Creekside Physical Therapy and Rehabilitation

PATIENT INFORMATION

Patient's Name: _____ Social Security #: _____

Age: _____ Sex: M/ F Date of Birth: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone (Hm): _____ Work: _____ Mobile: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Spouse's Name: _____

Spouse's Employer: _____ Phone #: _____

Primary Care Physician First/Last Name: _____ Phone #: _____

Whom May We Thank for Referring You to Our Office?: _____ Phone #: _____

PRIMARY MEDICAL INSURANCE: _____

Address: _____ Phone #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Social Security #: _____ Patient ID#: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

SECONDARY MEDICAL INSURANCE _____

Address: _____ Phone #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Social Security #: _____ Patient ID#: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claim to insure payment of services rendered on your behalf. I request that payment of authorized insurance or Medicare benefits be made to me or on my behalf to Westside Foot & Ankle Clinic, LLC (Jason R. Surratt, DPM or Thomas C. Melillo, DPM or Michael A. Gentile, DPM or Yama A. Dehqanzada, DPM) for any services furnished by that provider. I authorize any medical information about me be released to the insurance carrier or to Health Care Financing Administration and its Agents as needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

BILLING PROCEDURES:

I understand that I am ultimately responsible for payment on my account. A $25.00 Non-Sufficient Funds charge will be applied for a returned check. Westside Foot & Ankle Clinic, LLC has the right to request future services be paid in cash. Co-pays are due at time of service. Any co-pay not paid will be subject to a $5 processing fee. Unpaid balances over 120 days may be referred to an outside collections agency. If you have no insurance, payment is required at time of service. In divorce or custody situations, the person with full-time legal custody of the minor patient will be responsible for payment. If custody is shared, the parent with whom the child resides for school purposes will be responsible for payment. If another parent has insurance responsibilities, written authorization is needed, including legal signature and billing information.
I have read and understand the Westside Foot & Ankle Clinic, LLC account billing procedures.

Signature: Date:

HMO REFERRALS

I understand that in order for my insurance carrier to consider payment for this visit, a referral is required from my Primary Care Physician. I am seeking care from Westside Foot & Ankle Clinic, LLC (Jason R. Surratt, DPM or Thomas C. Melillo, DPM or Michael A. Gentile, DPM or Yama A. Dehqanzada, DPM), knowing that a referral has not been received from my Physician at the time of visit. I therefore understand that I may be financially responsible for part or all of the charges related to this or future visits, including Lab, X-rays, Treatments, and other Services. I understand that even with a physician referral, my insurance provider may not cover some provided services. I agree to pay for these services if they are not covered, either today or on future visits.

Signature: Date:

PLEASE FILL OUT THE FOLLOWING SECTIONS

REASON FOR TODAY'S VISIT:

Primary Concern: _____

Location of Problem: _____

Date of Onset (If Known): _____

Can You Describe Your Symptoms?: _____

_____

_____

Onset: Gradual/Sudden Duration: _____ D W M Y

Pain Assessment: Severity: None 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)

Pain Quality: Sharp Shooting Dull Aching Throbbing Burning Tingling

Timing of Pain: AM PM Constant Intermittent

[ ] During Activity [ ] After Activity [ ] At Rest

Does Anything Make it Feel Better?: _____

Does Anything Make if Feel Worse?:

_____

Have You Done Anything to Treat this Problem? (Describe): _____

_____

_____

Height: Weight: Shoe Size: Occupation:

Do You Have or Have You Ever Had:

Yes	No	CIRCLE those that apply & write in others
		Eye, Ear, Nose, Throat: (glaucoma, lens implants, dentures, loose teeth, dental caps or bridges, hearing aids, glasses/contacts, artificial eye)
		Heart Problems: (Chest pain, angina, heart attack, congestive heart failure, irregular heart beats, pacemaker)
		Vascular Problems: (high blood pressure, blood clots)
		Lung Problems: (asthma, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep apnea)
		Gastrointestinal Problems: (hepatitis, cirrhosis, ulcers, hiatal hernia, intestinal bleeding)
		Genitourinary Problems: (kidney disease/failure, dialysis, prostate problems, incontinence, OB/GYN, sexually transmitted disease, infections)
		Is There Any Possibility You Could Be Pregnant? Birth Control Y N LMP _____
		Musculoskeletal Problems: (back problems, broken bones neck/back/face, limited range of motion, arthritis, TMJ)
		Skin Problems: (rash, hives, bruise easily, open sores)
		Neurologic Problems: (stroke, seizures, paralysis, numbness, weakness, confusion, migraines)
		Mental Illness: (anxiety, depression, bipolar disorder)
		Diabetes: Diet Oral Med Insulin
		Other Endocrine Problems: (thyroid)
		Anemia/Unusual Bleeding:
		Cancer: Active Remission
		A Bad Reaction to Anesthesia? Describe:

Hospitalizations, Procedures, Illnesses, Surgeries (Last 10 Years)

Current Medications: (Include any Over-the-Counter or Herbal Meds):

Drug Allergies: _____

Do You Use:	Yes	No	How Often / Last Use
Tobacco			
Alcohol			
Illicit Drugs			

PATIENT / RESPONSIBLE PERSON SIGNATURE

PHYSICIAN ONLY

[ ] ROS Reviewed [ ] History Reviewed

DOB: _____ **PATIENT NAME**: _____ **INITIAL VISIT**: _____

Creekside Physical Therapy and Rehabilitation

(503) 245-5710

RECORDS RELEASE AUTHORIZATION

To:_____
(Name of Doctor releasing records, such as a primary care physician)

Patient's Name: _____
LAST FIRST MI

Patient's DOB: _____

I hereby authorize and request your office to release the following:

[ ] All Medical Records including X-Rays

[ ] Medical Records Only

[ ] X-Rays Only

[ ] Lab Test

[ ] Other: _____

To Be Faxed To: _____
Name of Medical Facility/Medical Office/Doctor/Insurance/Other

To Be Mailed To: _____
Name of Facility/ Street Number/ Suite Number/ City/ State/ Zip Code

To Be Picked Up: _____
Name of patient or relative picking up information to be hand carried to Westside Podiatry Clinic

Patient's Signature:_____ Date: _____

Please state relationship to the patient if not signed by patient: _____

Creekside Physical Therapy
Privacy Officer: JaLinda Lowry
(503) 245-2420
Effective Date: April 14, 2003

Notice of Privacy 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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Office at this practice.

Who Will Follow This Notice: Any health care professionally authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes, or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use And Disclose Medical Information About You: The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses and disclosures. Not every possible use or discloser in a category is listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: in treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses Or Disclosures That Can Be Made Without Consent Or Authorization:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses And Disclosures Of Protected Health Information Requiring Your Written Authorization: Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with our authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information:

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right To Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right To Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on this practice.

Right To Inspect And Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes, information complied for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Office at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right To Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request and amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information of which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right To An Accounting Of Non-Standard Disclosures: You have the right to request a list of the disclosure we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right To A Paper Copy Of This Notice: You have the right to a paper 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. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Office at this practice.

Changes To This Notice: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of this current Notice, with the effective date in the Upper right corner of the right page.

Creekside Physical Therapy and Rehabilitation

(503) 245-5710

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practices' Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

Please indicate below the name(s) of any person(s) you allow Creekside Physical Therapy to disclose personal/medical information to.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship