Body in Balance

Patient History

First Name:_____ Last Name:_____ MI:_____

Address:_____City:_____ Zip:_____

Email Address:_____ Cell Number:_____

Date of Birth:_____ Gender_____ SS#:_____

Referring Physician:_____ Insurance provider: _____

Describe the current problem that brought you here?

_____

- When did your problem first begin?

_____

- Was your first episode of the problem related to a specific incident? Yes / No
- Please describe and specify:_____
- Since that time has the problem: □ stayed the same □ gotten worse □ gotten better
- Have you seen another provider (MD, PT, etc) for this current problem? Yes / No
- If Yes – Please list provider

_____

- Describe previous treatment/exercises:_____
- Did you get relief from the treatment(s) listed above? Yes / No
- Rate the severity of this problem from 0 -10, 0 is no pain at all, 10 being the worst pain imaginable
- Currently _____ At its Best _____ At its Worst _____
- General Health: □ Excellent □ Good □ Average □ Fair □ Poor
- Activity/Exercise: □ None □ 1-2 days/week □ 3-4 days/week □ 5+ days/week
- Have you fallen in the past year? Yes / No
- If Yes – How many times in the past year: _____ In the past Two Years: _____
- Has a fall resulted in an injury? Yes / No
- If Yes – Please describe your injury_____
- Height _____ Weight _____

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🎬 Tobacco Usage / Day _____

🎬 Have any of your medication changed recently? Yes / No

Medications and/or Supplements – oral, patches, injection, etc Dosage Reason for taking

(Please indicate if you have attached a separate list of Medications by checking box - □)

_____

_____

🎬 Have you had any surgeries? Yes / No

Type of Surgery Date

_____

_____

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Anemia	Chronic fatigue	Depression/Anxiety
Heart problems	Diabetes	Fibromylagia	Headaches
Emphysema/	Hearing Loss	Latex Senility	Kidney Disease
Chronic bronchitis	Raynaud's	Vision Problems	Arthritic Conditions
Epilepsy/seizures	Bone Fracture	Joint Replacement	Low Back Pain
Head Injury	Sports Injury	TMJ/neck pain	Pelvic Pain
High BP	Multiple Sclerosis	Stroke	Ankle Swelling

Allergies: _____

Other: Please List

_____

MEDICARE PATIENTS:

During this calendar year - have you received ANY Physical Therapy or Speech Therapy for ANY part of the body? (Neck/ Back/ Shoulder, etc.) □ Yes □No

Signature: _____Parent/Guardian Date:_____

Consent for Physical Therapy Evaluation and Treatment

Informed consent for treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy evaluation and treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks :I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 2-3 days, I agree to contact my therapist.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Release of medical records: I authorize the release of my medical records to my insurance company, physicians/primary care provider or otherproviders that are managing my care.

I WILL INFORM MY THERAPIST OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO HAVE

AN EVALUATION OR TO BE TREATED. I HEREBY REQUEST AND CONSENT TO THE EVALUATION. I HAVE ALSO READ AND CONSENT TO THE NOTICE OF PRIVACY PRACTICES.

Printed Name:_____

Signature:_____ Date:_____

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Georgia Department of Public Health (DPH) to maintain the privacy of your health information, inform you of its legal duties and privacy practices with respect to your health information through this Notice of Privacy Practices, notify you if there is a breach involving your protected health information, agree to restrict disclosure of your health information to your health plan if you pay out-of- pocket in full for health care services, and abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice at any time. The Notice will be posted on the DPH website at www.dph.georgia.gov. Copies of the Notice are available upon request.

The Department of Public Health and the County Boards of Health will follow this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment: We may use or disclose your health information to provide you with treatment or services. County Boards of Health may disclose your health information to doctors, nurses or other healthcare personnel involved in your care. For example, County Boards of Health may share your information with programs involved in your follow-up care, such as the Babies Can't Wait program. Also, the DPH Public Health Laboratory will return lab test results to the person who ordered the tests, and those results may be used for your treatment or follow-up care.

Payment: We may use or disclose your health information to bill and collect payment for the services that you receive. For example, your health insurance company may need to provide your health plan with information about the treatment you received so that it can make payment or reimbursement for services provided to you.

Health Care Operations: We may use and disclose information about you for health care operations. For example, we may review treatment and services to evaluate the performance of our staff in caring for you, and to determine what additional services should be provided.

Appointment Reminders, Follow-Up calls: We may use or disclose medical information about you to remind you of an upcoming appointment or to check on you after you have received treatment.

Individuals Involved in Your Care: If you do not object, we may disclose your health information to a family member, relative, or close friend who is involved in your care or assists in taking care of you. We may also disclose information to someone who helps pay for your care. We may disclose your health information to an organization assisting with disaster relief to help notify your family member, relative, or close friend of your condition, status and location.

Business Associates: We may disclose your information to contractors (business associates) who provide certain services to us. We will require these business associates to appropriately safeguard your information.

Public Health Activities: We may disclose your health information for public health activities which include: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting reactions to medications or problems with products or notifying a person of product recalls; and notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your medical information to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only disclose this if you agree, or when required or authorized by law or regulation.

Health Oversight Activities: We may disclose your health information to a health oversight agency that is authorized to conduct audits, investigations, inspections, licensure and other activities necessary to monitor the health care system, government programs and compliance with civil rights laws.

Health Information Exchange: We may disclose your health information to the Georgia Health Information Network, Inc. (GaHIN), the statewide health information exchange network through which we securely share and access medical information in accordance with applicable state and federal laws and regulations. This exchange of information allows us to provide you with access to better treatment and coordination of healthcare services. GaHIN has established Network Operating Policies and Technical Requirements, which members and member affiliates of GaHIN must meet, to ensure the confidentiality and integrity of data.

Judicial and Administrative Proceedings: We may disclose your health information if ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process, but only if reasonable efforts have been made to notify you of the request or to protect the health information requested.

Law Enforcement: We may release health information to law enforcement to comply with a court order, warrant, subpoena or similar process in order to identify or locate a suspect, fugitive, material witness or missing person about the victim of a crime in certain circumstances. For example, if we believe a death resulted from criminal conduct, to report a crime occurring on our premises in emergencies, to report a crime, the location or victims of the crime, or the identity, description and location of the person committing the crime.

Research: Under certain circumstances we may use or disclose your health information for research. In most cases, we will ask for your written authorization before doing so. Sometimes, we may use or disclose your health information for research without your written authorization. In those cases, the use or disclose of your health information without your consent will be approved by an Institutional Review Board or Privacy Board.

Coroners, Medical Examiner and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information if necessary to prevent or lessen a serious and imminent threat to your safety, another person, or the general public. We will only disclose your information to a person who can prevent or lessen that threat.

National Security and Intelligence Activities and Protective Services for the President: We may disclose your health information to authorized federal officials conducting intelligence and other national security activities. We may also disclose your health information to authorized federal officials for the provisions of protective services to the President, other authorized persons, foreign heads of state or to conduct special investigations.

Military and Veterans: We may disclose the health information of Armed Forces personnel to appropriate military command authorities for the execution of their military mission. We may also disclose health information about foreign military personnel to foreign military authorities.

Inmates: If you are an inmate, we may disclose your health information to the law enforcement official or correctional institution having custody to provide you with health care, and to protect your health or safety or that of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation: We may release your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

As Required by Law: We will disclose your health information when required to do so by law.

Except in limited circumstances, we must obtain your authorization for 1) any use or disclosure of psychotherapy notes, 2) any use or disclosure of your health information for marketing, and 3) the sale of your health information. If your health information has information relating to mental health, substance abuse treatment, or HIV/ AIDS, we are required by law to obtain your written consent before disclosing such information. Any other use or disclosure not mentioned in this Notice will be made only with your written authorization, and you can revoke that authorization at any time. The revocation must be in writing, but will not apply to disclosures made in reliance on your prior authorization.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your records. You must submit your request in writing to the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street, N.W., 15th Floor, Atlanta, Georgia, 30303, and include your name, date of birth, social security number, and the location where services were received if you received services at a local county health department. We may deny your request and in some circumstances, you may request a review of the denial.

Right to Request an Amendment of PHI: You may request that we amend information that we have about you, for as long as we keep that information. You must submit your request in writing to the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street, N.W., 15th Floor, Atlanta, Georgia, 30303, and include your name, date of birth, social security number, a reason that supports your request, and the location where services were received if you received services at a local county health department. Your request may be denied if 1) the information was not created by us unless the creator of the information is not available to make the requested amendment, 2) the information is not kept by us, 3) the information is not available for your inspection, or 4) the information is accurate and complete.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date on which the accounting is requested. The accounting will not include any disclosures 1) to you or your personal representative, 2) made pursuant to your written authorization, 3) made for treatment, payment or business operations, 4) made to your friends and family involved in your care or payment for your care, 5) that were incidental to permissible uses or disclosures of your health information, 6) of limited portions of your health information that excludes identifiers, 7) made to federal officials for national security and intelligence activities, and 8) to correctional institutions or law enforcement officers about inmates. To request an accounting of disclosures, submit your request in writing to the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street, N.W., 15th Floor, Atlanta, Georgia, 30303. Please include your name, date of birth, social security number, the period for which the accounting is being requested, and the location where services were received if you received services at a local county health department.

Right to Request Restrictions: You may request that we restrict the way we use and disclose your health information for treatment, payment or health care operations. You may also request that we limit how we disclose your health information to a family member, relative or close friend involved in your care or payment for your care. We are not required to agree to your request, but if we do, we will comply with your request unless you need emergency treatment and the information is needed to provide the emergency treatment. We may terminate our agreement to a restriction once we notify you of the termination. To request a restriction on the use or disclosure of your health information, please send your request in writing to the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street N.W., 15th Floor, Atlanta, Georgia 30303. Please include your name, social security number, and date of birth, what information you want to limit, to whom you want the limitation to apply, and the location where services were received if you received services at a local county health department.

Right to Request Confidential Communications: You may make reasonable requests to receive communications of your health information by alternate means or at alternate locations. For example, you may ask to be contacted only by mail, and not by phone. To request confidential communications, please send your request in writing to the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street N.W., 15th Floor, Atlanta, Georgia 30303. Please include your name, social security number, date of birth, how you would like to be contacted, and the local county health department where you received services.

Right to Receive a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice, which you may request at any time. You may obtain a paper copy by writing to the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street N.W., 15th Floor, Atlanta, Georgia 30303.

COMPLAINTS

If you believe that your privacy rights have been violated, you may send a written complaint to the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street N.W., 15th Floor, Atlanta, Georgia 30303. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

For further information you may contact the DPH Privacy Officer, Office of the General Counsel at (404) 657-2700.