Trumble Physical Therapy
Medical History

Name:_____ **Date:**_____

What is your Major Complaint?_____
Symptoms you are Experiencing:_____
Is your pain getting better or worse?_____ Have you had this pain before? [] Yes [] No
Current Duration of Pain: [] Intermittent []Constant []With Certain Activities:_____
Current Level of Pain: [] Mild [] Moderate []Severe [] Excruciating
Please, list any additional information that would assist us in providing care to you:_____

History:

Current Exercise Frequency:_____ Types of Exercise:_____
Are you currently pregnant? []Yes []No If pregnant, how many weeks?_____
Current Medications:_____
[] Pain Medication:_____ [] Birth Control:_____
[] Muscle Relaxers:_____ [] Anti-Inflammatories:_____
Any Surgical History with Relation to current Pain?_____
Any Allergies? []Yes [] No If yes, explain:_____

Do You Have Any of the Following Today? (Check All that Apply)

[]Asthma, Emphysema []AIDS,HIV,STD []Anemia, Blood Clots, Circulation Issues
[]Cancer,Radiation,Chemotherapy []Endometriosis []Fibroids/Ovarian Cysts
[]Constipation []Bowel/Bladder Weakness []History of UTI's
[]High/Low Blood Pressure []Heart Attack/ Stroke []Uncomfortable Intercourse
[]Menopause–Date Began:_____ []Leaking Urine (when): _____
[]Musculoskeletal Problems:_____

Have You had any Diagnostic, Medical, or Rehabilitative Services in the Past Year for this Issue?

[] Chiropractor_____ [] Massage Therapy_____ []Occupational Therapy_____
[] Physical Therapy: If yes, how many visits:_____ []MRI/ CT/ XRAYS_____

Mark Areas of Discomfort:

By signing below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Signature:_____ Date:_____

Trumble Physical Therapy

840 HANSHAW ROAD ITHACA, NY 14850

PATIENT INFORMATION

Name: Today's Date:

Is this your legal name?	If not, what is your legal name?	Preferred Name:	Date of Birth	Age:
◯ Yes ◯ No				

Billing Address: (P.O Box, Street, City, State, Zip)

Home Phone:	Cell Phone:	Email:
Primary Care Physician:	Referring Physician:	Appointment reminders via: __Voicemail __Email __Text

How did you hear about us?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:	ID#:	Subscriber:	Relationship to you:
		Subscriber DOB:	
Secondary Insurance:	ID#:	Subscriber:	Relationship to you:
		Subscriber DOB:	

Address (If different from above):

*****Co-Payments are due at the time of service along with any payments towards deductibles and Co-Insurance if applicable.

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home/Cell phone:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Trumble Physical Therapy. I understand that I am financially responsible for any balance; including supplies or equipment not covered by my insurance as well as any finance charges or collection fees. I also authorize Trumble Physical Therapy or my insurance company to release any information required to process my claims and communicate with each other.

**If for any reason you are unable to attend your physical therapy appointment, if possible, please provide us with at least 24 hrs. notice. Thank you.

Patient/Guardian signature Date

Trumble Physical Therapy
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Why you're receiving this Notice:
We are required to maintain the privacy of your protected health information (PHI) and other non-public, personal information (collectively, "Information"). We are providing you this Notice of Privacy Practices, as required by law, to inform you about our privacy principals and your rights concerning your Information.

This Notice takes effect January 1, 2018, and we will follow these terms while it is in effect. We may revise this Notice at any time and apply those changes to all Information we maintain (including Information previously created or received).

What you need to know:
PHI is health information that identifies you or could be used to identify you that was created or received by a health care provider, a health plan, etc. and relates to:

(1) Your past, present, or future physical condition
(2) Providing your health care; or
(3) The past, present, or future payment for providing your health care.

Our Privacy Principles and Procedures
The privacy and security of your Information is very important to us and we take precautions to protect it. Information in oral, written, and electronic form is protected by establishing and enforcing security and privacy policies and procedures, providing all of our employees with the knowledge of the appropriate safeguards to protect and prevent unauthorized access to your information.

Information We May Collect and Share with Others
We collect your information as necessary to provide you with health insurance products and services- for example

(1) Information you provide on applications or in person, by phone, email, or through our website which may include: names, addresses, dates of birth, etc.

How We May Use and Disclose Your Information

- **Treatment-** Purposes to your health care providers so they can administer appropriate care.
- **Payment-** to coordinate benefits, determine medical necessity, or issue explanations of benefits to the subscriber of your health plan or insurance policy.
- **Health Care Operations-** for medical review, legal services, auditing, customer service, resolutions of grievances, or other purposes. These are all subject to HIPPA Privacy Rules: quality assessment, improvement activities, fraud, abuse and compliance.

Disclosures to Others Involved in Your Direct Care
Subject to certain criteria and requirements, we may also use and disclose your Information:

- **To your family-** or other individual you identify as your health care representative or helps with payment for your health care. The person requesting your Information must be listed on your Patient Form as an Emergency Contact and allowed to receive information from us. They must accurately verify your name and date of birth and any other information requested by Trumble Physical Therapy. You may add or restrict this kind of disclosure by notifying us in writing.
- **Right to Authorize Individuals to act on your behalf-** with respect to your information, you must identify your authorized representative on a HIPPA Compliant Form and explain what type or all information they may receive.
- **You have the right to Revoke an Authorization-** except for actions already taken, the new date and revocation will take effect immediately as long as it is signed on a HIPPA Compliant Form.
- **You have the right to receive a paper copy of this Notice-** or you may decline to receive a paper copy and just acknowledge its contents.

Signed:_____ **Date:**_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____