:
Artifical Defibrilator: YES NO	PHONE NUMBER(S):
Do you currently live alone?: YES NO	RELATIONSHIP:

Insurance Coverage *(Please Circle One)*

Major Medical **Medicare** **Self-Pay** **No-Fault**

NOTE: Some insurance coverage may require a pre-authorization, referral or additional paperwork n Northern RI Physical Therapy is required to retain copies of your current insurance card and your driver's license/ID *or* parent/legal guardian driver's license/ID

Is this injury accident-related? (auto, WC, other injury) ***Please circle one***	**Yes No**	**Motor-Vehicle Other:** **Worker's Comp**

Accident Contact Information:

Claim Number: _____

Contact Name/Title: _____

Contact Number: _____

FINANCIAL AGREEMENT: In consideration of the services rendered by Northern RI Physical Therapy at my request and direction, I understand I am responsible for, and agree to pay in full, to the order of Northern RI Physical Therapy, all charges incurred for services rendered. I further understand that in the even that special arrangements have been made to have payment made through my insurance company (ie, for a worker's compensation or no-fault claim) and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full. I further agree to pay lawfula and reasonable interest charges after thirty (30) days from date of billing on any unpaid balance. In the event that this agreement is placed in the hands of an attorney for collection or enforcement of any of the therms in this agreement, I agree to pay an attorney's fee equal to thirty-three and one-third percent (33 1/3%) of the outstanding balance due.

SIGNATURE DATE SIGNATURE OF PARENT OR GUARDIAN DATE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: Northern RI Physical Therapy is Authorized to provide to my referring physician, insurance company or their representatives, my attorney and/or _____ (other) all information they may have regarding my condition while under their treatment or observation, including, but n ot liminted to, history obtained, medical thermograms, physical findings, diagnosis, and prognosis

SIGNATURE DATE WITNESS DATE

SIGNATURE OF PARENT OR GUARDIAN DATE SIGNATURE OF WITNESS DATE

HOW DID YOU HEAR ABOUT NORTHERN RI PHYSICAL THERAPY

Previous Patient_____ Family Member:_____ Employee:_____ OTHER:_____

School:_____ Newspaper:_____ Referral from Dr._____

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
❑ YES ❑ NO ❑ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
❑ YES ❑ NO ❑ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:
❑ YES ❑ NO ❑ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
❑ YES ❑ NO ❑ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

- ❑ chest pain, angina
- ❑ heart attack
- ❑ stroke
- ❑ shortness of breath
- ❑ rheumatic fever
- ❑ mitral valve prolapse
- ❑ heart murmur
- ❑ pacemaker
- ❑ lung disease
- ❑ tuberculosis
- ❑ cancer
- ❑ steroid therapy
- ❑ diabetes
- ❑ stomach ulcers
- ❑ arthritis
- ❑ seizures (epilepsy)
- ❑ kidney disease
- ❑ thyroid disease
- ❑ drug/alcohol dependency
- ❑ osteoporosis medications (e.g. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
❑ YES ❑ NO ❑ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ❑ YES ❑ NO ❑ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

NORTHERN RHODE ISLAND PHYSICAL THERAPY

APPOINTMENT REMINDERS and HEALTH CARE INFORMATION AUTHORIZATION

Your Physical Therapist and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or cellular phone. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time. However, your revocation must be in writing and mailed to us at our office address(es). We will not be able to honor your revocation request if we already have your health information before we receive your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the remainder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement of your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternative, or other health related information at any time (§ 164.524). This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I acknowledge that I have received a copy of this authorization:

_____	_____
Date	Patient Name (*Printed*)
_____	_____
Authorized Provider Representative	Patient Signature
_____	_____
Authorized Representative (*Printed*)	Patient Representative Signature

NORTHERN RHODE ISLAND PHYSICAL THERAPY

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION 8.2007
~OUR PRIVACY PLEDGE~

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services
- We may need to use your health information within our practice for quality control or other operational purposes

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices

YOUR RIGHTS TO LIMITED USE OF DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies and organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is biding on us.

YOUR RIGHTS TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time. However, your revocation must be in writing. We will not be able to honor revocation requests if we have already released your health information before we receive your request to revoke your authorization. If you were requested to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that I have received a copy of this notice.

Date	Patient Name (*printed*)
Authorized Provider Representative	Patient Signature

NORTHERN RI PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMAITON

I, the undersigned, have been given a copy of the notice of privacy practices for protected health information for NORTHERN RHODE ISLAND PHYSICAL THERAPY.

Date: _____

Patient Signature: _____