PATIENT HEALTH HISTORY

BASIC INFORMATION

Name _____ Referring Provider _____

Primary Care Physician _____ Date of Injury/Onset of Symptoms _____

Date of Last Physician's Visit _____ Date of Next Physician's Visit _____

Employer _____ Occupation _____

INJURY/CONDITION DETAILS

Please describe injury or event _____

_____ Work related? YES or NO

Type and date of surgery (if applicable) _____

Medications _____

Have you had tests for this injury/condition? Circle all that apply: X-RAY / CT SCAN / MRI / OTHER

What is your current pain level when at rest (1-10 scale; 0 = no pain, 10 = extreme pain)? _____

HEALTH HISTORY

Are you currently experiencing or do you have a history of the following?

CANCER	YES or NO	HIGH BLOOD PRESSURE	YES or NO
PACEMAKER	YES or NO	JOINT REPLACEMENT	YES or NO
HEART DISEASE	YES or NO	PREGNANT (Answer "yes" only if you currently are or could be pregnant.)	YES or NO
OSTEOPOROSIS	YES or NO		

Do you have any other medical history that may prohibit you from exercise or physical therapy?

_____

_____

What are your goals for physical therapy?

_____

_____

_____ _____

Patient's Signature Date

PRIVACY NOTICE

Welcome! We are pleased that you and/or your physician have chosen Stockwell Physical Therapy to provide you with your rehabilitation services. Please read the following information carefully regarding your privacy of medical information. 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. 164.520 (b)(i)(i) Stockwell Physical Therapy is required by law to protect the privacy of its patients regarding all health information.

Your protected health information may be released to your insurance provider and physician for the purpose of receiving payment for services rendered. Additionally, information regarding your appointment time, presence at our facility, or other general details of your scheduled appointments may be provided over the phone to callers who request so by you providing their name. Otherwise, your protected health information may be released only after receiving written authorization from you, with the exception of those situations listed above or for treatment, payment, or healthcare operations. You may revoke your permission to release protected health information at any time, except if Stockwell Physical Therapy has taken action in reliance of your authorization or consent to use or disclose the protected health information. The revocation must be in writing with effective date and be specific to the health information being protected. Stockwell Physical Therapy is not required to agree to your request.

You have the right to restrict the use of your protected health information. Stockwell Physical Therapy may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation. Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, crime or domestic violence, unless as otherwise required by law. Your protected health information may be released to other healthcare providers in the event you need emergency care.

You have the right to review and photocopy any/all portions of your health information. Stockwell Physical Therapy has the right to assess a fee for the photocopying of the health information. You will be contacted by Stockwell Physical Therapy by mail, email, or phone to remind you of appointments and verify insurance/demographic information. A message may be left on an answering machine or automated answering device. You have the right to request a more confidential way of providing your protected health information or communication method at the time you are seen at Stockwell Physical Therapy.

You have the right to possess a copy of this Statement of Privacy upon request. This copy can be in the form of an electronic transmission or paper. You have the right to complain to Stockwell Physical Therapy if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to Stockwell Physical Therapy, Attn: Patient Information Privacy Officer, 54 Park Ave Plaza (PO Box 819), Contoocook, NH 03229-0819, or to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights (1-800-368-1019) JFK Building – Room 1875, Boston, MA 02203 (617-565-1340). All complaints will be investigated. No personal issue will be raised for filing a complaint. Stockwell Physical Therapy will abide by the terms of this notice.

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

I consent to evaluation and treatment by Stockwell Physical Therapy, LLC, and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of protected health and other medical information in the course of my treatment, including, but not limited to, medical records, electronic media, and oral communications, to my insurance company, employer, primary care physician, referring physician, and/or other third-party payor. I understand that if my account becomes delinquent, my billing records may be forwarded along to collections and/or relatives in order to obtain payment.

I understand phone messages regarding my appointments or care may be left on a machine at any phone numbers I have provided. I have read and understand my rights and responsibilities as a patient. If you are under the age of 18, a parent or guardian must sign below to authorize consent for evaluation and treatment.

Note: We ask that you give us 24 hours advance notice if you need to cancel or reschedule your visit, as another patient may be able to take that appointment.

_____ _____

Patient's Signature Date

_____ _____ _____

Signature of Responsible Party Relationship to Patient Date