PHYSIO MED
Outpatient Rehabilitation Center
Physical ◆ Occupational ◆ Manual ◆ Massage

MAIN OFFICE
443 Plaza Drive
Eustis FL 32726
Ph (352) 589-5595
Fax (352) 589-5747

Welcome to Physio Med, Inc.

APPOINTMENTS-

Patients are scheduled 2-3 times a week depending on your doctor's order, authorization, and/or financial situation. It is very important you keep your appointments as scheduled. Medicare and Work-Comp are extremely strict if you are not compliant with the therapist's Plan of Care. A gap in treatment greater than a week is unacceptable and could result of non-payment from your insurance company.

INSURANCE-

We participate in many insurance plans. We will bill your insurance accordingly. Please be sure to give our office the correct information. If you have a change of insurance please notify us ASAP to avoid any confusion.

RECORDS-

Your medical records are confidential. If you wish to have copies of your office reports released to another physician or to an attorney, we must have written consent. Please inform our office of any changes to your address, and telephone number.

OFFICE FEES-

We believe that our professional fees are within the range of usual and customary charges for this region. Our practice expects payment at the time of check-in. We will send you a statement for any additional charges deemed patient responsibility by the insurance.

Print Name _____ Date _____

Signature _____

EUSTIS
443 Plaza Drive
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Ph: (352) 589-5595
Fax: (352) 589-5747

LADY LAKE
920 Rolling Acres Road, Suite 7
Lady Lake, FL 32159
Ph: (352) 259-2522
Fax: (352) 259-2554

LEESBURG
1127 E. North Blvd.
Leesburg, FL 34748
Ph: (352) 365-1114
Fax: (352) 365-0111

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PATIENT INFORMATION FORM

Today's Date: _____/_____/_____

NAME: _____ _____ _____
First Last M. Initial

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____
(MUST BE 9 DIGITS)

OUT OF STATE ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____
(MUST BE 9 DIGITS)

E-MAIL ADDRESS : _____

HOME PHONE : _____ **WORK/CELL PHONE:** _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SS#:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

□ MALE □ FEMALE

MARITAL STATUS □ married □ single □ widowed □ divorced
(must be filled out)

EMPLOYMENT STATUS □ EMPLOYED □ UNEMPLOYED □RETIRED
(must be filled out)

REFERRING PHYSICIAN: _____
PHYSICIAN'S PHONE #: _____
PHYSICIAN'S ADDRESS: _____

DIAGNOSIS/REASON FOR THERAPY: _____
Is Primary Diagnosis related to an accident? □ YES □ NO
If yes, what kind? □ work related □ auto related □ other
DATE OF ONSET/ACCIDENT/LATEST EXACERBATION: _____/_____/_____
DATE YOU FIRST SAW DOCTOR FOR THIS: _____/_____/_____

EMERGENCY CONTACT INFORMATION
NOTIFY: _____ **RELATIONSHIP:** _____
HOME PHONE #: _____ **WORK PHONE #:** _____

INSURANCE INFORMATION □ SEE COPY OF CARDS
SUBSCRIBER NAME _____ **DOB** _____
(mandatory) (Mandatory)
INSURANCE COMPANY NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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LIST OF MEDICATION (if none taken check box below then sign)

_____

_____

_____

_____

_____

_____

_____

( ) I do not take any medication

_____
Print Name Date

_____
Signature

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NAME: _____ **REFERRING PHYSICIAN:** _____

DATE: ____/____/____ **AGE:** _____ **SEX:** M__ F__

R__/L__ HANDED **DIAGNOSIS:** _____

DATE OF ONSET: ___/___/___ **DATE OF SURGERY:** ___/___/___

HISTORY OF PRESENT PROBLEM:

_____
_____
_____
_____
_____

TOBACCO USE: Y___/N___ **HOW MUCH:** _____

HEIGHT: _____ **WEIGHT:** _____

DIAGNOSTIC TESTS: X-RAY ____ MRI _____ CT SCAN ____ OTHER _____

PRIOR WORK STATUS: FULL DUTY ____ RESTRICTED _____ RETIRED_____
NOT WORKING DUE TO INJURY _____
UNEMPLOYED _____

PRESENT WORK STATUS: FULL DUTY ___ RESTRICTED___ RETIRED _____
NOT WORKING DUE TO INJURY _____
UNEMPLOYED _____

OCCUPATIONAL REQUIREMENTS ☐ **N/A**

☐ Sitting ☐ Computer work
☐ Squatting/Rising ☐ Driving
☐ Standing ☐ Walking
☐ Overhead Reaching ☐ Climbing
☐ Push/ Pull
☐ Lifting/ Carrying
☐ Repetitive Wrist/Forearm

WHAT INCREASES SYMPTOMS:

☐ _____
☐ _____
☐ _____

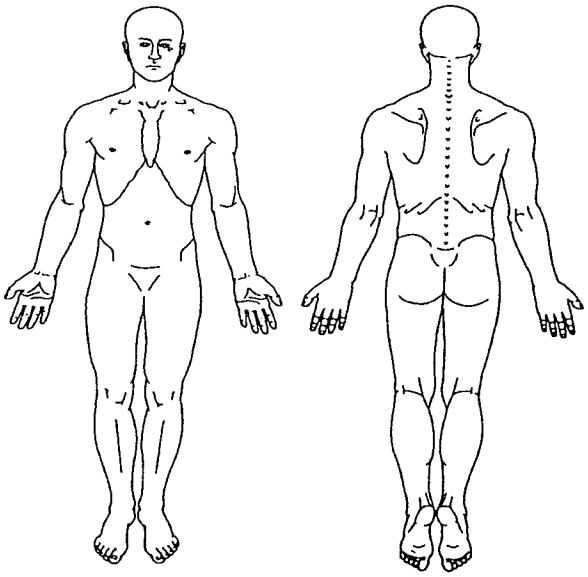
WHAT DECREASES SYMPTOMS:

☐ _____
☐ _____
☐ _____

PAIN SCALE: NOW: ___/10+
WORST: ___/10+
BEST: ___/10+

KEY
10+ MAX PAIN
10 VERY, VERY STRONG PAIN
9
8
7 VERY STRONG PAIN
6
5 STRONG PAIN
4 SOMEWHAT STRONG PAIN
3 MODERATE PAIN
2 WEAK PAIN
1 VERY WEAK PAIN
0.5 VERY, VERY WEAK PAIN
0 NO PAIN AT ALL

Please locate on body chart:
O: NUMBNESS
X: PAIN
///: RADIATING



PAST MEDICAL HISTORY

PLEASE SPECIFY

☐ HYPERTENSION _____

☐ DIABETES _____

☐ VISUAL DEFICITS _____

☐ HEARING DEFICITS _____

☐ PACEMAKER _____

☐ CARDIAC PROBLEMS _____

☐ CIRCULATORY PROBLEMS _____

☐ RESPIRATORY PROBLEMS (ASTHMA, SHORTNESS OF BREATH) _____

☐ SURGERIES _____

☐ METAL IMPLANTS _____

☐ NEURLOGICAL DEFICITS (MS, PARKINSONS, CVA, etc) _____

☐ OTHER _____

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AUTHORIZATION FOR RELEASE OF INFORMATION, INSURANCE ASSIGNMENTS, VALUABLES, AND CONSENT FOR TREATMENT

Authorization to release medical information: Physio Med, Inc. is hereby authorized to disclose all or any part of the medical records for me and/or the patient named in this registration such as insurance companies, organizations, or agencies that may be concerned with the payment of the rehabilitation cost of me and/or other named on this registration.

This authorization is given with full knowledge that such disclosure may contain information, which may result in denial of insurance benefits or which may be otherwise harmful or inimical to me and/or the registered patient.

I also agree that if all or any part of insurance benefits is denied, I and/or undersigned will be liable for all rehabilitation charges.

Assignment of benefits: I hereby authorize payment of the insurance benefits and medical benefits due to me, directly to Physio Med, Inc. The patient/spouse and/or legal representative hereby also revokes the right to sue Physio Med, Inc. or its staff in any way. This assignment will remain in effect until revoked by me in writing. **Authorization:** I certify that the information given in applying for payments under Title XVIII of the Social Security Act is correct. I authorize any holder of medical (or other) information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I hereby authorize Physio Med, Inc. to treat and, I understand that I am responsible for any health insurance deductibles and co-insurance.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient, as the patient's legal representative, to execute the above and accepts its terms.

Name of Patient (PRINT)	**Date**
Witness	**Signature**
Admitting Person	**Relationship to Patient**

CR 01/06/2016

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Physio-Med., Inc. ("Physio-Med")
Notice of Privacy Practices

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.

If you have any questions about this Notice please contact our Privacy Officer, Cecil Roberts.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Permitted Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of Physio-Med's practice.

Following are examples of the types of uses and disclosures of your protected health care information that Physio-Med is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to your physicians who may be treating you. For example, your protected health information may be provided to a physician who referred you to us to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care.

Payment: With your consent, your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for continued therapy may require that your relevant protected health information be disclosed to the health plan to obtain approval for continued services

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of Physio-Med's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing and collection services) for Physio-Med. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about Physio-Med and health and wellness information. You may contact our Privacy Officer to request that these materials not be sent to you.

Others Involved in Your Healthcare: We may disclose your protected health information to your legal representative or other persons you consent to and identify in writing. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

2. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent or Authorization

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of Physio-Med, and (6) medical emergency (not on Physio-Med's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved and the use or access to your protected health information has been determined to be necessary by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and Physio-Med created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

3. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described above. You may revoke this authorization, at any time, in writing, except to the extent that Physio-Med., Inc. has taken an action in reliance on the use or disclosure indicated in the authorization.

4. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that Physio-Med., Inc. uses for making decisions about you. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Physio-Med is not required to agree to a restriction that you may request. If Physio-Med believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Physio-Med does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with our Privacy Officer. You may request a restriction by submitting your request in writing to our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you. You have the right to receive specific information regarding these disclosures that occurred for a 6-year period prior to the date of your request but not before April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us. You have the right to request a paper copy of this notice. No later than the date of the first service delivery on or after April 14, 2003, a copy of this notice shall be provided to you.

You have the right to a copy of changes to this notice. We reserve the right to change this notice and to make the revised or changed notice also effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at each of our office locations on the wall next to the reception desk and on our website located at www.physiomedinc.com reflecting its effective date.

5. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Cecil Roberts at 352-589-5595 or in writing at 443 Plaza Drive, Eustis, Florida 32726 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Physio-Med, Inc. Notice of Privacy Practices as required by Federal Law.

Date	Patient/Personal Representative	Description of PR Authority

Reason Patient / PR failed to sign:

_____

_____

_____
Staff Signature

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