Hamburg Physical Therapy, P.C.

Patient Information

Last Name: _____ First Name: _____ MI: __

Address: _____ City:_____ State:__ Zip:_____

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Email: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Emergency Contact Information

Last Name: _____ First Name: _____

Relationship:_____ Home Phone: (____) ____-_____

Accident Information

Accident Type: Work Related ___ Auto Accident: ___ Other: (Describe) _____

Employer Information *(Only required with Workers Compensation claim)*

Company Name: _____ Phone: _____

Address: _____ City: _____

Address2: _____ State: _____ Zip: _____

State Accident occurred in: _____

Problem

Problem Description: _____ Date of Injury: _____

Referred By: _____ Last Physician Visit: _____

Primary Insurance

Insurance: _____ Deductible: _____ Subscriber Name: _____

ID: _____ Max Benefit: _____ Relationship: _____

Group # _____ Coinsurance: _____ Date of Birth: _____

Secondary Insurance

Insurance: _____ Deductible: _____ Subscriber Name: _____

ID: _____ Max Benefit: _____ Relationship: _____

Group # _____ Coinsurance: _____ Date of Birth: _____

Tertiary Insurance

Insurance: _____ Deductible: _____ Subscriber Name: _____

ID: _____ Max Benefit: _____ Relationship: _____

Group # _____ Coinsurance: _____ Date of Birth: _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. *(Enclosed and also online at www.hamburgpt.com)*
(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

Pain Diagram and Pain Rating

Name: _____ Date: _____

Please use the diagram below to indicate the symptoms you have experienced **over the past 24 hours**. Use the key to indicate the type of symptoms.

Please rate your **CURRENT** level of pain on the following scale, (check one).

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your **WORST** level of pain in the last 24 hours on the following scale, (check one).

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

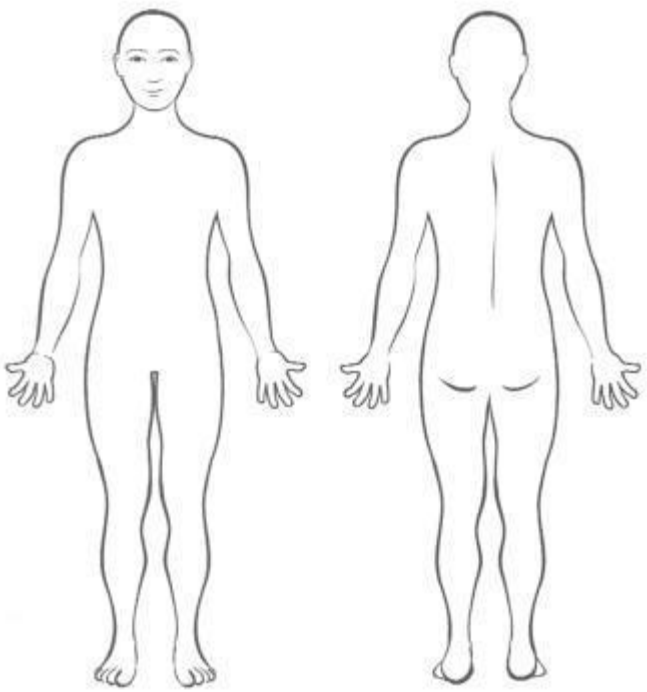
Please rate your **BEST** level of pain in the last 24 hours on the following scale, (check one).

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Mark Your Pain and Symptoms

Pins and Needles = 000000 Stabbing = //////

Burning = XXXXXX Deep Ache = zzzzzzz



Describe your symptoms by checking the appropriate boxes.				
	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

Medication List for ____

Date: ______________________________________

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other
		❒ As Needed ❒ Once Daily ❒ Twice Daily ❒ Three Times Daily ❒ Other	❒ Oral ❒ Sublingual ❒ Topical ❒ Subcutaneous injection ❒ Other

HAMBURG PHYSICAL THERAPY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH IN FORMATION IS IMPORTANT TO US.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of notice that is currently in effect.

The terms of this notice apply to all records containing your PHI (Personal Health Information) that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. *You may request a copy of our most current Notice at any time.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment** - Hamburg Physical Therapy may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. We may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. We may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment** - Hamburg Physical Therapy may use and disclose your PHI in order to pay for the services and items you may receive. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may also disclose your PHI to other health care providers and entities to assist in their health care operations.

3. **Health Care Operations** - Our practice may use and disclose your PHI to operate our business for our operations which include: internal administration, planning, quality improvement, peer review, evaluating performance of our staff to ensure that all of our patients receive quality care. We may be required by federal and New York State law to submit some protected health information about you to regulator agencies. We may also disclose your PHI for personnel review and learning purposes.

4. **Appointment Reminders** - Our practice may use and disclose your PHI to contact you and remind you of an appointment. If you do not wish us to contact you for appointment reminders you must notify us in writing.

5. **Treatment Alternatives** - We may use and disclose medical information to tell you about or recommend possible treatment alternatives or health related benefits that may interest you.

Uses or disclosures that Require Your Written Authorization

- **Worker's Compensation** - Upon your written authorization, we may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Lawsuits or Disputes** - If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to judicial subpoena, court order or administrative order as allowed by federal, state or local law. We may also release information when you have sent us a written request authorizing and consenting to the release of the information to specified attorneys.

Use or disclosure of your PHI in Certain Special Circumstances

Public Health Risks:

- Maintaining vital records, such as births and deaths.
- Notifying a person regarding potential exposure to a communicable disease.
- Notifying a person regarding a potential risk for spreading or contacting a disease or condition.
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they may be using has been recalled.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- To prevent or control disease, injury or disability.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

The Right to Inspect and Copy – You have the right to inspect and obtain a copy of your PHI that we maintain and have in our possession, including medical records and billing records. If you request copies, we will charge you a fee for the costs of copying, mailing, labor and supplies associated with your request. To inspect and copy your PHI, you must submit your request in writing. Under certain circumstances we have the right to deny your request to inspect and copy.

The Right to Amend Your PHI – If you feel that any PHI we have about you is not correct 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 by Hamburg Physical Therapy. To request an amendment, your request must be made in writing. Additionally, you must provide a reason that supports your request. We have the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request.

The Right to an Accounting of Disclosures – An accounting of disclosures is a list of the disclosures we have made, if any, of your PHI. You have the right to request an accounting of disclosures. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operation as described in this notice. It excludes disclosures made to you or those made for notification purposes. Your request must be made in writing and state a time period that cannot be longer than six years and cannot include any dates before April 13, 2003. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

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. You also have the right to request a limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Right to Confident Communications – You have the right to request to receive communications from us about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We will accommodate all reasonable requests made in writing. We must accommodate your request if it is reasonable.

Right to a Paper Copy of This Notice – You have the right to a paper copy of this notice. You may ask us to give 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.