Journey Physical Therapy, LLC

MEDICAL HISTORY/SCREENING FORM

To be completed by the patient:

Patient Name: _____ Spoken Language: _____
Emergency Contact: _____ Telephone #: _____
Family physician/internist: _____ Telephone #: _____
Religious/Cultural Needs: NO YES Please Explain: _____
Special Learning Needs: NO YES Please Explain: _____

Date of Injury: _____

Why are you here?_____

Medical Information

	YES	NO		YES	NO
Hypertension (High blood pressure)	Y	N	Alzheimer's	Y	N
Hypotension (low blood pressure)	Y	N	Shortness of Breath	Y	N
Pacemaker	Y	N	Chest Pain / Angina / Heart Attack	Y	N
Emphysema/Asthma	Y	N	Urinary Urgency/ Incontinence	Y	N
Bleeding/Bruising (recent history)	Y	N	Are you Pregnant?	Y	N
History of Diabetes:	Y	N	Have you had/have a Stroke	Y	N
Hypoglycemia	Y	N	Brain Injury	Y	N
Cancer / Tumors/ Growths	Y	N	Multiple Sclerosis	Y	N
Active seizure disorder	Y	N	Spinal Cord Injury	Y	N
Osteoporosis	Y	N	History of Pressure Sores	Y	N
Osteoarthritis	Y	N			
Rheumatoid Arthritis	Y	N	Other_____		
Swelling of Extremities	Y	N	**Are you in Pain?**	Y	N
Fractures:	Y	N	Location of Pain?_____		
DATE: AREA:			_____		
DATE: AREA:					
Artificial Joints:	Y	N	**If you answered yes to any of the above:**		
Light-headedness / Dizziness	Y	N	Are you under the care of an MD for these		
Anxiety / Panic Attacks (recent)	Y	N	conditions?	Y	N
Depression (recent)	Y	N			

Allergies: _____

Surgery(s) within the last 3 months – Include Dates: _____

What are your treatment goals? _____

_____

FALL RISK ASSESSMENT:

Have you fallen within the last year? If so, how many times? _____	YES	NO
Have any of these falls resulted in an injury within the last year?	YES	NO
Are you afraid of falling?	YES	NO
Have you recently felt unsteady on your feet or in your wheelchair?	YES	NO
Do you experience dizziness or vertigo?	YES	NO
Do you have vision problems that are not corrected by glasses?	YES	NO
Do you use sedatives that affect your level of alertness during the day?	YES	NO
Do you have memory / cognitive difficulties?	YES	NO
Do you have a lower extremity disability that affects walking?	YES	NO

(As per CMS Fall Screening Criteria: Patient is considered a fall risk if patient has fallen two or more times in the past year OR if patient has fallen one time with resulting injury in the past year)

NUTRITION SCREENING:

Unexplained weight loss? (>5% in last 30 days)	YES	NO
Recent loss of appetite/aversion to food?	YES	NO
Do you have difficulty swallowing?	YES	NO
Decrease in food intake? (<50% for 3 days or more)	YES	NO
Are you under the care of a MD for these conditions?	YES	NO

CURRENT MEDICATION: (List below)

_____

_____

_____

_____

Are all meds prescribed by a physician?	YES	NO

PATIENT SIGNATURE:_____**DATE**:_____**TIME**:_____

Relationship if other than patient / parent / guardian if minor : _____

This information will be used as a guide to your treatment plan.
If you need any medical follow-up, please contact your physician.

To be completed by evaluating Therapist:

Patient has been identified as a fall risk:	yes	no
Patient has been identified as a nutrition risk:	yes	no

Therapist Signature:_____**Date:**_____**Time:**_____

(Therapist has reviewed medical history form with patient)

Patient Authorization Record

Initial here	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by New Jersey Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Journey Physical Therapy, LLC may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Journey Physical Therapy, LLC services rendered. ➢ I agree that Journey Physical Therapy, LLC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read “Notice of Privacy Practices” mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Journey Physical Therapy, LLC for services rendered.
	Patient Agreement ➢ I agree to pay Journey Physical Therapy, LLC charges for services rendered to me during my course of treatment. ➢ If I do not pay for charges that are my responsibility, I agree to pay Journey Physical Therapy, LLC collections costs including attorney and court fees.

_____

Patient signature Date

_____

Printed patient name Witness Signature Date

_____

Signature of Legal Representative/POA

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address law enforcement and other government requests

We can use or share health information about you:

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.