Magnolia

PHYSICAL THERAPY

"Quality Care Close to Home"

Patient Information

**Please fill out this form completely, blue or black ink only. If you have any questions, please ask and we will be happy to assist you.*

Personal Information

Name:	• Male • Female	Date of Birth:	Driver's License Number:
Address:	City:	State:	Zip:
Social Security Number:	Status: -Minor -Single -Married -Divorced -Widowed		
Home Phone:	Work Phone:	Cell Phone:	
Where do you prefer to receive calls? -Home -Work -Cell			
When is the best time to reach you? Time_____ Days_____			

Employer Information

Patient's/Parent's Employer:	Occupation:	Supervisor:	Work Phone:
Business Address:	City:	State:	Zip:

Referral

Who may we thank for referring you? Or how did you hear about us?

Referring Physician

Name of Physician:	Phone Number:	Fax Number:	
Address:	City:	State:	Zip:

Emergency Contact

Person to contact in case of Emergency:	Relationship to Patient:	Phone Number:

Insurance Information/ Responsible Party

Primary Insurance Company:	Name of Insured:	Relationship to Patient:
Group Number:	ID Number:	
Insured's Date of Birth:	Social Security Number:	
Employer:	Date Employed:	Occupation:
Secondary Insurance Company:	Name of Insured:	Relationship to Patient:
Group Number:	ID Number:	

Rensford Pain Drawing

Instructions

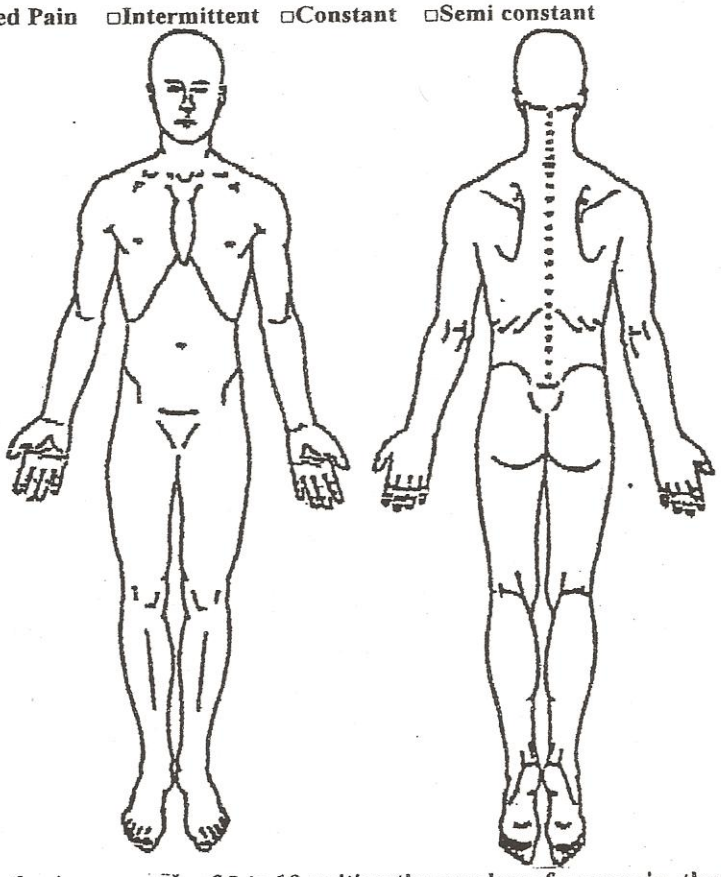
Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

Key

/// Stabbing XXX Burning OOO Pins and Needles ═══ Numbness

SSS Sharp AAA Aching TTT Tingling DDD Dull ~~~ Throbbing RRR Soreness

□Shooting Pain □Localized Pain □Intermittent □Constant □Semi constant



Please rate you major area of pain on a scale of 0 to 10 writing the number of your pain, that corresponds to appropriate word descriptors at the present time, as well as your best and worst the past 30 days.

No Pain	Weak Pain	Moderate	Very Strong	Very, Very Strong	Emergency/ Hospitalization
0	1-2	3-4	5	6-7	10

What increases your pain? _____

What decreases you pain? _____ Medication List:_____

Previous Medical History/ Surgeries:_____

Medical attention sought after accident or injury □ Yes □No Date:_____ Where?_____ Dr._____

X-rays: □ No fractures □ Fractures □ Arthritis □ Degeneration □ others:

MRI: □ Normal □ Disc Bulge □ Herniation □ Degeneration □ Others:

Results Available? □ Not at this time, results will be available on___ □ Yes results are available

Required to perform the following tasks:

	Occasionally	Frequently	Constantly		Occasionally	Frequently	Constantly
Sitting				Reaching			
Standing				Bending			
Walking				Squatting			
Push/pull				Overhead act.			
Carrying				Trunk rotation			
Lifting				Climbing			

Job Demand Level			Physical Demand Level
	0-10 pounds	Sedentary	
	10-20 Pounds	Light	
	20-50 pounds	Medium	
	50-100 pounds	Heavy	
	100+ pounds	Very Heavy	

□ Patient is a student at _____ □ Full-time □ Part-time

Patient Signature_____

Authorization and consent for Medical Assessment, Services and Treatment

I (for) undersigned patient do hereby voluntarily consent to such medical care encompassing evaluative, diagnostic, and therapeutic procedures, medical photography, physical therapy and medical treatment as may be ordered by my physician, my physician's assistance(s) or designee(s), as is necessary in my physician's judgment. I realize that any physicians outside of Magnolia Physical Therapy furnishing service to me (the patient), including radiologists, pathologists, and anesthesiologists are independent contractors and are no employees of agents of Magnolia Physical Therapy. I am also aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of ant treatments or examinations to be rendered during this or any visit.

X_____ _____

Signature of Patient or Parent/ Guardian of Minor Date

Release of Liability

I understand that my treatment includes therapeutic exercises and modalities to enhance my functional potential to perform my activities of daily living. I release to Magnolia Physical Therapy, all of its employees, all of its agents, and all of its business partners any and all liability which arises that is not due to any obvious and gross negligence. I also understand that if I need contract transportation services to and from Magnolia Physical Therapy, Magnolia Physical Therapy will not be held responsible for any mishaps during the trip.

X_____ _____

Signature of Patient or Parent/Guardian of Minor Date

Authorization to Release Medical Information

I agree and grant authorization that my physician and Magnolia Physical Therapy authorities may give out written and verbal information concerning my records to any insurance carrier or agent that is authorized to have access to, and to make copies of my records. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/ or other health practitioners. I authorize to release or receive medical information requested to comply with the terms of the Confidentially of Medical Information Act.

X_____ _____

Signature of Patient or Parent/ Guardian of Minor Date

Assignment and Release to Pay Insurance Benefits

I hereby authorize payment directly to Magnolia Physical Therapy for medical services rendered to me and assign all insurance benefits. Payment is not to exceed my indebtedness to said provider. I accept the insurance company to honor my behalf of my dependents. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

X_____ _____

Signature of Patient or Parent/ Guardian of Minor Date

Financial Agreements

I understand that I am responsible for my total charges. I also understand that if outside physicians are used in the course if my treatment there may be a physician's charge that will not be included in bill charges incurred through Magnolia Physical Therapy. If I have insurance that will cover a portion of my bill, I agree to pay the patient's portion of my bill either upon admission by way of deposit, with the balance paid at discharge. If I do not have insurance, I will be required to pay a deposit which will be based on my estimated length of stay an admitting diagnosis. All balance are to be paid within (30) days after the date of discharge.

X_____ _____

Signature of Patient or Parent/ Guardian of Minor Date

HIPPAA NOTICE OF PRIVACY PRACTICES

Magnolia Physical Therapy

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH 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 or concerns about this notice, do not hesitate to **contact Torrance Earle**, Privacy Officer at **(281) 356-8645**.

WHO WILL FOLLOW THIS NOTICE:

**** Magnolia Physical Therapy***

This notice describes our privacy practices. All these entities, sites, and location follow the term of this notice. In addition, these entities, sites, and location may share health information with each other for the treatment, payment, or healthcare operation purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that the **health information** about you **and** your **healthcare is personal** and we are **committed to protecting** health **information** about you. We create a record of care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways in which we may use and disclose health information about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are **required by law** to:

- Make sure health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect of health information about you
- Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- The following categories describe different ways that we use and disclose health information.
- For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment:

We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. **For Example:** A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so we can arrange for appropriate meals. We may also disclose health information about you to a entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment:

We may use and disclose health information about you so that the treatment and services you receive from us may be billed to, and payment collected from you, an insurance company or a third party. **For Example:** We may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations:

We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. **For Example:** We may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Health-Related Services and Treatment Alternatives:

We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to send you this information, or if you wish to have us use a different address to send this information to you.

As Required By Law:

We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety:

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans:

If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Worker's Compensation:

We may release health information about you for worker's compensation or similar programs. These programs provided benefits for work-related injuries or illness.

Public Health Risks:

We may disclose health information about you for public health activities. **These activities generally include the following:**

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify person or organization required to receive information on FDA-regulated products
- To notify a person who may have been exposed to a disease or may be at risk for victim abuse, neglects, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities:

We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, **for example,** audits, investigations inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance wit civil rights laws.

Lawsuits and Disputes:

If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement:

We may release health information if asked to do so by a law enforcement official:

- In reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime
- In response to a court order, subpoena, warrant, summons, or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person:
    - Name and address
    - Date of birth or place of birth
    - Social security number
    - Blood type or rh factor
    - Type of injury
    - Date and time of treatment and/or death (if applicable)
    - Description of distinguishing physical characteristics
- About the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct

Acknowledgement of Receipt of HIPPAA "Notice of Privacy Practices"

I, _____, have received the "Notice of Privacy Practices" from *Magnolia Physical Therapy.*

X_____ _____
Patient/Guardian Signature Date

In Lieu of patient signature, I, _____, a staff member of *Magnolia Physical Therapy*, state that _____ has been given our current "Notice of Privacy Practices".

X_____ _____
Staff Member Signature Date

*Thank You for your cooperation