Patient Information

Name: Last_____ First_____ Preferred _____ MI ___

Gender ☐ M ☐ F Age_____ DOB___/___/_____ Student: ☐ Yes: FT/ PT ☐ No

Marital Status: ☐ Married ☐ Single ☐ Other

(Optional) Gender Identity: ☐ M ☐ F Other _____ Pronouns: _____

Address_____City,State,Zip _____

Phone Numbers: Cell _____Home_____Work _____

Email _____Preferred Phone ☐ Home ☐ Work ☐ Cell

Would you like appointment reminders by email? ☐Yes ☐No

Referring Physician _____ Primary Care Physician_____

Billing Information

Responsible Party: Last_____First_____MI _____

Phone Numbers: Home _____ Work _____ Mobile _____

DOB ___ /___ /_____ Relationshipp to Patient_____

Address_____City, State,Zip _____

Is this Worker's Comp or an auto accident? ☐ YES ☐ NO Date of injury/accident ___ /___ /_____

Insurance Company _____ Case # _____

Case Manager Name _____ Phone _____ Fax _____

Employer _____ SS# _____ (needed to receive payment)

Employer Address _____ City, State, Zip _____

Insurance Information

Primary Insurance _____

Subscriber Name _____

Subscriber Date of Birth ___ /___ /_____

Relationship to Patient _____

Insured Policy ID # _____

Group Number _____

Effective Dates _____

Secondary Insurance _____

Subscriber Name _____

Subscriber Date of Birth ____ / ____ /_____

Relationship to Patient _____

Insured Policy ID # _____

Group Number _____

Effective Dates _____

Emergency Contact

Name: Last_____ First_____ Relationship to Patient _____

Address_____ City, State, Zip _____

Phone Numbers: Home _____ Work _____ Mobile _____

Release of Information

I authorize Callan-Harris Physical Therapy to provide my confidential health information to the following individuals:

Name: Last_____ First_____ Relationship to Patient _____

Name: Last_____ First_____ Relationship to Patient _____

Authorizations & Acknowledgements

☐ I hereby certify that the above information is complete and accurate according to the best of my knowledge and ability.

☐ I understand that the information provided above may be used and shared for the purposes of treatment, billing for services rendered, and conducting of administrative operations of Callan-Harris Physical Therapy per their **Notice of Privacy Practices** which I have had an opportunity to read, review, and receive. (They are available at the reception desk when requested)

☐ I give my consent to proceed with a therapy evaluation and corresponding treatment. I also give my consent that services may be observed and/or provided by a PT or PTA student under the supervision and instruction of a licensed physical therapist. Due to the nature of physical therapy and the physical exertion required to perform activities with increasing degrees of difficulty, I understand that there may be possible complications associated with my care such as an increase in my current level of pain, an aggravation of my existing injury, or very rarely, the development of a new injury. My signature below acts as a waiver of liability for treatment received at Callan-Harris Physical Therapy excepting acts of negligence.

Patient/Guardian Signature: _____ Date:_____

Patient Name (Print): _____ DOB ___ /___ /_____

Patient Medical Information

Patient Name:_____ Age: _____ Today's Date: ___ /___ /_____

Height: _____ Weight: _____

What is your reason for coming to Physical Therapy today? _____

_____

What are your goals and expectations for physical therapy? _____

_____

Current Injury, Surgery, or Pain

Date of Injury: _____ Date of Surgery: _____ Date Pain Started: _____

Referring Physician: _____ Last MD Visit: _____ Next MD Visit: _____

Is your injury related to any of the following?

☐ Work ☐ Car accident ☐ Surgery ☐ Lifting/Carrying ☐ Fall

☐ Slow onset ☐ Athletics ☐ Chronic/Reoccurring

Occupation: _____ Work Status: ☐ FT ☐ PT ☐ Unemployed

Diagnostics performed for this condition? ☐ X-ray ☐ MRI ☐ CT Scan ☐ EEG ☐ EMG ☐ Injections

If yes, date: _____

Have you received treatment for your condition before today? If yes, from whom: _____

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist

☐ Other: _____

Have you recently experienced any of the following:

☐ Dizziness/Lightheaded
☐ Fainting
☐ Unexplained weight loss
☐ Difficulty swallowing
☐ Changes in bowl or bladder
☐ Incontinence
☐ Muscle weakness
☐ Numbness/Tingling
☐ Are you pregnant, # wks_____

Allergies

Please list any allergies :

Medical History

Have you ever been diagnosed with any of the following?

- ☐ High/Low blood pressure
- ☐ Heart problems
- ☐ Stroke/CVA
- ☐ Pacemaker
- ☐ Blood clots/Circulation issue
- ☐ Diabetes: Type 1/Type 2
- ☐ Osteoporosis
- ☐ Arthritis: OA/RA
- ☐ Cancer
- ☐ Bladder/Urinary/Kidney Disease
- ☐ Lung Problems COPD/Emphysema
- ☐ Tobacco use: #_____/day
- ☐ Asthma
- ☐ Seizures
- ☐ Neurological disease: MS/Parkinson's
- ☐ Depression/Anxiety/Panic
- ☐ Back pain: Degenerative/Stenosis/Herniation
- ☐ Back injury
- ☐ Neck injury
- ☐ Chronic headaches
- ☐ Other injury
- ☐ Fracture _____
- ☐ TB/HIV/Hepatitis A, B, C
- ☐ Visual/Hearing Impaired
- ☐ Other condition: _____

Surgical History

- ☐ Joint Replacement(s) *please explain:*_____ *date:* _____
- ☐ Orthopedic Surgery *please explain:*_____ *date:* _____
- ☐ Heart Surgery *please explain:*_____ *date:* _____
- ☐ Fracture Repair *please explain:*_____ *date:* _____
- ☐ Spinal Surgery *please explain:*_____ *date:* _____
- ☐ Other Surgeries *please explain:*_____ *date:* _____

Please list your current medications:

☐ See attached list

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that it is important for my therapist to understand my medical history in order to create a comprehensive treatment plan. I certify to the best of my ability, the above information is complete and accurate.

Patient/Guardian Signature _____ Date _____

Patient Name _____ DOB ___ /___ /_____

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: Callan-Harris Physical Therapy, PC _1328 University Ave Rochester NY 14607-1622

Patient Name	Date of Birth	
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at www.RochesterRHIO.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at www.RochesterRHIO.org or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: 877-865-RHIO; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

Financial Policy

If your visit is related to an automobile or personal injury accident, please notify the front desk.

☐ I understand it is my responsibility to understand my health insurance benefits, verify necessary referrals/authorizations are on file, and pay subsequent out of pocket expenses. I request and authorize my health insurance carrier to pay Callan-Harris Physical Therapy for all charges related to services provided to me. I understand that I am entirely financially responsible to Callan-Harris Physical Therapy for all services rendered and agree to pay in full any amounts not paid by an insurance company or other third party payer in addition to all co-payments, deductibles, or co-insurance which are due at time of service. All other payments are due 30 days after time of service. Should my account go to collections, I agree to pay all attorneys fees, court costs, filing fees, and all other charges that may be assessed.

We ask that you pay any outstanding balance at your visits to keep your account up to date. There will be a $5 charge for any bills that need to be mailed.

☐ **I understand that not showing for scheduled appointments will delay my plan of care, and that if I cannot attend one of my scheduled appointments, I must give a minimum of 24-hour notice when canceling. Failure to do so will result in a $40 fee for a no show or a cancel.**

☐ Callan-Harris Physical Therapy verifies insurance coverage and obtains a summary of insurance benefits for company purposes only. Although we may provide you with a copy of the benefits we were quoted, you are ultimately responsible for understanding your benefits. When we obtain a quote, we are given the following disclaimer: *This is an estimate of benefits only and in no way guarantees coverage or payment of claims*. If you have questions regarding your coverage, please call your insurance company.

☐ I understand that should my insurance benefits limit my physical therapy to a specific number of visits per year/condition, monetary amount, or require a referral or pre-authorization, it is MY responsibility to keep track of those numbers and verify with the front desk that the appropriate documents are on file. If I happen to go over my benefit limitations or neglect to verify authorizations/referrals are on file, I will be responsible for the entire balance on the exceeding visits or amounts.

☐ I understand that regardless of insurance, I am responsible for the cost of all services rendered at Callan-Harris Physical Therapy. Should my insurance company pay my claims at a different rate than was quoted to Callan-Harris Physical Therapy and listed above, I will honor the actual assignment of benefits. If I am not satisfied with the actual assignment of benefits, it will be my responsibility to contact my insurance company.

☐ I understand it is my responsibility to know which insurance is my primary carrier and which is my secondary. I recognize that Callan-Harris Physical Therapy relies on the information I provide to obtain my benefits information. I verify that I have provided them with the correct info at the time of my visit. Should there be changes, I will notify the office immediately.

Patient/Legal Guardian Signature _____ Date _____

Patient Name (Print): _____ DOB ___ /___ /_____