PHYSICAL THERAPY PATIENT MEDICAL HISTORY FORM

NAME:_____ SEX:_____ MARITAL STATUS:_____ AGE:_____

ADDRESS:_____ CITY:_____ STATE/ZIP:_____

PHONE:_____ DATE OF BIRTH:_____

EMPLOYER:_____ PHONE:_____

OCCUPATION:_____ REFERRING DOCTOR:_____

MEDICAL INFORMATION

Before you saw the doctor, when did your MOST RECENT injury occur?

Month_____ Date_____ Year_____

Have you had therapy before? If yes, explain:_____ YES___ NO___

Do you have a history of heart trouble?_____ YES___ NO___

Do you have a pacemaker?_____ YES___ NO___

Do you have a history of circulatory problems?_____ YES___ NO___

(i.e. thrombosis, clots, increased blood pressure, etc.)

Do you have any metal implants?_____ YES___ NO___

(i.e. pins, shrapnel, etc.)

Do you have diabetes?_____ YES___ NO___

Do you have a history of cancer? If yes, explain:_____ YES___ NO___

Are you pregnant?_____ YES___ NO___

Do you have infectious diseases or a history of such?_____ YES___ NO___

If yes, explain:_____

Please list any surgeries, including dates:_____

_____

What medications are you currently taking?_____

Is there any additional information you feel would be beneficial for the therapy department to be aware of?

(i.e. tendency to faint, dizziness, seizures, etc.) If yes, explain:_____

_____

VOCATIONAL INFORMATION

Is your injury being affected by stress or other factors?_____ YES___ NO___

Has your injury resulted in financial or job difficulties?_____ YES___ NO___

If yes, would you like to learn skills to help you cope with the difficulties?_____ YES___ NO___

Are you currently receiving vocational rehabilitation or other counseling services?_____ YES___ NO___

PATIENT SIGNATURE:_____ DATE:_____

THERAPIST SIGNATURE:_____ DATE:_____

WELLNESS PHYSICAL THERAPY

AUTHORIZATION FOR TREATMENT

I HEREBY CONSENT TO AND AUTHORIZE WELLNESS PHYSICAL THERAPY CENTER TO ADMINISTER TREATMENT TO ME. I UNDERSTAND THAT I WILL BE FULLY INFORMED AS TO THE NATURE OF THE TREATMENT TO BE PERFORMED OR ADMINISTERED BY WELLNESS PHYSICAL THERAPY CENTER. I ACKNOWLEDGE THAT HERE MAY BE ADDITIONAL PROCEDURES THAT ARE CONSIDERED NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID TREATMENT AND CONSENT TO SUCH PROCEDURES AFTER EXPLANATION OF THEIR NATURE.

I FURTHER ACKNOWLEDGE THAT RESULTS ARE NOT GUARANTEED. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT.

_____ _____

SIGNATURE DATE

IF THE PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR_____AGE OF PATIENT_____

PATIENT IS UNABLE TO SIGN BECAUSE:_____

_____

PERSON WHO IS AUTHORIZED TO FOR PATIENT:

_____ _____

NAME RELATIONSHIP

ADDRESS OF PERSON SIGNING:

_____ _____

STREET CITY/STATE/ZIP CODE

_____

PHONE NUMBER

WITNESS:_____DATE:_____

WELLNESS PHYSICAL THERAPY CENTER

Mark J. Brennan. M.D.
Director
(586) 263-0820
Physical Therapy
(586) 263-0820 ext. 501

46350 Garfield Rd.
Clinton Twp., MI 48038

SCHEDULING POLICY AND PATIENT RESPONSIBILITIES

Wellness Physical Therapy Center thanks you for allowing us to help you with your rehabilitation. Be assured that your Physical Therapy program will be individualized to suit your special needs.

For a successful Physical Therapy experience the following is recommended:

- Attendance is crucial for optimal recovery. Each session builds on the previous one. Please attend all scheduled appointments without interruption.
- Complete required home exercise programs prescribed to insure a stable outcome in a timely manner.

In order to provide you with the best possible physical therapy *please arrive on time.* Late arrivals, cancellations, or simply not showing will affect all patient care. If you are more than 15 minutes late you may be rescheduled, thus jeopardizing a successful rehabilitation. We also understand that circumstances arise beyond control, please notify our office prior to your scheduled appointment to cancel and reschedule as soon as possible.

Failing to show or canceling any two consecutive physical therapy appointments will result in an immediate discharge from Wellness Physical Therapy Center. You will be referred back to your physician/family practitioner for further treatment and medications.

We at Wellness Physical Therapy Center take pride in our facility and will work hard to help you with a successful and favorable recovery.

Wellness Physical Therapy Center

I have read and understand the above policies as stated above.

_____ _____

PATIENT SIGNATURE DATE

ACCT #_____

WELLNESS PHYSICAL THERAPY

Each time you are seen by a medical professional, a written report is generated detailing your visit and treatment recommendations. We need your signed authorization to release medical information. Please complete the information below,

1. Who referred you to our office? Please note, if this area is completed, a written report MUST be sent.
   NAME_____
   ADDRESS_____
   _____
   PHONE NUMBER_____

2. Do you have a primary care (family) physician? Do you want our report sent? _____
   NAME_____
   ADDRESS_____
   _____
   PHONE NUMBER_____

3. Can we speak to family members/other individuals regarding your medical condition?
   YES_____ NO_____
   NAME_____RELATIONSHIP_____
   NAME_____RELATIONSHIP_____

4. By initialing here, you do NOT want medical information release to anyone _____

   (Please note: By law, we must send our reports to Workers Compensation or Auto insurance carriers if your care is related to a work or auto injury.)

   This authorization will stay in effect until revoked by you.

   PRINT NAME_____DATE_____
   SIGNATURE_____DATE_____
   WITNESS_____DATE_____

Wellness Physical Therapy Center
Patient's Right to Privacy

This notice describes how medical information about you may be disclosed and how you obtain access to the information. Please review it carefully. It is the right of this office to change this policy at any time as long as the changes are in accordance with applicable laws. If you receive this notice via website or by email, you are also entitled to receive this notice in written form from our office.

Healthcare Privacy
Each time you visit a hospital, physician or other healthcare provider, a written electronic record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. Protecting your privacy is very important to us. All of our patients have the right to considerate and respectful care.

Privacy Practices for Protected Health Information
The provision of high-quality healthcare requires the exchange of personal, often sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patient's ability to trust the information shared will be protected and kept confidential.

Consent Agreement
Providing "consent" allows for the use and disclosure of protected health information only for treatment, payment, and healthcare operations.
As part of your healthcare, we originate and maintain health records describing your health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

This information is a Basis For:

- Planning for future care or treatment.
- A means of communication among many health professionals who contribute to your care.
- A source of information for applying your diagnosis and medical information to your bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner in the facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of our information
- Obtain a paper copy of this notice upon request.
- Inspect a copy of your health record.
- Request to amend your health record.
- Obtain an accounting of disclosures.
- Request communication of your health information by alternative locations.
- Revoke your authorization to use or disclose health information except to the extent action has already been taken.
- Receive notification if ever there is a breach of unsecured public health information.

You Have the Right to:

- Take part in decisions about your care. Before agreeing to any treatment, your doctor will tell you about your plan of care in terms you can understand.
- Refuse further medical care. If you make this decision, it is important that you understand the risks and how it can affect your health. If you refuse care, you become responsible for your future health outcome. If you and your doctor can not agree about your care, which meets ethical and professional standards, you may be asked to seek treatment elsewhere.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE HEALTHCARE INFORMATION DISCLOSURE

Wellness Physical Therapy Center

By signing below, I acknowledge that I have received a notice of the privacy practices of The Neurosurgery Group, and Wellness Physical Therapy Center.

I consent (the above named organizations) to disclose and receive pharmacy clearinghouse healthcare information. This request is effective until revoked by the beneficiary.

The Neurosurgery Group, P.C. and Wellness Physical Therapy Center have consent through routine use and disclosure of health records whether communicated electronically, on paper, or orally.

_____ _____

Printed Name (Patient or Authorized Representative) Date

_____ _____

Signature (Patient or Authorized Representative) Date

_____ _____

Witness (Staff Member) Date

D.B.A. of the NSG