BROOME Orthopedic & Sport PHYSICAL THERAPY

PATIENT INFORMATION SHEET

□ New Patient □ Previous Patient

PATIENT INFORMATION				
Patient's Name (First, Middle Initial, Last)			□ Female □ Male	Date of Birth / Age
Address (Street/PO Box, City, State, Zip Code)			Social Security Number	
Telephone # (Home)	Telephone # (Cell)	Email Address		
Employer Name & Address (Street, City, State, Zip Code)			Telephone # (Work)	
How Did You Hear About Us?				
RESPONSIBLE PARTY (Must Be Completed, If Patient Under 18 Years of Age)				
Responsible Party's Name & Address			Relationship to Patient	
EMERGENCY CONTACT				
Emergency Contact (Name)			Telephone # (Contact)	
INSURANCE INFORMATION				
Primary Insurance (Company Name)	Insurance Identification #		Group #	
Secondary Insurance (Company Name)	Insurance Identification #		Group #	
WORKER'S COMP/NO FAULT OR SCHOOL RELATED INJURY				
Insurance Company	Name of Adjustor or RN	Claim #		
Address (Street/PO Box, City, State, Zip Code)			Date of Accident	
PHYSICAL THERAPY INFORMATION				
Name of Referring Physician	Problem Area			
Have you had Physical Therapy Before? □ Yes □ No	If Yes, When & What For?			

I authorize the release of information including evaluation and treatment notes from Broome Orthopedic & Sport Physical Therapy ("BPT") to process any claim(s) and **authorize** payment for any physical therapy services including supplies to BPT. I understand that I will be responsible for any charges for services/supplies that are denied or uncovered by my insurance company. **I acknowledge** that it is my responsibility to verify my insurance coverage for physical therapy and to obtain any referrals necessary. **I also acknowledge** that I am responsible for any copays and any outstanding balance on my account at the time of visit.

I acknowledge receipt of the Notice of Privacy Practices required by law.

X _____ _____

Signature – Patient (Responsible Party if Patient Under Age 18) Date

Revised 06/30/2011

BROOME Orthopedic & Sport PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Today's Date

PATIENT INFORMATION

Patient's Name	Date of Birth

PERSONAL & FAMILY HISTORY

Indicate if you or someone in your family has/ever had any of the following conditions. If family, please indicate relationship to you.

	Personal		Family				Personal		Family		
DESCRIPTION	YES	NO	YES	NO	RELATION	**DESCRIPTION**	YES	NO	YES	NO	RELATION
Hearing Problems						High Cholesterol					
Heart Disease/ Circulatory						Epilepsy or Seizures					
High Blood Pressure						Migraine Headaches					
Stroke / TIA						Arthritis / Gout					
Asthma/Emphysema/ Bronchitis						Depression/Nervous Problem					
Ulcers/Digestive Problems						Diabetes					
Drug / Alcohol Problems						Hepatitis or Liver Problems					
Cancer: Breast						Thyroid Disease					
Colon						Sleep Apnea					
Prostate						Anemia / Blood Disease					
Other; Where?						HIV / AIDS / STD's					
Kidney Stones/ Cysts/Failure						Tuberculosis					
Gallbladder						Osteoporsis/Osteopenia					

SURGERIES AND/OR HOSPITALIZATIONS

List name and approximate date for any surgeries and/or hospitalizations.

CURRENT MEDICATIONS

List all prescription and non-prescription medications that you are currently taking. Include the Dose and How Often.

RECENT X-RAY, MRI, OR OTHER DIAGNOSTIC TESTS

List any recent X-Ray, MRI, or other tests below; please include date and location tests were done.

ALLERGIES AND/OR ADVERSE REACTIONS

List any allergies and/or adverse reactions.

(1) What is your chief complaint? ➡	
(2) Have you had more than one episode of pain/symptoms?	□ Yes □ No
(a) If "Yes", how many?	
(b) How long does an episode last?	
(c) How much time between episodes?	
(d) Are the episodes (Check One)	□ Increasing □ Decreasing □ Same In Intensity
(3) Current Episode	
(a) What caused the pain to start?	
(b) When did it start?	Date or Month:
(c) Where do you feel the pain?	
(d) Did the pain/symptoms spread?	
(e) What makes the symptoms worse?	□ AM/PM □ Sitting □ Standing □ Walking □ Rising □ Lying □ Rest □ On The Move □ Other:
(f) What makes the symptoms better?	□ AM/PM □ Sitting □ Standing □ Walking □ Rising □ Lying □ Rest □ On The Move □ Other:

(4) How would you describe your pain?

□ Cramping, Dull, Aching	□ Sharp, Shooting	□ Constant
□ Burning, Pressure Like, Stinging, Aching	□ Deep, Nagging, Dull	□ Intermittent
□ Throbbing, Diffuse	□ Sharp, Bright, Lightning Like	□ Occasional

(5) Do you experience any of the following Symptoms?	□ Numbness □ Tingling □ Weakness
(a) Where?	
(6) Did you receive any treatment?	□ Yes □ No
(a) If "Yes", what treatment?	
(b) Did the treatment help?	□ Yes □ No
(7) Were you involved in an accident?	□ Yes □ No
(a) If "Yes", when?	Date:
(b) How did it happen?	

(8) Pain Scale:

Please select one in each of the following three categories.

0 being no pain and 10 being the most pain.

	0	1	2	3	4	5	6	7	8	9	10
At Worst:											
Current:											
At Best:											

BROOME
Orthopedic & Sport
PHYSICAL THERAPY

CONSENT FORM

RELEASE OF MEDICAL RECORDS		
Patient's Name (First, Middle Initial, Last)	Age	Date Of Birth

I, _____, request that all available medical reports, MRI reports, and X-Rays be released to Broome Orthopedic & Sport Physical Therapy from Dr. _____ .

I understand that all the information contained in these reports will be kept confidential and will only be provided to my physical therapist.

I understand that the information will be faxed or mailed to Broome Physical Therapy at the address listed below.

X _____ _____
Signature – Patient (Responsible Party if Patient Under Age 18) Date

BROOME ORTHOPEDIC & SPORT PHYSICAL THERAPY
800 VALLEY PLAZE, SUITE 9, JOHNSON CITY, NY 13790
TELEPHONE: (607) 729-2200 FAX: (607) 729-2202

OFFICE POLICIES

Welcome to Broome Orthopedic & Sport Physical Therapy!

Below are our office and financial policies. Please read it, ask us any questions you may have, and sign it in the space provided. A copy will be provided to you upon request.

(1) CANCELLING YOUR APPOINTMENT

Please give us 24 hours advanced notice.

We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office prior to your appointment. Should you experience any unforseen circumstances that cause you to miss your appointment, please call our office to have it rescheduled.

Patients that miss more than one appointment, without notifying our office prior to the scheduled appointment, are subject to a $25.00 missed appointment fee for any future no shows.

(2) IF YOU ARE LATE FOR AN APPOINTMENT

Your time is valuable and so is the therapists, please be prompt.

If you arrive 10 or more minutes past your scheduled time, your appointment will need to be rescheduled.

We will give all patients a printout of their appointments to avoid scheduling mistakes.

(3) CO-PAYMENTS/DEDUCTIBLES

Your insurance company requires us to collect co-payments/deductibles at the time of service.

Waiver of co-payments/deductibles may constitute fraud under state and federal law.

(4) **BILLING**

A statement will be mailed to you on a monthly basis. The statement will reflect the balance, after insurance, that is due from you. The balance due is your responsibility and is **due upon receipt of the statement.** If the balance due is not paid prior to the next statement cycle (within 30 days), a service charge of **$5.00** will be added. This service charge will be added monthly until the balance is paid in full. Accounts that are not paid in full within 60 days will be sent to **Small Claims Court and all fees associated will be added to your balance.** If you cannot pay the statement balance within the 30 days, you must call the office to make payment arrangements to avoid the service charge.

Thank you for your cooperation!

SIGN: _____ DATE: _____

Patient Signature

WITNESS: _____ DATE: _____

BROOME ORTHOPEDIC & SPORT PHYSICAL THERAPY
800 Valley Plaza, Suite 9
Johnson City, NY 13790
Telephone: (607) 729-2200 Fax: (607) 729-2202

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Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY:

We respect the privacy of your personal health information and are committed to maintaining the confidentiality of your information. This Notice applies to all information and records related to your care that our facility has received or created. It extends to information received or created by our employees, staff, volunteers and physicians. This Notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and our obligations regarding your personal health information.

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your personal health information; and
- Abide the terms of the Notice that are currently in effect

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices, change, we will mail you a revised notice.

WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

We have described uses and disclosure of information of treatment, payment and health care operations below and provide examples of the types of uses and disclosures we may make in each of these categories.

For Treatment: We will use and disclose your personal health information in providing you with treatment and services. We may disclose your personal health information to facility and non-facility personnel who may be involved in your care, such as physicians, nurses, nurses' aides, and physical therapists. For example, a nurse caring for you will report any change in your condition to your physician. We also may disclose personal health information to individuals who will be involved in your care after you leave the facility.

For Payment: We may use and disclose your personal health information for facility operations. These uses and disclosures are necessary to manage the facility and to monitor our quality of care. For example, we may use personal health information to evaluate our facility services, including the performance of our staff.

WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your personal health information to a family member or close personal friend, including clergy, who is involved in your care.

Public Health Activities: We may disclose your personal health information for public health activities. These activities may include, for example:

- Reporting to a public health or other government authority for preventing or controlling disease, injury or disability, or reporting abuse or neglect;
- Reporting the federal Food and Drug Administration (FDA) concerning adverse events or problems with products for tracing products in certain circumstances, the enable product recalls or to comply with other FDA requirements;

- To notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition or
- For certain purposes involving workplace illness or injuries.

Reporting Victims of Abuse, Neglect, or Domestic Violence: If you believe that you have been a victim of abuse, neglect, or domestic violence, we may use and disclose your personal health information to notify a government authority if required or authorized by law, or if you agree to the report.

Rights to Receive Confidential Communication: If you are dissatisfied with the manner or location in which you are receiving communication related to your health information, you may request that we provide you with such information by alternative means or at an alternative location.

Right of Access to Health Information: You have the right to request, either orally or in writing, your medical or billing records or other written information that may be used to make decisions about your care. If you request copies of the records, we must provide you with copies within two business days of that request. We may charge reasonable fee for our costs in copying and mailing y our requested information.

Right to Receive an Accounting of Disclosures of Health Information: You have the right to request that we provide you with a written accounting of all disclosures of your health information that we have made during a time period you specify (not to exceed 6 years). Please understand that such an accounting will not include informant on disclosures;

1. For treatment, payment, or health care operations;
2. To you or your legal representative, or any other individual involved with your care
3. Incident to a use or disclosure permitted or required by the federal Privacy Rule;
4. Based on your authorization to release information;
5. For nation security or intelligence purposes;
6. As part of a limited data set for research, public health or health care operations; and
7. To a health oversight agency or law enforcement official for the period time that the agency or official asked to have the information not disclosed.

Right to Notice of Privacy Practices: You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file on complaint in writing with the facility or with the Office of Civil Rights in the US Department of Health and Human Services.

To file a complaint with the facility, contact the office at (607)729-2200.

We will not retaliate against you if you file a complaint.

CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual right, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provision effective all personal health information already received and maintained by the facility as well as for all personal health information we receive in the future. We will post a copy of the current Notice in the facility. In addition, we will provide a copy of the revised Notice to all patients via U.S. mail or our in-house mail system.

FOR FURTHER INFORMATION

If you have any questions about this Notice, please contact the office at (607)729-2200.

EFFECTIVE DATE: March 1, 2003