PATIENT INFORMATION

Today's Date _____

Last Name _____ First Name _____ MI _____

Home Address _____Town _____State _____ Zip_____

Mailing Address (if different from above) _____

Birthday _____ E-mail Address _____

Work/Cell Phone _____ Alternate Phone_____

Prescribing Physician _____ Dr.'s Phone Number _____

Primary Care Physician _____Dr.'s Phone Number _____

Diagnosis _____ Date of Follow-up appt with Prescribing Dr. _____

Is your injury related to work or a car accident? YES or NO

Date of injury_____ Date of surgery _____

Occupation _____ Employer _____

Insurance Carrier _____ I.D. # _____

Subscribers Name _____ DOB _____

Are you presently working or has your job been modified? _____

Have you had treatment for this injury/diagnosis before? _____If yes, how long ago? _____

Are you currently taking medication for this particular injury? _____ If yes, please list

_____

Please Indicate all of the following conditions that apply to you, either presently or in the past:

_____High Blood Pressure	_____Gout	_____Currently Pregnant
_____Cancer	_____Stroke	_____Epilepsy/Seizure
_____Emotional/Psychological	_____Pacemaker	_____Respiratory Condition
_____Heart Condition	_____Diabetes	_____Arthritis

_____Other _____

IN CASE OF EMERGENY PLEASE NOTIFY:

Name _____ Relationship_____ Phone#_____

Current Functional Status

Instructions

Please read carefully and fill this form out as accurately as possible. Your insurance company uses this list to determine your need for physical therapy and how much your injury affects your functional ability.

Patient Name _____ Date _____

What is your current daily pain level on average 0-10?
(0 = no pain at all, 10 = so intense, it is incapacitating) _____

Please rate your ability to perform these daily activities

	Completely Unable	Severe pain	Moderate pain	Mild discomfort	Fully able	Not Applicable
Personal Care	0	1	2	3	4	N/A
Household Mobility	0	1	2	3	4	N/A
Community Mobility	0	1	2	3	4	N/A
Sitting Tolerance (30 mins)	0	1	2	3	4	N/A
Stair Climbing (2 flights)	0	1	2	3	4	N/A
Standing Tolerance (30 mins)	0	1	2	3	4	N/A
Household Chores	0	1	2	3	4	N/A
Lift Objects 1-10 lb	0	1	2	3	4	N/A
Lift Objects 10-20 lb	0	1	2	3	4	N/A
Work Tolerance	0	1	2	3	4	N/A
	0	1	2	3	4	N/A
Sports/Recreation	0	1	2	3	4	N/A
Walking (30 min)	0	1	2	3	4	N/A
Running	0	1	2	3	4	N/A
Driving (60 mins)	0	1	2	3	4	N/A
Getting in and out of car	0	1	2	3	4	N/A
Ability to sleep (6 hours)	0	1	2	3	4	N/A
Rolling over in bed	0	1	2	3	4	N/A
Getting in and out of bed	0	1	2	3	4	N/A
Squatting	0	1	2	3	4	N/A
Kneeling	0	1	2	3	4	N/A
Putting on shoes and socks	0	1	2	3	4	N/A
Reaching overhead	0	1	2	3	4	N/A
Getting up from a chair	0	1	2	3	4	N/A
	0	1	2	3	4	N/A

Signature _____ Name _____

Signature of the Person Submitting this Form

Name of the Person Submitting this Form (print)

Orthopedic Rehab Associates Authorization

I hereby authorize Orthopedic Rehab Associates to release information to my insurance carrier and my physician including PA, NP and office staff concerning my diagnosis and treatment.

I hereby authorize the payment of medical benefits to Orthopedic Rehab associates for services provided to me, or others for whose medical benefit I am responsible.

I understand that I am financially responsible for charges not covered by my insurance carrier and agree to pay all the required deductible and co-insurance payments required by the policies of my insurance coverage. I further agree to pay these bills, 30 days after notification by Orthopedic Rehab Associates.

I understand that it is my responsibility to understand the terms of my insurance coverage. I further understand that if my insurance requires a referral from my primary care physician, that it is my responsibility to obtain that. If my insurance coverage requires prior authorization, as well as approvals for a limited number of visits, it is my responsibility to keep track of the number of visits and the time frame given to complete those visits.

I understand that if my insurance is to deny my claim, that I will be responsible for payment.

I understand that if I underwent physical therapy at another provider, that it is my responsibility to disclose that information for billing purposes.

I agree that if my injury is related to an auto accident or workers compensation, that I will disclose the information to Orthopedic Rehab Associates and complete all appropriate paperwork with the carrier before commencing treatment.

I understand that co-payments and out of pocket payments are due at the time services are rendered. I furthermore understand that if my insurance company has a deductible or co-insurance that I am required to have a valid credit card on file.

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

I agree to pay a $20 NO SHOW/CANCELLATION fee if I do not show up for my appointment or call 24 hours prior to cancel my scheduled visit.

Signature_____
Date_____
Print Name_____

Orthopedic Rehab Associates P.C.

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Pembroke, MA 02359
781-829-9966
www.orthopedicrehabassociates.com

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

6/16/21

This Notice of Privacy Practices applies to the following organizations.

Orthopedic Rehab Associates P.C.

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Pembroke, MA 02359

289 Saint George Street Unit 101
Duxbury, MA 02332

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