FIRST REHABILITATION

Initals_____

West Palm Beach Office
1920 Palm Beach Lakes Blvd.,Ste. 110
West Palm Beach, FL 33409

Patient Registration Form

- **Patient Information**

_____ Sex _____ male _____ female
patient name (first, middle initial, last)

_____ _____ _____ _____
patient's address city state zip code

_____ _____ _____
telephone S.S. # cell phone

_____ / _____ / _____ _____ ____ single ____ married ____ separated ____ divorced ___ widowed
date of birth age marital status

_____ _____ _____ _____
spouse's name work telephone emergency contact other than spouse telephone

_____ _____ _____
referring doctor telephone whom may we thank for this referral

_____ _____
employer's name telephone

_____ _____ _____ _____
employer's address city state zip code

_____
primary insurance company

_____
secondary insurance company

_____
E-mail Address

- **Cause of Injury**

_____ / _____ / _____ _____yes _____ no _____ yes _____ no
date of accident automobile accident injured on job

_____ _____
attorney name telephone

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made with our office.

Insurance Authorization and Assignment:
I request that payment of authorized insurance company benefits be made on my behalf to the provider of any services furnished to me by that therapist. I authorize any holder of medical information about me to release to any insurance company or billing company and its agents. I also authorize FIRST Rehab to sign any payments made out to me for such services. Any information needed to determine these benefits or the benefits payable to related services. I understand my signature request payment be made and releases information to insurer or agency.

Consent For Treatment:
I hereby consent to be evaluated and treated for my injury or condition at FIRST Rehab, under the guidance and supervision of the licensed physical therapist.

Patient's signature: _____ dated: _____

MEDICAL HISTORY FORM

name: _____ date: _____ / _____ / _____

Past History **(Have You Ever Had?)**	***check if yes***
Rheumatic fever/heart murmur	
High blood Pressure	
Any Heart Trouble	
Disease of Arteries	
Varicose Veins	
Lung Disease	
Injuries to Back	
Epilepsy	
Diabetes	
Gout	
Operations	

Family History	***check if yes***
Have any one in your immediate family or grandparents had ?	
Heart Attacks	
High Blood Pressure	
High Cholesterol	
Stroke	
Diabetes	
Congenital heart Disease	
Heart Operations	
Early Death	
Other:	

Present Symptoms **(Have You Recently Had ?)**	
Chest Pain/Discomfort	
Shortness of Breath	
Heart Palpitations	
Cough on exertion	
Coughing of Blood	
Back Pain	
Arthritis/Swollen, Stiff, Painful Joints	
Orthopedic Problems Explain:	
Do You Awaken at Night to Urinate? Explain:	

Medications (That you are taking or prescribed to you)
Digitalis Preparations
Anti-Arrythmais (Qunidine, Procaine, Amides)
Diuretics & Electrolytes
Tranquilizers or Sedatives
Metabolics - Insulin, Thyroid
Others medications:
Allergies include -
Please List All The Food and Medical Allergies

Risk Factors

If you Smoke Please Circle Which Applies.	Do Your Engage in Physical Activities ?
Cigarettes Cigar Pipe	What ?
How Much Per Day ? How Many Years ?	How Often ?
What Is Your Weight Now ?	How Much Time a day Do You Exercise (Please Circle One)
Is Your Occupation (Please Circle One) Sedentary Active Inactive Heavy Work	None 15-30min. 30-45min. 45-60min. 60-75min. 75-90min.

PACEMAKER *(circle one)* **YES / NO**

FIRST REHABILITATION

Florida Institute of Rehabilitation & Sports Training

Acknowledgement of Receipt of Notice of Privacy Practices

FIRST Rehab reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for FIRST Rehab.

_____

Name – Print or type

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship to patient

FIRST
REHABILITATION

Florida Institute of Rehabilitation & Sports Training

Notice of Privacy Practices

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of any testing in physical therapy will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Options: Your health information may be used as necessary to support the day-to-day activities and management of FIRST Rehab. For example, information on the service you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support governmental audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information: Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights:

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.

FIRST Rehab Duties:
We are required by law to maintain the privacy of your protected information and to provide you with this notice of privacy practices that are outlined in this notice.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information:
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. We may obtain a form to request access to your records by contacting the Receptionist or the Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to:

Barbara Harden
FIRST Rehab
1920 Palm Beach Lakes Blvd, Suite 110
West Palm Beach, FL 33409
561-688-7911

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person:
The name and address of the person you may contact for further information concerning our privacy practices is:

Barbara Harden
FIRST Rehab
1920 Palm Beach Lakes Blvd, Suite 110
West Palm Beach, FL 33409
561-688-7911

Effective Date:
This notice is effective on or after April 14,2003.