Mass Sport & Spine

Last Name:_____First Name:_____

Date of Birth: ___/____/____Sex: M/F Parent's Name (under 18)_____

May we contact parent's (if under 18) Y/N Phone:_____

Address:_____ City/State_____Zip:_____

Phone:_____Cell:_____

Email:_____May we contact you this way Y/N

Occupation:_____How did you hear about us?_____

Physician Information

PCP Name:_____

Referring Doctor:_____

Insurance Information

Insurance Carrier:_____Member ID:_____

Subscriber Name & Dob:_____

Secondary Insurance:_____Member ID:_____

Subscriber Name & Dob:_____

Is this WC or MVA related? Y/N Auto/WC information:_____

Adjustor Name and Phone Number:_____

Claim Number:_____Date of Injury/Accident:_____

Authorization to pay Mass Sport and Spine Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Mass Sport & Spine and I am financially responsible for non-covered services. I also Authorize MSS to release any information to process this claim.

Signature (Must be 18):_____

Consent to treat:

I undersigned, voluntarily authorize MSS to administer physical therapy that is necessary as appropriate in the opinion of the referring physician and/or allied health personal. Physical Therapy is not an exact science and no guarantee has been made to the result of treatment administered. By signing this , I acknowledge Receipt of the notice of information practices of MSS. I also acknowledge I have read the clinic policies posted at the front desk.

Patients Signature:_____**Date:**_____

Parent or Guardian:_____Date:_____

Mass Sport & Spine

HISTORY OF PRESENT ILLNESS:

For what condition or symptoms are you being seen for at this time?

_____

When did this condition begin? _____Did it begin suddenly or gradually? Y/N

Have you had PT in THIS Calendar year? Y/N Have you had HOME PT? Y /N
Have you been discharged? Y/N Has this problem occurred in the past? Y/N

Have you received treatment that makes it better/worse?_____

On a scale of 0-10 (**0 being no pain and 10 being the worst pain**) how would you rate your symptoms at their best? _____ At their worst? _____ And currently? _____

Please list or supply us with a list of **ALL** medications/vitamins/supplements that you are currently taking:_____

CONDITION:	*Y or N*
Concussion (#___)	
Cancer (Type:_____)	
Heart Disease	
Rheumatoid Arthritis	
Osteoarthritis/ Gout	
High Blood Pressure	
Bleeding Tendency	
Diabetes	
Stroke	
Kidney or Bladder Problem	
Pneumonia	
Emphysema/Bronchitis	
Asthma	
Hernia	
Thyroid Disorder	
Other (_____)	
Are you currently pregnant?	
Do you have any surgical implant/pacemaker?	
Do you have a latex allergy?	

Please Indicate all past Surgeries:

_____

_____

_____

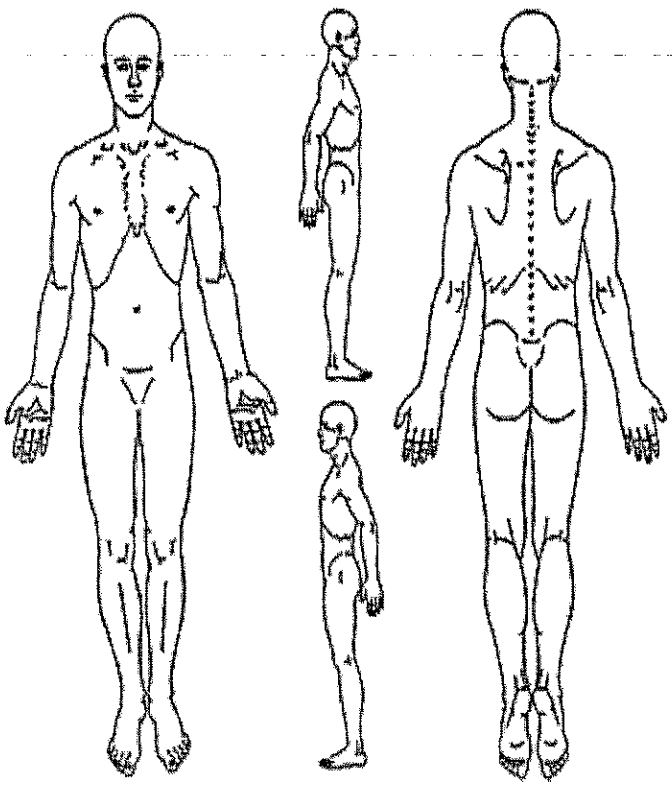
Do You have a history of Falls? Y/N

If Yes, When was your last fall?

_____

Mass Sport & Spine

Please use the following diagram to indicate where your pain is. Use the pain scale below to help describe the pain and indicate under each site of pain



1 –Dull
2- Aching
3- Throbbing
4- burning
5- Tingling
6- Numbness
7- Sharp
8- Shooting
9- Stabbing
10- Other (Specify for each site)

***I have read and Received the HIPPA form:**_____

(Please see last page in packet)

MASS SPORT & SPINE NOTICE OF INFORMATION OF PRACTICES

UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:
-Request a restriction on certain uses and disclosures of your information (45CFR164,522)
-Obtain a paper copy of the notice of information upon request
-Inspect and obtain a copy of your health record (d5 CFR164,524)
-Request and amend your health record (45 CFR 164,528)
-Obtain an accounting of disclosures of your heath information (45 CFR 164,528)
-Request communications of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose heath information except to the extent that actions has already been taken

OUR RESPONSIBILTY:.

We are required to:
-Maintain privacy of your health information
-Provide you with a notice as to our legal duties and privacy practices with respect to your information
-Abide by the terms of this notice
-Accommodate reasonable requests you may have to communicate health information by alternative means or locations. We reserve the right to change our practices and to make the changes effective for all protected health care information we maintain. If our information practices change we will notify you the next time you come in to our office for treatment.

If you have any questions and would like additional information, you may contact Health and Human Services. If you believe your privacy rights have been violated you can file a complaint with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for treatment, Payment and Health Operations

We will use and disclose your health information for treatment for example: information obtained by us will be recorded in your record and used to determine the course of treatment that should work beast for you. Members of your healthcare team will then record the actions they took and their observations. In that way your physicians and other providers will know how you are responding to treatment. Copies of these records as well as other reports will be provided to others providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For ex., a bill may be sent to you or a third-party payer. The information on or accompanying the bill may
EFFECTIVE DATE APRIL 14, 2003
include information that identifies you, as well as your diagnosis, procedure sand supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with worker's compensation or other similar programs established by law.

We will use and disclose your health information for regular health operations. For example, members of our staff may use the information in your health record to phone you regarding confirmation of appointments or to notify patient of missed appointments. Logistics may dictate the portions of treatments are conducted in an open gym atmosphere where disclosures may be overheard. Every reasonable precaution is taken to limit these events.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform their job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information or assist in the notifying a family member, personal representative or another person responsible for your care, of your location, and general condition.

Family Communication: After careful judgment, we may disclose to a family member or other person you designate health information relevant in that person's involvement in your care or payment related to your care, of your location and general condition.

Funeral Directors & Organ Procurement Organizations We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
Public Health As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement and Correctional Institution We may disclose health information for law enforcement purposes required by law should you be an inmate of a correctional institution; we may disclose to the institution or agents thereof health information necessary for your heath and the health and safety of other individuals.
Federal Law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.