HEALING HANDS

REHABILITATION SERVICES

105 Lexington Drive
Suite H
Madison, Mississippi 39110
(601) 910-7300

Patient Demographic Information

Name: ____

Address:______________________ City/State:_________________ Zip Code:_____________

Home Phone:______________ Cell Phone:_______________ Email: ______________

Age:_____ Date of Birth:____________ Sex:_____ Marital Status:___________

Social Security Number: ________________________ Driver's License Number: ______________

Referring Physician:________________________________ Phone:_______________

If patient is a minor, name of parent/guardian:____

Employment Information

Employer:____________________________________ Occupation:_________________________

Employer's Address: ____

Employer's Phone:___________________ Email Address:_________________________________

Spouse's Name: ______________________________ Spouse's Date of Birth: __________________

Spouse's Employer: __________________________________ Occupation: ____________________

Spouse's Employer Address: ____

Spouse's Employer Phone: ______________________ Email Address: _______________________

Emergency Contact

Name:____________________________ Relationship:________________ Phone:______________

Insurance Information

Insurance Company:____

Insurance Company's Address: _____________________________________ Phone: ____________

Name of Insured:_____________________________ Insured's Date of Birth:___________________

Insured's Address (only if different than patient):____

Policy Number: ________________________ Group Number: ________________________

Before signing this document, verify that the content you are signing is correct.

Patient Signature ____ Date ________

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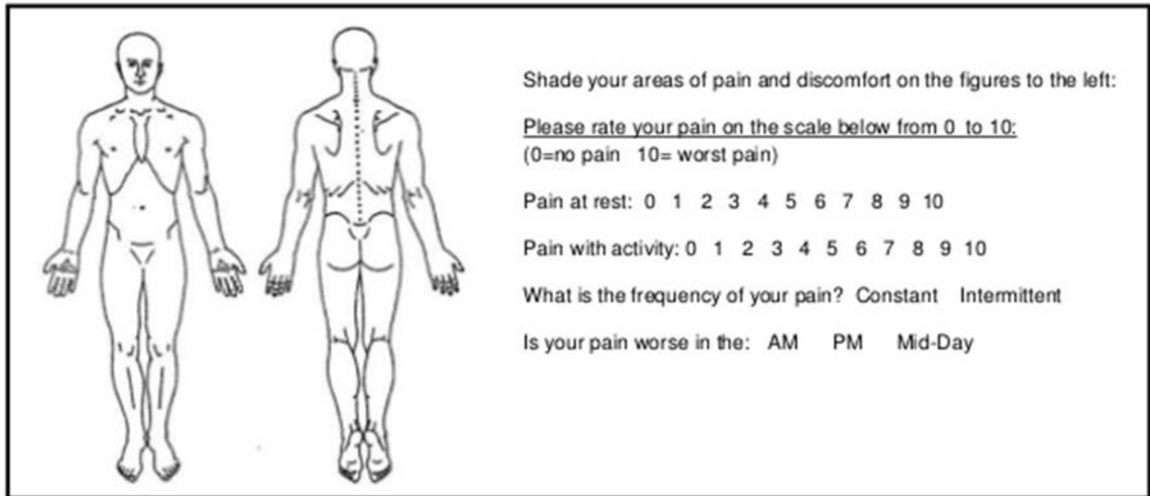
Medical History Form

Patient Name: ____ Date: _______________________

1) What areas of the body or conditions are you currently seeking physical therapy treatment for?
____
____

2) If there are multiple areas of involvement, which region/problem is of greatest concern at this time?
____
____

3) Have you been treated for this same problem before? _________
   a. If yes, when and who treated this problem?
   ____



Shade your areas of pain and discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:
(0=no pain 10= worst pain)

Pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Pain with activity: 0 1 2 3 4 5 6 7 8 9 10

What is the frequency of your pain? Constant Intermittent

Is your pain worse in the: AM PM Mid-Day

4) Current Level of Physical Activity: High Medium Low None

5) Please list all prescription medications you are taking, reason for medication, frequency, and route of administration. Attach list if needed.
____
____
____
____

6) Medical History (Please circle any that apply past or present):

Cardiovascular Disease	Asthma/Shortness of Breath	Hepatitis/Liver Disease	Depression
High Blood Pressure	Congestive Heart Failure	Epilepsy/Seizures	Anemia
Diabetes (Type 1 or 2)	Multiple Sclerosis	Thyroid Condition	Osteoporosis
Stroke or Heart Attack	Fibromyalgia	Neurological Condition	Chronic Infections
Arthritis (Osteo/Rheumatoid)	Migraines/Headaches	Eating Disorder	Lupus
Kidney/Renal Disease	Dizziness/Vertigo	Drug/Alcohol Abuse	HIV/AIDS

Cancer (Type ___________ Location _____________________ Year __________ Status ________________)

Other ____

7) Do you have a pacemaker, internal defibrillator, insulin pump, metal factor or any other implanted medical devices?
____

8) Are you currently pregnant or is there a possibility that you may be pregnant? __________
   a. If yes, how many weeks pregnant are you? ________________

I certify, to the best of my knowledge that the above information is complete and true. If my medical health status changes, I will inform a member Healing Hands Rehab Staff immediately.

Patient Name (Please Print): ___________________________________ Date of Birth: _______________________

Patient Signature: ____ Date: ______________________________

Parent Consent to Treat a Minor (for patients under the age of 18)

Being the parent or legal guardian of ____(minor's printed name), I ___________________________________ (parent/guardian printed name) hereby authorize Healing Hands Rehabilitation Services, LLC to perform physical therapy evaluation and/or treatment of the above mentioned minor.

Minor's Date of Birth: ______________________________________

Parent/Legal Guardian Signature ___________________________________ Date ________________

TERMS OF ACCEPTANCE AND CONSENT TO TREATMENT

Informed Consent

A patient willfully choosing to be treated by Healing Hands Rehabilitation Services, LLC gives Healing Hands Rehabilitation Services, LLC permission and authority to care for him/her in accordance with physical therapy tests, procedures and treatments. Physical therapy is usually beneficial and seldom causes any problems, and in rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Therefore in no way will the treating clinician provide services of any kind if he/she is aware that such care may be contraindicated.

It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever it is he/she is suffering from; latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the treating practitioner. The treating practitioner provides a specialized, non-duplicating health care service, and furthermore, any risk involved regarding physical therapy will be explained to you upon your request. Your treating practitioner is licensed in a special practice and is available to work with other types of physicians, practitioners and providers in your health care regimen.

Acknowledgement and Consent to Treat

I have read and understand the terms outlined above and consent to all necessary treatment as determined by Healing Hands Rehabilitation Services, LLC.

I have reviewed the notice of privacy rights (HIPAA) and have been provided an opportunity to discuss my right to privacy. I will be given a copy of the privacy rights upon request.

Print Name: ___________________________ Signature: _____________________ Date: _______________

Consent to Evaluate and Treat a Minor

I, ________________________________ being the parent or legal guardian of ______________________, have read and fully understand the above terms of acceptance and hereby grant authorization for my child to receive Physical Therapy services.

Signature: ____ Date: ______________________

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Healing Hands Rehabilitation Services, LLC is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

PAYMENT

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

WORKERS' COMPENSATION

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition in the event of an emergency or of your death.

PUBLIC HEALTH

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS

We may disclose your health information to coroners or medical examiners.

ORGAN DONATION

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

RESEARCH

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES

We may disclose your health information for military, national security, prisoner and government benefits purposes.

MARKETING

We may contact you for marketing purposes or fund raising purposes.

CHANGE OF OWNERSHIP

In the event that Healing Hands Rehabilitation Services, LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Healing Hands Rehabilitation Services, LLC.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Healing Hands Rehabilitation Services, LLC amend your protected health information. Please be advised, however, that Healing Hands Rehabilitation Services, LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Healing Hands Rehabilitation Services, LLC.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY RIGHTS

Healing Hands Rehabilitation Services, LLC reserves the right to amend this Notice of Privacy Rights at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Healing Hands Rehabilitation Services, LLC is required by law to comply with this Notice.

Healing Hands Rehabilitation Services, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Healing Hands Rehabilitation Services, LLC by calling this office (601) 910-7300. If Healing Hands Rehabilitation Services, LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS

Complaints about your Privacy rights, or how Healing Hands Rehabilitation Services, LLC has handled your health information should be directed to Healing Hands Rehabilitation Services, LLC by calling (601) 910-7300 if Healing Hands Rehabilitation Services, LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complain, you may submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201

This notice is effective as of today's date listed below.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Healing Hands Rehabilitation Services, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____ ____________________

Patient Signature Date