SENNOGROUP
WELLNESS & REHABILITATION

WELCOME

We value our relationship and thank you for choosing our services.

The information you provide is very important for your medical, rehabilitation, therapeutic needs and treatments. Do your best to provide facts that are accurate, truthful and up to date.

Please take time to carefully read, understand and fill out all these forms. We recognize that some of the information is repetitive, but it is needed on each document. Each form will become part of your medical record.

Every time you visit us you will be asked to update your information. Essential facts such as medications, allergies, insurance, contact information and hospitalizations change. It is very important to let us know of such changes so we can better serve you.

If you have any questions, please let us know as we are more than happy to answer them. We always strive to improve our services and your suggestions are appreciated.

Thank you.

Welcome Letter
Form HIPPA # 1
Number of Pages: 1
Created: 12/20/2008
Revised: 4/13/2010, 1/10/2020

SENNOGROUP
WELLNESS & REHABILITATION

PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

Primary Care Doctor & Phone #: Today's Date:

Patient's Last Name | First | Middle | How would you like to be addressed?

Is this your legal name? ☐ Yes ☐ No | If not, please provide your legal name | Former Name | Birth Date / / | Age | Gender:

Patients Street Address | City | State | Zip Code

Patients Social Security Number - - | Patients Occupation | Employer | Employer Address

Home Phone Number ( ) - | Cell Phone Number ( ) - | Home Fax Number ( ) - | Employer Phone Number ( ) -

Patients e-mail

Choose SENNOGROUP • Wellness & Rehabilitation because or referred by *(please check one box)*

☐ Family ☐ Friend ☐ Close to Home/Work ☐ Yellow Pages ☐ Doctor/Hospital ☐ Insurance Plan ☐ On-Line ☐ Other

INSURANCE INFORMATION

Person Responsible for Bill | Birth Date / / | Home Address | Phone Number ( ) -

Cell Phone Number ( ) - | Fax Number ( ) - | E-mail

Occupation | Employer

Employer Address | Employer Phone

Is Patient Covered By Insurance? ☐ Yes ☐ No Please Indicate Primary Insurance Company:

Insurance Company Address | City | State | Zip Code | Phone Number

Subscriber's Name | Subscriber's Soc. Sec. # - - | Birth Date / / | Group # | Policy # | Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Partner ☐ Friend ☐ Significant Other ☐ Other

Name of Secondary Insurance | Subscribers Name | Group # | Policy #

The above information is true and accurate. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize SENNOGROUP • Wellness & Rehabilitation or the insurance company to release any information required to process my claims.

DATE *(above)* **PATIENT/GUARDIAN SIGNATURE *(above)***

Patient Registration
Number of Pages: 1
Created 12/20/2008
Revised: 4/13/2010,1/10/2020

SENNOGROUP
WELLNESS & REHABILITATION

PATIENT
EMERGENCY CONTACT INFORMATION

Patient's Last Name: _____First: _____ Middle Initial: _____

Patient's Date of Birth: _____ Social Security Number: _____

Patient's Home Phone Number: _____ Cell Number: _____

Patients Address: _____

Patient's Food Allergies & Reactions: _____

Patient's Drug Allergies & Reactions: _____

Patient's Primary Care Doctor & Phone Number: _____

IN CASE OF EMERGENCY PLEASE CONTACT THE FOLLOWING PEOPLE
(Please list 3 contacts)

	Name of Contact	Relationship	Home #	Mobile #	Work #
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

I UNDERSTAND THAT IN CASE OF EMERGENCY,
911 WILL BE CALLED AND I WILL BE
TAKEN TO THE NEAREST HOSPITAL EMERGENCY DEPARTMENT.
FEES & CHARGES FOR SUCH AN EMERGENCY WILL BE MY RESPONSIBILITY.

Patient Printed Name _____

Patient Signature _____

Legal Representative Name & Relationship _____

Signature of Patient Representative _____

Today's Date _____

Emergency Contact Information
Number of Pages: 1
Created:12/20/2008
Revised: 4/13/2010, 1/10/2020

SENNOGROUP
WELLNESS & REHABILITATION

PATIENT INFORMATION *(Page 1 of 3)*

During each visit please update your medical information

PATIENT NAME: _____ **TODAY's DATE:** _____
Last First Middle

Date of Birth: _____ Age: _____ Social Security #: _____

Referring Doctor: _____ Date of Last Visit: _____

CURRENT ISSUES

For what problem are you seeing the doctor today? _____

How long have you had this problem? _____

What makes it better? _____

What makes it worse? _____

What medications have you taken for this problem? _____

Is this related to an injury or fall? (*If yes, please explain)* _____

What treatments or therapies did you have for this problem and when?

Physical or Occupational Therapy	□ No	□ Yes	Date _____	Results _____
Injections	□ No	□ Yes	Date _____	Results _____
Surgery	□ No	□ Yes	Date _____	Results _____

Other *(please explain)* _____

What tests did you have done for this problem and when?

Blood Test	□ No	□ Yes	Date _____	Results _____
X-rays	□ No	□ Yes	Date _____	Results _____
MRI	□ No	□ Yes	Date _____	Results _____
CAT Scan	□ No	□ Yes	Date _____	Results _____
EMG	□ No	□ Yes	Date _____	Results _____

Other *(please explain)* _____

Is this related to worker's compensation? □ No □ Yes **Do you have a lawyer?** □ No □ Yes

PAIN DIAGRAM

Please circle the number to show the amount of pain you are in now:

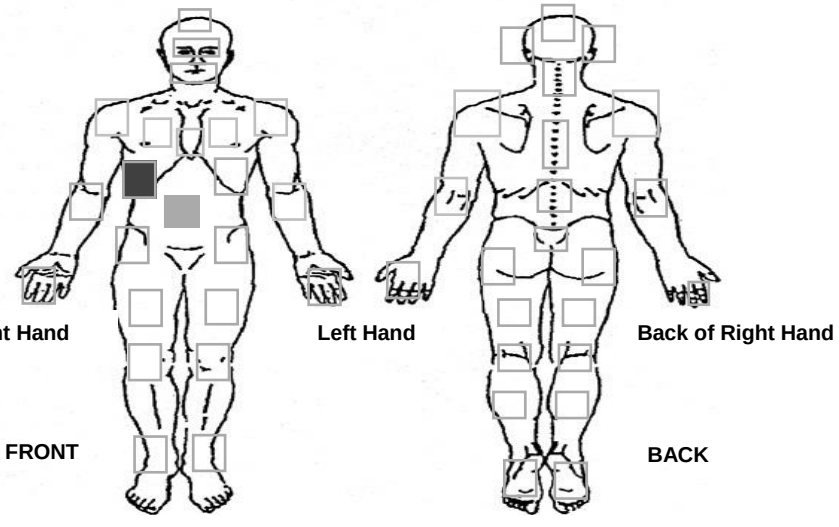
0 □ **1** □ **2** □ **3** □ **4** □ **5** □ **6** □ **7** □ **8** □ **9** □ **10** □

No Pain ***Worst Pain Ever***

Describe your pain: □ Ache □ Burning □ Stabbing □ Pins & Needles □ Numbness □ Throbbing □ Sharp □ Spasm □ Shooting

Aching ΔΔΔΔ Numbness ===== Pins & Needles OOOOO Burning XXX Stabbing ///// Other .....

Mark the area of your body where you feel the pain



Front of Right Hand **Left Hand** **Back of Right Hand**

FRONT **BACK**

Patient Information
Number of Pages: 1 of 3
Created 12/20/2008
Revised: 4/13/2010,1/10/2020

PATIENT INFORMATION, Cont. *(Page 2 of 3)*

PATIENT NAME: _____ **TODAY'S DATE:** _____

PAST MEDICAL HISTORY: *Please list **all** medical problems such as diabetes, arthritis, ulcers, high blood pressure, asthma, emphysema, stroke, heart attacks, M.S., accidents, HIV, sexually transmitted infections, etc. & date when first occurred. For women please list pregnancies.*

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

PAST SURGICAL HISTORY: *Please list **all** prior surgeries such as appendix, gallbladder, baclofen pump, heart surgery, etc. that you had & date.*

1._____ 4._____
2._____ 5._____
3._____ 6._____

IMPLANTABLE DEVICES: *Please list **all** devices such as joints, baclofen pump, insulin pump, pacemaker, deep brain stimulator that are in you.*

1._____ 3._____
2._____ 4._____

MEDICATIONS:
(Dose & Frequency, Include vitamins, Over- the- counter, herbals & alternatives)

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

DRUG & FOOD ALLERGIES:
(List reactions)

1._____ 3._____
2._____ 4._____

RECENT HOSPITALIZATIONS: _____

FAMILY HISTORY: *please circle appropriate status, list medical problems & surgeries that your family members had.*

Father: Alive / Deceased / age & issues: _____
Mother: Alive / Deceased / age & issues: _____
Children: Alive / Deceased / age & issues: _____
Other family members: _____

SOCIAL HISTORY:

Marital Status: M / S / D / W / Other **Smoking:** No / Yes Packs Per Day:_____, # of years_____
Education Level: _____ **Alcohol:** No / Yes Drinks Per Day:_____, # of years_____
Occupation: _____ **Drug Use:** No / Yes Type:_____, Last Use _____
Currently Working: No / Yes **Last Day of Work:** _____
Housing: 1 level / multilevel / # of steps to enter _____

FUNCTIONAL HISTORY: *please circle appropriate equipment that you use or have.*

Equipment: wheelchair / walker / cane / quad cane / electric wheelchair / scooter / splints
Recent Therapies: _____
Falls *(when & where):* _____
How much help do you require for bathing, dressing, eating? 0% 25% 50% 75% 100%
Other physical limitations: _____
Current diet & consistency: _____

PATIENT INFORMATION, Cont. *(Page 3 of 3)*

PATIENT NAME: _____ **DATE:** _____

REVIEW OF SYSTEMS: *please mark all that apply & explain.*

Headache	□ No	□ Yes	_____
Dizziness	□ No	□ Yes	_____
Lightheadedness	□ No	□ Yes	_____
Vision issues	□ No	□ Yes	_____
Hearing problems	□ No	□ Yes	_____
Difficulty swallowing	□ No	□ Yes	_____
Neck problems	□ No	□ Yes	_____
Back pain	□ No	□ Yes	_____
Difficulty breathing	□ No	□ Yes	_____
Shortness of breath	□ No	□ Yes	_____
Chest pain	□ No	□ Yes	_____
Nausea or vomiting	□ No	□ Yes	_____
Heartburn	□ No	□ Yes	_____
Diarrhea	□ No	□ Yes	_____
Constipation	□ No	□ Yes	_____
Problems with urination	□ No	□ Yes	_____
Joint pain	□ No	□ Yes	_____
Osteoporosis *(brittle bones)*	□ No	□ Yes	_____
Numbness or tingling	□ No	□ Yes	_____
Memory issues	□ No	□ Yes	_____
Sleep issues	□ No	□ Yes	_____
Depression	□ No	□ Yes	_____
Anxiety	□ No	□ Yes	_____
Fever or Chills	□ No	□ Yes	_____
Weight loss	□ No	□ Yes	_____
Weight gain	□ No	□ Yes	_____
Falls	□ No	□ Yes	_____
Balance issues	□ No	□ Yes	_____
Seizures	□ No	□ Yes	_____
Skin issues	□ No	□ Yes	_____
Immunizations	□ No	□ Yes	_____

Have you been abused or neglected? □ No □ Yes _____
Are you participating in research or clinical trials? □ No □ Yes _____
Do you have a sexually transmitted infection? □ No □ Yes _____
Other: _____

Are you currently pregnant □ No □ Yes
Date of last menstrual cycle: _____
Date & result of last mammogram & pelvic exam: _____

Date & result of last prostate exam: _____

Would you prefer an extra staff member be present during your history & examination? □ No □ Yes

I certify that the above is correct and true:

_____ _____
Patient Signature **Date**

All of the above, including present (current) issues, past, family, social, functional, medication history & review of systems were reviewed, pertinent areas were discussed with the patient.

_____ _____
Physician Signature **Date**

SENNOGROUP
WELLNESS & REHABILITATION

PAYMENT POLICY

We strive to deliver the best in standard of care for our patients and understand you have choices. We therefore deeply appreciate your trust in our services.

PAYMENT POLICY.

At SENNOGROUP ● Wellness & Rehabilitation we see patients with or without insurance coverage.
For patients without insurance coverage or covered by managed care plans with which we have no contract, we anticipate payment prior to service.
For patients with insurance, as a courtesy our billing agency will file a claim with your primary and secondary insurance plans. During your visit we will ask to take copy of your state ID and insurance cards. **However, you are ultimately responsible for your medical bill, co-pay, co-insurance and for change of insurance notification.**

CO-PAY IS DUE AT THE TIME OF EACH VISIT.

We accept cash and checks. We **do not** accept credit cards.

BALANCE STATEMENTS.

When there is an outstanding balance, as a reminder, we will mail you a payment of balance statement every month and remind you of payments due when we call to confirm your follow-up appointment. Payments due must be paid within **two months** (60 days) from the date of initial statement. If it becomes necessary to place your account with a **collection agency**, all costs related to this process will be your responsibility.

We understand that there can be a situation where payment of balance may have to be delayed or be paid in installments. In such a situation, we will be happy to work with you on a payment plan.

PUBLIC AID / MEDICAID POLICY.

Our office **does not** accept Public aid, Medicaid or Medicaid Plans. If these are your insurance plans, payment (in advance) for the visits will be your responsibility. If your insurance plan changes to Public Aid or Medicaid during your treatment or care - you are responsible for notifying our office and you will be responsible for payments (in advance) of ongoing visits.

WORKER'S COMPENSATION POLICY.

We expect written documentation from your employer/claim adjustor verifying the worker's compensation status and information regarding the injury coverage. Without this documentation, payment (in advance) for the visit will be your responsibility.

VISITS / PROCEDURES NOT COVERED BY YOU INSURANCE.

You will be responsible for payment.

Our billing professionals are available to assist you in negotiating with your insurance plan for timely payments. **However, any balance remaining on your account for more than 60 days will be considered your responsibility and will be billed to you. After an additional 60 days of non-payment your account will be considered delinquent and sent to a collection agency.**

We thank you in advance for your kind understanding.

I acknowledge that all my questions have been answered. I have read, understood and agree with all of the above.

Patient Signature or Authorized Representative **Printed Name** **Date**

SENNOGROUP
WELLNESS & REHABILITATION

CANCELLATION, PRE-APPROVAL, CO-PAY, INSUFFICIENT FUND & INSURANCE COVERAGE WAIVER POLICY

We take every opportunity to make your visit as pleasant and timely as possible and give all possible considerations to the schedule and needs of our patients. As a courtesy, approximately one business day prior to your visit our office will send you reminder.

During our scheduling we prepare and set aside time to specifically address your medical and therapeutic needs. It is our practice not to "double book" patients. Therefore, we ask that you, make every attempt to keep your appointment and be on time.

If you can not make it to your scheduled appointment, for the benefit of all our patients, we ask that you let us know one business day prior to your visit. **$80.00 will be charged directly to you if you miss your appointment without notifying our office or are more than one hour late.** Being late to your appointment might result in having to be re-scheduled.

If you missed your appointment, we will make attempts (home phone, cell, letter or e-mail) to reschedule.

We would like to remind you that **your Co-Pay is due at the time of service.** We accept cash and personal checks, if your personal check has insufficient funds ("bounces") $**40.00** will be charged directly to you.

Most insurance companies including Medicare have pre-approvals and pre-authorizations for procedures, imaging and medications. At Sennogroup we strive to provide the most appropriate patient care and treatments. **You will be charged a $20.00 administration fee for each pre-approval, pre-authorization or form completion** that our office has to perform.

I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time. I wish to receive medical services from Dr. Ricardo Senno. If it is determined that I am not eligible for coverage**, I fully understand that I am and will be responsible for the full and timely payments of all services provided.** I addition, I am also responsible for all deductibles, co-pays and co-insurances.

I have read and understand the above.

_____	_____	_____
Patient or Representative Signature	**Printed Name**	**Date**

Cancellation Policy
Form HIPPA # 3
Number of Pages: 1
Created: 12/20/2008
Revised: 4/13/2010, 1/10/2020

SENNOGROUP
WELLNESS & REHABILITATION

NOTICE OF PRIVACY PRACTICES FOR PROTECTED MEDICAL INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

TO BE GIVEN TO PATIENT, FOR PATIENT TO TAKE & KEEP

Federal law requires SENNOGROUP ● Wellness & Rehabilitation to maintain the privacy of the individual's identifiable health information and to provide you with notice of its legal duties and privacy practices with respect to such information. SENNOGROUP ● Wellness & Rehabilitation must abide by the terms and conditions of this Privacy Notice, as revised from time to time.

OUR RESPONSIBILITES

We are required by law to:

1. Maintain the privacy of your health information.
2. Provide you with an additional current copy of our Notice upon request.
3. Abide by the terms of our current Notice.
4. Notify you if we cannot accommodate a requested restriction or request.
5. Accommodate your reasonable request regarding methods to communicate health information with you.
6. Accommodate your request for an accounting of disclosures.

We will not use or disclose your health information without your written authorization, except as described in this Notice. Such authorization may be revoked in writing at any time except with respect to any actions we have taken in reliance on it.

We may use and disclose your medical records only for each of the following purposes: **Treatment, Payment and Health Care operations and as required by law.**

"Treatment" could include consulting with or referring your case to another health care provider. The type of health information that SENNOGROUP ● Wellness & Rehabilitation could use or disclose includes, but is not limited to, such health conditions as blood type, diagnosis of your condition or pregnancy status. SENNOGROUP ● Wellness & Rehabilitation may use or disclose your individually identifiable health information for its own provision of treatment or may disclose such information for the treatment activities of another health care provider.

"Payment" could include SENNOGROUP ● Wellness & Rehabilitation efforts to obtain reimbursement from you or a responsible third party for services that SENNOGROUP ● Wellness & Rehabilitation has provided to you. SENNOGROUP ● Wellness & Rehabilitation may use or disclose your individually identifiable information for its own payment or for the payment and activities of another health care provider or health plan or health care clearinghouse.

"Health care operations" could include activities such as quality assessment and improvement activities and audits of the process of billing you or a third party for health care services SENNOGROUP ● Wellness & Rehabilitation provides to you. As part of SENNOGROUP ● Wellness & Rehabilitation treatment of you and its operations, SENNOGROUP ● Wellness & Rehabilitation may contact you, by phone or by mail, to provide appointment reminders or to provide information about treatment alternatives or other health-related services that may be of interest to you. SENNOGROUP ● Wellness & Rehabilitation may also contact you for fundraising purposes. SENNOGROUP ● Wellness & Rehabilitation may use or disclose your individually identifiable health information for its own health care operations or for limited health care operations of a health plan, he alth care clearinghouse, or health care provider that is subject to certain federal health information privacy laws. The entity which receives this information must have or have had a treatment relationship with you and the information we disclose must pertain to that relationship. Limited health care operations include various quality assessment and improvement activities, credentialing and training activities, and health care fraud and abuse detection or compliance activities.

YOUR HEALTH INFORMATION RIGHTS

- **Your Right to Receive Confidential Communications and to Request Restrictions.**

Federal and state laws protect your right to keep your individually identifiable health information private. You may request that you receive communications from SENNOGROUP ● Wellness & Rehabilitation regarding individually identifiable health information by alternative means or at alternative locations. You must make your request for confidential communications in writing and must submit this request to the office listed below. SENNOGROUP ● Wellness & Rehabilitation reserves the right to condition your request on the receipt of information regarding how you wish SENNOGROUP ● Wellness & Rehabilitation to handle payment and/or on the availability of an alternative address or method of contact that you may request. You may request other restrictions on certain uses and disclosures of protected health information for purposes of treatment, payment and health care operations; however, the law does not require SENNOGROUP ● Wellness & Rehabilitation to agree to the requested restrictions unless the restriction request is a reasonable restriction on communication.

- **Your Right to Inspect and Copy.**

You have the right to inspect and obtain a copy of any individually identifiable health information in your medical record unless your attending physician has determined that there is a sound medical reason to deny you access or unless the law restricts SENNOGROUP ● Wellness & Rehabilitation from disseminating the information.

- **Your Right to Amend.**

You also have the right to amend your individually identifiable health information, unless SENNOGROUP ● Wellness & Rehabilitation did not create such information or unless SENNOGROUP ● Wellness & Rehabilitation determines that your medical record is accurate and complete in its existing form.

- **Your Right to an Accounting.**

You have the right to request and receive an accounting of disclosures of your individually identifiable health information that SENNOGROUP ● Wellness & Rehabilitation has made either in the six (6) years prior to the request date, or during the period between the request date and the date that federal law required SENNOGROUP ● Wellness & Rehabilitation to comply with federal privacy regulations, whichever is more recent. Such an accounting may not include disclosures made to carry out treatment, payment or health care operations, to create an accurate patient directory or notify persons involved in your care, to ensure national security, to comply with the authorized requests of law enforcement, or to inform you of the content of your medical records, or those disclosures which you have previously authorized pursuant to a validly executed authorization form.

If you would like more information on how to exercise these rights or you believe your privacy rights have been violated, please contact Dr. Ricardo Senno at 1535 Lake Cook Rd, Suite 306, Northbrook, IL. 60069 (847-644-8242) in person or in writing during normal business hours. They will provide you with assistance on the steps to take to exercise your rights.

For more information about HIPPA or to file a complaint:

Office for Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

SENNOGROUP ● Wellness & Rehabilitation reserves the right to amend the terms of this Privacy Notice at any time and to apply the revised Privacy Notice to all individually identifiable health information that it maintains. If SENNOGROUP ● Wellness & Rehabilitation amends this Privacy Notice, you will be provided with a revised copy at your next visit to SENNOGROUP ● Wellness & Rehabilitation, or upon request. We will post a copy of the current notice in our office.

Thank You

SENNOGROUP
WELLNESS & REHABILITATION

ACKNOWLEDGEMENT
OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED MEDICAL INFORMATION

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices for Protected Medical Information of SENNOGROUP • Wellness & Rehabilitation*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I have received, read the ***Notice of Privacy Practices for Protected Medical Information of SENNOGROUP • Wellness & Rehabilitation*** containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this office at any time to obtain a current copy of its ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by coming into our office.

If you have any questions about our ***Notice of Privacy Practices***, please contact:

Dr. Ricardo G. Senno or his staff.

I acknowledge receipt of the ***Notice of Privacy Practices of SENNOGROUP • Wellness & Rehabilitation.***

Patient's Name: _____

Signature: _____ Date: _____
(Patient or legal representative)

……..
FOR MEDICAL PROVIDER ONLY

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the acknowledgement and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgment was not obtained:

☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

☐ Good faith effort: _____

Signature of provider: _____ Date: _____

SENNOGROUP
WELLNESS & REHABILITATION

AUTHORIZATION FOR USE, DISCLOSURE, TRANSFER & ACQUIRING OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
DATE OF BIRTH: _____

I hereby authorize the use, disclosure, transfer, of the Protected Health Information described below to be provided to, obtained or used by Ricardo G. Senno, MD or his representatives of SENNOGROUP●Wellness & Rehabilitation at 1535 Lake Cook Road, Suite 306. Northbrook, IL. 60062 as well as disclosure to other professionals that Dr. Senno deem appropriate. The Information can be verbal, written, electronic or take any other form.

CIRCLE YOUR CHOICES. I authorize that the following information can be acquired, transferred, used, or disclosed:

●History & Physical	●Discharge Summaries	●Operative Reports	●Emergency Dept. Records	●Consultations
●Lab Reports	●Progress Notes	●Imaging Studies	●Photographs	●Other
●Psychology/Psychiatry Reports		●Insurance Information	●Emergency Contact Information	● STD/HIV

You may restrict the dates of the information between: _____ to _____
or choose no limit by circling: ●No Limit

CIRCLE YOUR CHOICES. The information will be obtained, used, disclosed, or transferred for the following purposes only:

●Continued Treatment	●Insurance	●Legal	●At the Request of the Patient or Patients Representative	●Billing
●Emergency Treatment	●Other	●Communication with Other Professionals		●Worker's Compensation

I Understand:

I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used, disclosed or transferred in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights or upon the occurrence of the following:
_____.

I release the entities listed above, their agents and employees from any liability in connection with acquiring, use, disclosure, and/or transfer of protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.

Information acquired, used, disclosed, and/or transferred pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited form disclosing substance abuse information under the Federal Abuse Confidentiality Requirements.

I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.

Unless the purpose of this authorization is to determined payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that my medical information may indicate that I have a communicable disease or venereal disease (sexually transmitted disease) which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and Human Immunodeficiency Virus (HIV) also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological, psychiatric conditions or substance abuse.

_____	_____	_____
SIGNATURE OF PATIENT / REPRESENTATIVE	**PRINTED NAME**	**DATE SIGNED**

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT FOR THE PATIENT: _____

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and can not be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or Department of Health or by law.

SENNOGROUP
WELLNESS & REHABILITATION

CONSENT TO TREAT & COMMMUNICATE

Treatment of patients includes history and physical exam, communication, prescription of medications, therapies, follow-up, modification of treatment plan and other modalities. We take reasonable steps to explain medical findings, labs, medications, side effects and interactions.

Please keep in mind that the doctor - patient relationship is mutual, with both the doctor and the patient playing active roles.

We encourage and empower our patients to understand their treatments, medications, side effects and interactions. Specific treatment modalities and therapies can be discussed with your doctor and physical therapist. We encourage you to ask questions.

For the coordination of care, we at SENNOGROUP ● *Wellness & Rehabilitation* consider communication with our patients, their clinicians, referring physicians and other members of the treatment team of importance. Following your visit an attempt is made to send a note to your referring doctor.

We use different ways to communicate with you, your designated representative and your clinical team. These include but are not limited to conversation, letters, phone (cell, work, home), fax and e-mail.
We make reasonable attempts to maintain confidentiality.

I have read, understand the above, and give permission for communication to the following:

Doctors	**Phone Number**	**Fax Number**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
Family Members	**Phone Number**	**Fax Number**
1._____	_____	_____
2._____	_____	_____
Lawyer (if any)	**Phone Number**	**Fax Number**
1._____	_____	_____

NOTE: *Communications are not limited to people listed above. It is the patient's responsibility to notify us of changes.*

We look forward to our mutual relationship as well as answering your questions.

I have read, understand the above and give permission for treatment and realize that I have an active role in my care. I also realize that all medications, treatments and procedures have side effects and interactions. In addition, I understand that individual patient results vary and there are no guarantees as to success of treatment or care.

_____	_____	_____
Patient or Representative Signature	**Printed Name**	**Date**

Consent to Communicate
Form HIPPA # 7
Number of Pages: 1
Created: 12/20/2008
Revised: 2/20/2011, 1/10/2020