Patient Background

Name: ______________________________ Referring Physician: ____
Date: _______________________________ Primary Care Physician: ____________________________________

Past Medical History: (please check all that apply)

___ Alzheimer's Disease
___ Anxiety
___ Arthritis (Rheumatoid)
___ Arthritis (Osteo)
___ Asthma
___ Blood Clots
___ Bowel/Bladder problems
___ Cancer
___ Circulatory Disease
___ Depression
___ Diabetes
___ Emphysema
___ Gout
___ Heart Attack
___ Heart Disease
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ HIV/AIDS
___ Kidney Disease
___ Multiple Sclerosis
___ Osteoporosis
___ Pacemaker
___ Implants
___ Scoliosis
___ Stroke
___ Thyroid Problems
___ Other:

Medications: (Please list all prescription and over the counter medications you are currently taking)

____
____
____
____
____

Allergies: (And associated reactions)

____
____
____
____
____

Current Conditions/ Symptoms: (please check all that apply)

- ☐ Nausea Vomiting
- ☐ Pregnancy
- ☐ Fainting
- ☐ Dizziness
- ☐ Headaches
- ☐ Fatigue
- ☐ Fever/Chills/Sweating
- ☐ Pain at night
- ☐ Unexplained weight change
- ☐ Shortness of Breath

Please rate your pain using the following scale:

☐0	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

(no pain) (worst pain
imaginable)

Today: __/10 At Best: __/10 At Worst: __/10

What is the main reason for today's visit? ____________________

If you sustained an injury, when and how did it occur? ____________________

____

What would you like to achieve as a result of today's visit? ____________________

Please state a specific symptom or complaint you want to discuss. ____________________

____

What makes your symptoms worse? ____________________

Do any activities or positions improve your symptoms? ____________________

Please list any previous treatment you've had for this condition: ____________________

____

What is your occupation? ____________________

What is your goal for therapy? ____________________

NOTICE OF PRIVACY POLICIES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

VBPTW is committed to maintaining and protecting our patient's private Patient Health Information (PHI). We want you to know how your PHI is going to be used in this office and your rights concerning those records. We keep our patients' financial and health information private as required by law, accreditation standards, and our own policies. This notice explains your rights, our legal duties, and our privacy practices. We share PHI only with our employees and affiliates who need it to provide service on your account, to do billing, or for other legally allowed or required purposes.

Our Responsibilities

-Maintain the privacy of protected health information.
-Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you and will abide by the terms of this notice.
-Follow the terms of our notice that is currently in effect. Should our information practices change, we will communicate any changes through mail and/or post to our website.

How We May Use and Disclose Health Information

The following describes the ways we may use and disclose health information that identifies you. Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment: We may use and disclose personal health information for your treatment, for treatment documentation, and to provide you with treatment-related health care services with our clinical staff, administrative staff, and/or your referring physician. For example, we may disclose personal health information to your referring medical provider to provide you with the most appropriate medical care.

For Payment: We may use and disclose health information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. The information on or accompanying the bill may include your demographic, insurance, and coverage information, your diagnosis, services provided, and supplies used.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we use a billing agent, Rehab Medical Billing to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

For Healthcare Operations: We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.

As Allowed or Required by Law: Information about you may be shared with regulators for audits, licensure, or other proceedings; for administrative or other legal proceedings; to public health authorities; or to law enforcement officers, such as to comply with a court order or a subpoena.

Your Rights

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. But the information belongs to you. You have the right to:

Request and Inspect a copy of your health record and/or correct personal information that you believe is missing or incorrect. To the extent that we maintain your health information electronically, you may request that a copy in electronic format be sent to you or someone else at your direction.

Ask us not to use your health information for payment or health care operation activities. If you have paid the entire cost of an item or service out of pocket, you may ask us not to disclose information about that service to your healthcare plan. If you make this request, it will remain your responsibility to provide required information to your payment provider. We are not required to agree to these requests.

Obtain a list of disclosures of your health information that we make, except when: you have authorized the disclosure; the disclosure is made for treatment, payment, or other healthcare operations. The law otherwise restricts the accounting.

Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Be Notified of any breach of your unsecured health information as soon as possible, but in any event no later than 60 days following discovery of the breach.

Copies and Changes
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We are required by law to comply with whatever privacy notice is currently in effect.

Complaints
If you believe we have not protected your privacy, you can file a complaint with us or with the federal government. We kindly request notice of your complaints so that we may better serve you and other patients. We will not take action against you for filing a complaint.

Contact Information
If you want to exercise your rights under this notice, wish to talk with us about privacy issues, or to file a complaint, please contact our office directly at 757-555-5555.

Before we begin any healthcare operations we ask that you read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow VBPTW to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
3. We may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. If there is such a person please identify them here and their relation to you. Your signature on this consent form will allow us to disclose such information. ***I hereby authorize the staff of VBPTW to disclose information related to my care to the following persons upon request ________________________ Relation: __________________.***

I hereby acknowledge that Virginia Beach Physical Therapy and Wellness, PLLC has the right to use my protected health information for the above governed approved applications.

Patient Signature:____________________________

Patient Name:______________________________ Date: ____________________________