PATIENT CLINICAL INFORMATION

Please complete ALL Questions. Use N/A if not applicable to you

Today's Date: ____/____/____ Previous Patient? Y N

Referring Physician: _____ Next Dr. Appointment: _____

Name _____ Birth Date _____ Male ___ Female ___

Social Security Number _____ - _____ - _____

Address _____

City _____ State _____ Zip _____

2nd Address _____

City _____ State _____ Zip _____

Home Phone _____Work Phone _____

Cell Phone _____

Email Address: _____

Single _____ Married _____ Widowed _____ Student _____ Child _____

Primary Insurance company name: _____

Secondary Insurance company name: _____

Person responsible for account _____

When did this problem start/Date of Injury _____

Is this a work related problem? Yes _____ No _____

Is current therapy required for an auto or other accident? Yes _____ No _____ if yes, circle: auto or other

If yes to above, have you retained an attorney? Yes _____ No _____

Attorney Name: _____ Phone #: _____

In case of emergency please notify: _____ Relationship: _____

Phone: _____

Do you wish us to file your insurance for you? Yes _____ No _____

How did you hear about us? _____

_____ ____/____/2010_____

Signature (Patient or Responsible Party) Date

Personal History

1. Currently taking medications? Yes / No

   Please list ,meds _____

2. Surgery – past 5 years? Yes / No

   Please list _____

3. Fractures – past 5 years Yes / No

   Please list _____

4. Physical Therapy- past 5 years? Yes / No Date: _____

   Condition(s) requiring treatment _____

   Occupational Therapy? Yes / No Date: _____

   Condition(s) requiring treatment _____

   Speech Therapy? Yes / No Date: _____

   Condition(s) requiring treatment _____

5. Have you had Home Health in the last 30 days? Yes / No

   If yes, what was the last day they visited your home: _____

   Name of facility _____

6. Do you have a blood pressure problem? Yes / No How long? _____

7. Do you have Diabetes? Yes / No How long? _____

8. Do you have heart problems? Yes / No Type/Symptoms _____

   Do you have a pacemaker? Yes / No

9. Other health problems? Yes / No Please list: _____

10. Any other problems or conditions that may affect your present treatment?

    Please explain: _____

11. What are your goals for therapy? _____

Signature: _____ Date:_____

P1-2000 Consent to Use and Disclosure of Protected Health Information

***Use* and Disclosure *of Your P*rotected health Information**

Your protected health information will be used by Greene Rehab Services or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

***Notice* of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your protected health Information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Greene Rehab Services may or may not agree to restrict the use or disclosure of your protected health information.

If Greene Rehab Services agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent **in writing.** Any use or disclosure that has already occurred prior to the date, on which your revocation of consent is received, will not be affected.

Reservation of Right to Change Privacy Practices

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

Signature

I have reviewed this consent form and give my permission to Greene Rehab Services to use and disclose my health information in accordance with it.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

PF-3000 **Standard Authorization of Use and Disclosure of Protected Health Information**

Information to Be Used or Disclosed

The information covered by this authorization includes:

Greene Rehab- Medical Records
Billing Information
Specifics-evaluations, notes, discharge, etc.

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by**:**

Greene Rehab Services- Personnel
(Name of person/organization)

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to**:**

Spouse or Family member: _____
Referring Dr: _____
Primary Dr: _____

Expiration Date of Authorization

This authorization is effective through ___/____/_____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **Greene Rehab Services** You should contact:
Chris Greene, Administrator to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient