REHABILITATION SERVICES OF TIFTON, INC.

PATIENT INFORMATION

PLEASE PRINT NEATLY IN INK

CHART #_____ DATE_____

☐ NEW ☐ RESTART ☐ RST ☐ LYMPH THERAPIST_____

PATIENT'S NAME (Last, First MI):_____

ADDRESS:_____ **CITY, ST:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____

SSN:_____ **DATE OF BIRTH:**_____ **AGE:**_____

GENDER: ☐ Male ☐ Female

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

STUDENT: ☐ No ☐ Part time ☐ Full time

Name of school_____

EMPLOYMENT STATUS: ☐ Employed ☐ Disabled ☐ Retired ☐ Other_____

EMPLOYER:_____ **CITY:**_____

(If you are under 18 or are a student, list parent's employment information.
If you are unemployed, list spouse's employment information.)

EMPLOYMENT INFORMATION IS FOR: ☐ Patient ☐ Parent ☐ Spouse

WORK PHONE:_____

SPOUSE'S / PARENT'S NAME:_____ **PHONE:**_____

EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____ **PHONE:**_____

EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____ **PHONE:**_____

REFERRING PHYSICIAN:_____ **DIAGNOSIS:**_____

INJURED ON JOB: ☐ Yes ☐ No

AUTO ACCIDENT: ☐ Yes ☐ No **DATE OF INJURY:**_____

SCHOOL SPORTS INJURY: ☐ Yes ☐ No ***OR* DATE OF FIRST SYMPTOM:**_____

ACCIDENT DETAILS:_____

CONTINUED ON BACK →

COVERAGE TYPE: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Work comp ☐ Cash ☐ Other_____

	PRIMARY INSURANCE	*SECONDARY INSURANCE*
INS CO NAME		
POLICY ID #		
INSURED'S NAME		
INSURED'S DOB		
INSURED'S EMPLOYER		
PATIENT'S RELATIONSHIP TO INSURED	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other

INDICATE METHOD OF PAYMENT FOR TREATMENT (deductibles, copays, coinsurance, supplies, non-covered items):

☐ Cash ☐ Check ☐ Visa / Mastercard

HOW DID YOU HEAR ABOUT US?

☐ Doctor ☐ Insurance company ☐ Internet

☐ Family / Friend ☐ Phone book ☐ Other_____

CONSENT FOR TREATMENT

I hereby authorize Rehabilitation Services of Tifton, Inc. / Orthopedic & Sports Physical Therapy, Inc. to provide physical therapy, occupational therapy, speech therapy, or athletic training, including treatment or tests that are deemed appropriate by the physician for the patient whose name appears on this form.

RELEASE OF INFORMATION

I hereby authorize Rehabilitation Services of Tifton, Inc. / Orthopedic & Sports Physical Therapy, Inc. to release any/all information, reports, and/or copies of records necessary to process insurance, etc. to my health insurance company, Medicare, Medicaid, and/or workers' compensation.

ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF ACCOUNT

I hereby authorize direct payment to Rehabilitation Services of Tifton, Inc. / Orthopedic & Sports Physical Therapy, Inc. the benefits herein specified and otherwise payable to me. **I understand that I am ultimately financially responsible for the charges** to all parties not covered by this assignment and/or third parties, etc. **I hereby guarantee payment of all charges incurred by the patient identified on this form.** If filing under workers' compensation, I understand that if my claim is denied, I will be responsible for all charges.

ACCURACY OF INFORMATION

I have answered these questions as accurately as possible and warrant that the information on this form is true and correct to the best of my knowledge.

_____ _____

Signature of patient or authorized legal representative

Date

REHABILITATION SERVICES OF TIFTON, INC.

"Committed to Excellence"

To:_____

I hereby authorize you to release to Rehabilitation Services of Tifton, Inc. any information including the diagnosis, test, and record of any treatment or examination rendered to me.

Patient's name:_____

Patient's date of birth:_____

_____ _____

Signature of patient or authorized legal representative

Date

_____ _____

Relationship to patient

Witness signature

1488 Old Ocilla Road • P.O. Box 7508 • Tifton, GA 31793 • 229-386-5200 • Fax: 229-386-1412

REHABILITATION SERVICES OF TIFTON, INC.

"Committed to Excellence"

Receipt of Our Notice of Privacy Practices

Rehabilitation Services of Tifton, Inc. Notice of Privacy Practices provides information about how we use and disclose protected health information about you. As provided in our notice, the terms of it may change. If changes are made, we will post the revised notice in a clear and prominent place in our rehabilitation clinic so you will be able to read it. You will be provided a copy of the revised notice upon request.

By signing below, you acknowledge that you have **received** a copy of our Notice of Privacy Practices on the date indicated below.

_____ _____

Signature of patient or authorized legal representative

Date

This receipt of notice will be kept on file at Rehabilitation Services of Tifton, Inc.

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REHABILITATION SERVICES OF TIFTON, INC.

"Committed to Excellence"

Notice of Privacy Practices

Effective Date: April 14, 2003

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.

WHO WILL FOLLOW THIS NOTICE

This notice describes the procedures of Rehabilitation Services of Tifton, Inc. (herein after referred to as "RST") and that of:

- any health care professional authorized to enter information into your medical record;
- all departments and units of RST;
- any member of a volunteer group we allow to help you while you are at RST; and
- all employees, staff and other medical office personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at RST. We need these records to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our clinic, its therapists, athletic trainers, exercise physiologists, and other medical staff members.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to (1) make sure that medical information that identifies you is kept private, (2) give you this notice of our legal duties and privacy practices with respect to medical information about you, and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that use and disclose medical information. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

➢ **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, therapists, or other personnel who are involved in taking care of you. For example, we may need to provide your medical information to a doctor's office to which we have referred you for treatment. Also, we may need to share your information to further meet you treatment needs, i.e. lab work, pharmaceutical prescriptions, etc.

➢ **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at our medical office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at our medical office so your health plan will pay us or reimburse you for this procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

➢ **For Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to operate our medical office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for your. We may also combine medical information about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, therapists, athletic trainers, exercise physiologist, medical students, and other medical personnel for review and learning purposes. We may also combine the medial information from other medical offices to compare how we are doing and see where

we can make improvements in the care and services that we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one type of surgery and treatment to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave our medical office. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **SPECIAL SITUATIONS**
  - **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
  - **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military authority.
  - **Worker's Compensation.** If applicable, we may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
  - **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

    We will only make this disclosure if you agree or when required or authorized by law.
  - **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

➢ **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if we receive satisfactory assurances that the party seeking the information has made efforts to tell you about the request or to obtain an order protecting the information.

➢ **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our medical office; or
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➢ **Coroners, Medial Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of our medical office to funeral directors as necessary to carry out their duties.

➢ **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

➢ **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

➢ **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

➢ **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records in certain cases.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Medical Records Custodian. If you request a copy of the information, we may charge a fee of the costs of copying and mailing.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed if the denial is made for certain reasons. Another licensed health care professional chosen by our medical office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

➢ **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our medical office.

To request an amendment, your request must be made in writing and submitted to our Medical Records Custodian. In addition, you must provide a reason that supports your request.

We may deny your request if you ask us to amend information that:
- was not created by us, unless that person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for our medical office;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

➢ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. The accounting will not include disclosures made to you at your request, or with your authorization.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

➢ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information to your spouse.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

➢ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

➢ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain an additional paper copy of this notice, please contact our Privacy Officer.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided you.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our medical office. The notice will contain on the first page, in the top right-hand corner, the effective date.

QUESTIONS OR COMPLAINTS

ATTN: Sommer Dunston, Privacy Officer
Rehabilitation Services of Tifton, Inc.
1488 Old Ocilla Road
P.O. Box 7508 Phone 229-386-5200
Tifton, GA 31793 Fax 229-386-1412

If you have any questions about this notice, please contact the Privacy Officer at RST.

If you believe your privacy rights have been violated, you may file a complaint with our medical office or with the Secretary of the Department of Health and Human Services. To submit a complaint to RST, you must do so in writing and submit to the Privacy Officer.

You will not be penalized for filing a complaint.