709 Robb Street, P O Box 1358, Summit, MS 39666
PH: 601-276-2200, FAX 601-276-3300

Patient Information

Name_____ Date of Birth_____

SSN_____ Martial Status _____M_____S_____D____W

Address_____Gender ____M____F

City_____ State _____ Zip_____

Home _____ Mobile _____ Work _____

Responsible Party Name_____

Date of Birth_____SSN_____

Address_____

City_____ State _____ Zip_____

Employer/School _____ Occupation/Sport _____

How did you hear about Fortinberry Physical Therapy? _____

Referring MD _____

Reason for visit today? _____

Date Symptoms began? _____ Date of Surgery/Injury _____

Emergency Contact _____ Phone _____

Parent or Guardian _____ Relationship _____

Privacy Policy: I have read the Health Information Privacy Policy

Signature_____ Date _____

Billing: Co-pays and deductibles will be collected at the time of service. Fortinberry Physical Therapy will bill your insurance. Please keep in mind that the co-pays collected at the time of your service are an estimate of your cost based in benefits quoted by your insurance company and you may be responsible for unpaid or disallowed amounts.

Printed Name _____ Signature _____

Date_____

Fortinberry

• PHYSICAL THERAPY •

709 Robb Street, Summit, MS 39666 PH: 601-276-2200 FAX: 601-276-3300
101 W. Freedom Rd Liberty, MS 39645 PH: 601-980-5017 FAX: 601-276-3300
4916 Plaza Dr Tylertown, MS 39667 PH: 601-876-1234 FAX: 601-876-1452

ARE YOU CURRENTLY BEING TREATED BY HOME HEALTH OR BY ANOTHER PHYSICAL THERAPIST? YES_____ NO_____

Arthritis/Joint Pain	YES____NO____	Cancer	YES____NO____
Osteoporosis	YES____NO____	Gastrointestinal Disorder	YES____NO____
Asthma/COPD	YES____NO____	Vision Impairment	YES____NO____
Angina, Heart Failure/ Heart attack or Pacemaker	YES____NO____	Hearing Impairment	YES____NO____
Stroke or TIA	YES____NO____	Seizures	YES____NO____
High Blood Pressure	YES____NO____	Incontinence	YES____NO____
Neurological Disease	YES____NO____	Anxiety or Depression	YES____NO____
Peripheral Vascular Disease	YES____NO____	Hepatitis/Tuberculosis/ Blood-borne diseases	YES____NO____
Headaches	YES____NO____	Prosthesis or Implants	YES____NO____
Diabetes	YES____NO____	Sleep Dysfunction	YES____NO____
		Height _____	Weight_____

Explanation of any questions answered yes:

_____

_____

Other medical conditions or prior surgeries:

_____

_____

Current medications:

_____

_____

Fortinberry

• PHYSICAL THERAPY •

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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Fortinberry Physical Therapy does not guarantee what your reaction will be to specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Printed Name_____ Signature_____

Date_____

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Mailing Address: P O Box 1358 Summit, MS 39666

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information Uses and Disclosures or Protected Health Information Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physical therapist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physical therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physical therapist. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physical therapist or the physical therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction to your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as descended in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physical therapist is not required to agree to a restriction that you may request. If physical therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically. You may have the right to have your physical therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosure we have made. if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on or before April 14. 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Complaints Office in person or by phone at our Main Phone Number.

Disaster policy. By signing the form titled "Patient information form" you have acknowledged understanding of all disaster training including but not limited to : Building orientation, exits, exit signs, HVAC controls, bathrooms, hand washing stations, safety on all therapy equipment, and necessary staff instructions. You are also instructed to listen to local radio and TV broadcasts for further information. Also, to the patient's role in specific disaster of inclement weather, hurricanes, fire, and active shooters.