Jaworski Physical Therapy, Inc.

Patient Medical History Form

Name:		SSN#		Phone:	
Address:		City:	State		Zip Code
Date of Birth	Sex ☐ M ☐ F	Employer:		Occupation:	
Cardholder (if different)		Relationship to cardholder			Phone:
Address:		City: State	State		Zip Code

Were you referred to this clinic by another medical provider? ☐ Yes ☐ No If yes: _____

Are you seeing anyone else for treatment of this same condition? ☐Yes ☐ No

Have you ever had this condition in the past? ☐ Yes ☐ No

Did you receive treatment at that time? ☐Yes ☐ No

Did that treatment help? ☐ Yes ☐ No

For Therapist Use Only

Past History: Please check if you have or ever had one of these conditions or problems.

☐ Cancer
☐ Heart Problems
☐ Circulation Problems
☐ High Blood Pressure
☐ Nervous System Disease
☐ Cardiac Pacemaker
☐ Metal implants (rods, pins etc)
☐ Joint Replacements
☐ Bone Fracture
☐ Back Problem
☐ Kidney Disease
☐ Stroke
☐ Muscular disease
☐ Lung Disease
☐ Arthritis
☐ Diabetes
☐ Hepatitis
☐ Epilepsy or Seizures
☐ Asthma
☐ Depression
☐ Neck Problem
☐ Other: _____

For Therapist Use Only

Are you or do you think you may be pregnant? ☐ Yes ☐ No

Please list any surgeries that you have had including date if known: _____

_____

Please list any prescription or non prescription medications that your are currently taking: _____

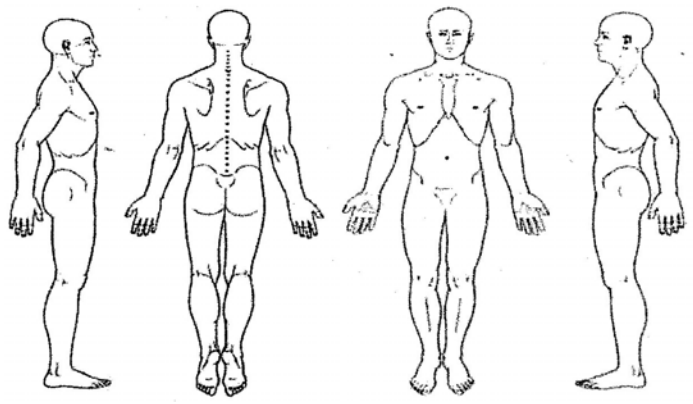
_____

Would you like to receive the services of a Social Worker ☐ Yes ☐No

Please briefly describe the problem(s) for which you are seeking treatment _____

_____

When did this problem start? _____



Please mark on the picture anyplace that you are having pain, tingling or numbness

What is your current pain level?:

0_____5_____10

No Pain Possible — Worst

Person to contact in case of an emergency: _____ Phone _____

Consent to Release

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Jaworski Physical Therapy, Inc. ("The Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use or disclosure. *By signing this Consent, I understand and acknowledge that I have reviewed the "Privacy Notice" which is attached before signing this Consent.*

General: I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said benefits. The assignment will remain in effect until revoked by me in writing.

Authorization for Treatment: I know that I am suffering from a condition(s) requiring physical/occupational/speech therapy. I hereby voluntarily consent to such treatment and procedures as prescribed by my physician and to be performed by employees of Jaworski Physical Therapy, Inc.

Permission to take Photograph: I hereby consent or deny Jaworski Physical Therapy, Inc. to take a photograph of me only for the purpose to use in my medical chart and will not be disclosed for any other reason without additional permission from me. I do so by checking yes or no below.

_____YES _____NO

Permission to take Photograph

_____ _____

Patient's signature — Signature other than patient (if patient is a minor)

_____ _____

Date — Relationship

_____ _____

Date — Witness

(rev 2/07)

Professional Services

Physical Therapy

Occupation Therapy

Hand Therapy

Speech Therapy

Pediatric Therapy

Aquatic Therapy

Pelvic Floor Rehab

Athletic Training

Social Service

JPT Jaworski

137 Winckles St., Elyria, OH 44035
Phone: 440-366-5993

1100 N. Abbe Rd., Elyria, OH 44035
Phone: 440-365-2211

6150 Emerald St.
N. Ridgeville, OH 44039
Ph: 440-327-1602

JPT Jaworski

Jaworski Physical Therapy, Inc.

Rehabilitation And Wellness Center

New Patient Information

Three Convenient Locations Serving Lorain and Surrounding Counties

www. JPTRehab.com

Welcome

Dear Patient,

We would like to welcome you to Jaworski Physical Therapy, Inc. and to thank you for selecting us to provide your therapy care. Our experienced and dedicated staff is committed to quality service and individualized attention.

Your initial evaluation will last approximately 1 to 1 1/2 hours. It will focus on the completion of a comprehensive evaluation and assessment of your condition. The data gathered will enable your therapist to provide a more individualized treatment plan and to communicate more effectively with your physician. After completion of your evaluation, a detailed report will be sent to your physician outlining our findings and plan of care.

Each additional visit will last anywhere from 30 - 45 minutes depending on your individual diagnosis and rehab program. We can provide you with our standard gowns or shorts, however if you would feel more comfortable in your own gym clothes, please feel free to wear them.

Prior to your initial visit, a member of our insurance office will contact your insurance company and verify your individual coverage. It is also recommended that you contact your insurance company to become familiar with your coverage for therapy. If by chance your insurance requires an authorization before initiating therapy, we will reschedule your initial visit until this authorization is received. At the time of your initial visit an explanation of your benefits will be given and you will be informed of any co-pays or deductibles required by you.

We have designed our office hours in hopes that they are most convenient for you. Our clinics have extened hours are on Monday, Wednesday and Thursday. In order to insure times that fit into your schedule we recommend that you keep your appointments scheduled two weeks in advance. Kindly provide 24 hours advance notice for any cancellations.

Please do not hesitate to contact us with any questions or concerns you may have. We look forward to seeing you!

Sincerely,

Jaworski Physical Therapy Staff

JPT Jaworski

137 Winckles St.
Elyria, OH 44035
Phone: 440-366-5993 Fax: 440-366-5313
www.JPTRehab.com

110 N. Abbe Road, Ste. C
Elyria, OH 44035

Phone: 440-365-2211
Fax: 440-365-2299

6150 Emerald St.
N. Ridgeville, OH 44039

Phone: 440-327-1602
Fax: 440-327-1656

Jaworski Physical Therapy, Inc.
137 Winckles Street
Elyria, Ohio 44035
440-366-5993

NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

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

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 42 CFR § 160.101 et seq. (the "Privacy Regulations"), Jaworski Physical Therapy, Inc. ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain. Should such terms change, we will mail a revised Notice to the mailing address most recently listed in your medical record.

Permitted Uses and Disclosures of Your Health Information

1. Uses and Disclosures with Patient Consent: Under the Privacy Regulations, we are permitted with your written consent, to use and disclose your health information for the following purposes:

    a. Treatment. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

b. Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record, which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

c. Health Care Operations. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. Uses and Disclosures With Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. Uses and Disclosures With Patient Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. Uses and Disclosures Without Patient Consent, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

a. Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.

b. Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

c. Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

d. Regulatory Agencies. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

e. Judicial and Administrative Proceedings. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, and warrant, discovery request or similar legal request.

f. Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.

g. Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

h. Research. Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. Threats to Health and Safety. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. Military/Veterans. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. Workers' Compensation. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. Marketing. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

m. Appointment Reminders. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our clinic.

n. Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. Uses and Disclosures to Business Associates. With the proper consent or authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity, which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request. If, however, we agree to the requested restriction, it is binding on us.

2. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. Right to Verbally Object. You have the right to verbally object to certain disclosures that are routinely made without any Consent or Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. Right to Seek an Amendment of Your Health Information. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. Right to an Accounting of Disclosure of Your Health information. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures to you based on your consent, authorization or other means permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to our compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. Right to Confidential Communications. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. Right to Revoke Your consent and/or Authorization. You have the right to revoke your consent or authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

8. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Jaworski Physical Therapy, Inc.

Liability / Car Accident

Date: _____/_____/_____ Patient Account #: _____

Accident Date: _____/_____/_____

Patient Name: _____Referred By: _____

Address: _____City: _____State: ____Zip: _____

Home Phone: _____ Work Phone: _____

Social Security #: _____-_____-_____ Birth date: _____/_____/_____

Responsible Auto Insurance Name:

_____

Address: _____City:_____State: _____Zip: _____

Adjuster: _____ Claim #: _____

If you have an attorney please complete the following:

Attorney Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____

Name of your Private Health Insurance Company:

_____

Address: _____City: _____State: _____Zip: ____

ID#: _____ Group#: _____

Who is the card holder? (circle one) Self Spouse Father Mother