



# Fairplay Therapy Center

## PATIENT INFORMATION

Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Date \_\_\_\_\_  
 Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Sec. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Drivers License# \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Numbers \_\_\_\_\_  
 Email Addy (optional) \_\_\_\_\_  
 Employer \_\_\_\_\_ Ph: \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Emergency Contact Person \_\_\_\_\_ Ph: \_\_\_\_\_

## GENERAL INFORMATION

Referring Doctor \_\_\_\_\_ Ph: \_\_\_\_\_  
 Primary Doctor \_\_\_\_\_ Ph: \_\_\_\_\_  
 Was there an Accident? Y / N Auto \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_ Was there a Surgery? Y / N  
 Description of Problem \_\_\_\_\_  
 How long? \_\_\_\_\_ Have you had this or similar issues before? \_\_\_\_\_  
 What aggravates your condition? \_\_\_\_\_  
 What improves your condition? \_\_\_\_\_  
 Is this condition becoming progressively worse? (circle) Yes No Constant Comes & goes  
 This condition interferes with: (circle all that apply) Work Sleep Daily routine Other \_\_\_\_\_  
 List previous diagnoses/treatments you have received for this condition \_\_\_\_\_  
 \_\_\_\_\_

## INSURANCE INFORMATION

Policy Holders Name (if other than the Patient) \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_ Is there Secondary Insurance? Y / N  
**We will need a copy of your insurance card(s)**

### Notice of Privacy Practices/Medical Release of Information

I authorize the release of any medical information necessary to process this claim. I acknowledge that I have received a copy of the privacy practices.  
 Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## ASSIGNMENT OF BENEFITS AND CONSENT FOR TREATMENT

I hereby assign payment directly to Sacred Living Inc. dba Fairplay Therapy Center. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I hereby give my consent to Fairplay Therapy Center, to provide services to myself and/or family.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**I understand insurance co-pays are expected at time of service. (Please Initial) \_\_\_\_\_**

**Missed Appointments:** Unless cancelled at least 24 hours in advance, we may charge for missed appointments. Please help us serve you better by keeping scheduled appointments. (Please Initial) \_\_\_\_\_



# Fairplay Therapy Center

## HEALTH HISTORY

Please list any medications you take – both prescription and over-the-counter medications: \_\_\_\_\_

Please list any serious injuries you have had in the last 10 years:

	<u>Description</u>	<u>Date</u>
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other	_____	_____

Women: Are you pregnant? Yes/No    If so, how far along? \_\_\_\_\_    Nursing? Yes/No

## MEDICAL CONDITIONS

Circle “Y”(Yes) or “N”(No) for each medical condition you have had in the past or currently have:

Y/N Heart Attack/Stroke	Y/N Arthritis	Y/N Ringing in ears	Y/N Ulcer/Colitis
Y/N Congenital Heart Defects	Y/N Frequent Neck Pain	Y/N Freq Headaches	Y/N Gout
Y/N Alcohol/Drug Abuse	Y/N Jaw Pain	Y/N Diabetes/TB	Y/N Numbness
Y/N Fainting/Seizures	Y/N Wrist Pain	Y/N Dizziness	Where? _____
Y/N Shingles	Y/N Shoulder Pain	Y/N Emphysema	Y/N Tingling
Y/N Psychiatric Issues	Y/N Arm Pain	Y/N Kidney Problems	Where? _____
Y/N Difficulty Breathing	Y/N Leg Pain	Y/N Artificial bones/joints	Y/N Muscle/Spasms
Y/N Hepatitis	Y/N Lower Back Pain	Y/N Cancer	Where? _____
Y/N Anemia	Y/N Frequent Earaches	Y/N HIV Positive/Aids	

## PERSONAL HABITS

Do you drink alcohol?    Y/N    If so, how much? \_\_\_\_\_

Do you drink coffee?    Y/N    If so, how much? \_\_\_\_\_

Do you smoke?    Y/N    If so, how many? \_\_\_\_\_

Do you exercise?    Y/N    If so, how much? \_\_\_\_\_

How many hours of sleep do you regularly get each night? \_\_\_\_\_

Is your appetite regularly:    Poor?    Typical?    Excessive?

Do you have any known allergies to food, medications or other substances?    Yes/No    If “Yes”, please list:

\_\_\_\_\_

\_\_\_\_\_

## AUTHORIZATON

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the physical therapist to help determine appropriate and healthful physical therapy treatment. If there is any change in my medical status, I will inform the physical therapist.

I authorize Fairplay Therapy Center to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: \_\_\_\_\_    Today’s Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_    Date of Birth: \_\_\_\_\_

## Protecting Your Confidential Health Information is Important to Us

### 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.

### Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

### So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

## How your HEALTH INFORMATION may be used

### To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

### In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

### Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

## For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

## Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

## To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

## Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

## Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

## Patient Acknowledgment

Patient Name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

\_\_\_\_\_  
Patient Signature  
Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

## Restrictions

*You have the right* to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

## Confidential Communications

*You have the right* to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

## Inspect and Copy Your Health Information

*You have the right* to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

## Amend Your Health Information

*You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

## Documentation of Health Information

*You have the right* to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

## Request a Paper Copy of this Notice

*You have the right* to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

*You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.