New Patient Form (PLEASE PRINT CLEARLY)

Name:_____

Address:_____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Birth Date: _____ **Age:** _____ **Sex:** M / F

Emergency Contact: _____**Phone Number:** _____

Referring Doctor: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Primary Insurance: _____ **Phone Number:** _____

ID Number: _____**Group #:** _____
Was the injury work related? Yes / No
Area(s) receiving treatment:
_____
_____

Who may we thank for referring you?
_____

CONSENT FOR TREATMENT OF A MINOR: As a parent and/or legal guardian, I authorize Melissa Matta, PT to treat the minor named above while I am present, or while I am not present.
Parent/Legal Guardian Signature: _____**Date:** _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Melissa Matta Physical Therapy and Pilates to furnish information to insurance carriers concerning this treatment.
Parent/Legal Guardian Signature:_____ **Date:** _____

Melissa Matta Physical Therapy and Pilates
KOR Physical Therapy and Wellness
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New Patient Instructions and Office Policies

(PLEASE INTIAL WHERE INDICATED)

Please fill out and sign all forms prior to your appointment. Please bring your forms with you to your appointment.

Payment by Cash, Check or Credit / Debit card is due at the time of service. Fees are:

- 55 minute treatment: $130
- 55 minute private Pilates session: $85
- Returned check fee: $25 ● Missed appointment fee: $130
- All credit/debit transactions will be billed a $5 service charge per session

Melissa Matta Physical Therapy and Pilates is out of network for all insurance providers. This allows us to treat our patients with more time and depth than insurance allows. We would be happy to provide you with a super bill for you to submit to your insurance provider for reimbursement.

Please arrive a few minutes prior to your scheduled appointment time. Feel free to use the restroom, get a drink of water and relax. We endeavor to run on time to provide the most effective treatment to all our patients.

Your scheduled appointment is our first priority. In the event you are unable to keep your scheduled appointment, please notify us at least 1 business day (24 hours) in advance. If we do not receive 24 hours notice of your cancellation, it limits our ability to accommodate other patients who may need that time slot.

Melissa Matta, PT strives to provide the best possible care to our patients. Attending scheduled appointments is a necessary part of your treatment process. Adhering to our cancellation and no-show policy is a courtesy to both our staff and other patients who are trying to arrange appointment times.

A missed appointment or cancellation within 24 hours will be charged at full rate. Initial _____

Feel free to arrive 5 or 10 minutes early. **If you arrive late, we may not be able to extend your treatment time, as that would take away from another patient's treatment.** Initial _____

I have read and agree to the above:

Parent/Legal Guardian Signature:_____ Date: _____

Patient Medical History

Patient Name: _____ **Age:** _____
Type of Injury / Condition:
_____

Onset / Injury Date: _____
Type(s) of Surgery: _____
_____**Date:** _____
Describe previous treatment for this condition:
_____
Chemotherapy? _____**Radiation?**_____Date of last radiation treatment_____

Have you had any imaging performed?
□ X-RAY □ MRI □ CT Scan □ Doppler □ Ultrasound
Have you recently noticed or suffer from any of the following?
□Weight Loss / Gain □ Weakness □ Numbness / Tingling
□ Depression □ Grief □ Headaches □ Insomnia □ Fatigue
□ Fever / Chills / Sweats □ Pain at Night □ Pregnant / IUD
□ Change in Vision or Hearing □ Cramps in Legs When Walking
Do you have now or have you ever had any of the following?
□ Surgeries □ Loss of Consciousness □ Fractures □ Diabetes
□ Sprains / Strains □ Cancer □ Blood Pressure Problems
□ Heart Problems □ Motor Vehicle Accident □ Lung Disease
□ Circulation Problems / Clots □ Asthma / Breathing Problems
□ Easy Bruising / Bleeding □ Leg / Ankle Swelling □ Fainting
□ Urinary Problems / Infections □ Indigestion / Heartburn
□ Allergies / Skin Sensitivity
□ **Any previous injury that may affect current care:**
_____

Are you currently taking medications? Yes / No. Name or Type of Medication(s):
_____

_____

What type(s) of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other:
_____

Rate your Pain (1 = minimal, 10 = severe)
At its worst: 1 2 3 4 5 6 7 8 9 10 **Currently:** 1 2 3 4 5 6 7 8 9 10

What goals do you want to achieve with physical therapy?
_____

_____

Is there anything else you would like to include or ask your physical therapist?

Signature of Patient or Legal Guardian: _____
Date: _____

Patient Information Consent Form

I have read and fully understand **Melissa Matta Physical Therapy and Pilates** Notice of Information Practices. I understand that **Melissa Matta, PT** may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Melissa Matta, PT** will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Melissa Matta Physical Therapy and Pilates** Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____
Signature: _____
Date: _____

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designee
Name: _____
Relationship:_____
It is acceptable to leave a message for you at (check all that apply):

☐ Home ☐ Work ☐ Cell phone

Patient Name: _____
Signature: _____
Date: _____

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart (and on a computer and in an electronic health record/ personal health record). This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes: We use medical information about you to provide your medical care. We disclose medical information
to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the
information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get
your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including

fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. (Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition).

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

By my signature below, I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____

Signature of Patient or Personal Representative Date

OFFICE USE ONLY

I attempted to obtain the patients signature on this HIPAA Notice of Privacy Practices, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason:

_____