SYMMETRY PT PATIENT DATA SHEET

PATIENT INFORMATION

Name: _____
Address: _____
City/Town: _____State: _____Zip: _____Sex: M / F
Date of Birth: ____ / ____ / _____ Social Security: _____
Home Phone: _____ Cell Phone: _____
Employer: _____
Employer Address: _____
Work Phone: _____
**Email Address: _____

EMERGENCY CONTACT INFORMATION

Relationship to Patient: Spouse Parent Other_____
Name:_____
Address:_____
Phone: _____

PRIMARY INSURANCE CARRIER

Carrier Name:_____Phone:_____
ID # or Claim #:_____Group Name or #:_____
Name of Policy holder: _____Date of Birth:_____
Employer Name:_____
Employer Address:_____
Work Phone:_____

SECONDARY INSURANCE INFORMATION (If Applicable)

Carrier Name:_____Phone:_____
ID # or Claim #:_____Group Name or #:_____
Name of Policy holder: _____Date of Birth:_____
Employer Name:_____
Employer Address:_____
Work Phone:_____

INJURY / CONDITION INFORMATION

Accident Type: None Work Comp Auto Other Injury Onset Date:_____
Injury Type:_____Surgery Performed: Y / N Date:_____
Referring Physician:_____MD Phone #:_____

How did you hear about Symmetry PT?_____
Have you had physical therapy this year? Yes/No If yes, when?_____

INITIAL APPT:_____INTAKE INITIALS/DATE:_____
Called patient to confirm on: _____ Initials: _____

SYMMETRY PT PAST MEDICAL HISTORY FORM

Referring Physician: _____ Family Physician: _____
Date of 1st Doctor Visit: _____
Last day of work due to injury: _____ Date returned to work after injury: _____
Is attorney involved? _____
Number of surgeries: 1 2 3 4 5 Other: _____
Surgery took place in: Hospital Surgery Center Other

Have you had surgery for this injury /condition? YES NO
Type of surgery performed: _____
Are your currently taking prescription medications? YES NO
Names of medications for current injury:_____
Names of medications for other conditions:_____
_____
Therapist Reviewed Medications _____ (Initials) _____ (Date)

Have you had any of the following medical or rehabilitative services for this condition?

TYPE OF CARE	Y	N	TYPE OF CARE	Y	N	TYPE OF CARE	Y	N
Chiropractic			General Practitioner			CT Scan		
EMG/NCV			Massage Therapy			MRI		
Myelogram			Bone Scan			Neurologist		
Occupational Therapist			Physical Therapist			Orthopedist		
Podiatrist			Emergency Room Care			X-Rays		

Do you now have or ever had any of the following conditions / injuries?

TYPE	Y	N	TYPE	Y	N	TYPE	Y	N
Asthma, Bronchitis, Emphysema			High Blood Pressure			Dizziness /Fainting		
Shortness of Breath / Chest Pain			Heart Attack / Heart Surgery			Weakness		
Anemia			Diabetes			Emotional Problems		
Coronary Heart Disease			Thyroid Trouble / Goiter			Infectious Disease		
Gout			Cancer/Chemotherapy			Hernia		
Numbness or Tingling			Allergies			Headaches		
Elbow / Hand Injury /Surgery			Osteoporosis / Osteopenia			Vision or Hearing Difficulty		
Back / Neck Injury / Surgery			Stroke / TIA			Leg/Ankle/Foot Injury/Surgery		
Knee Injury / Surgery			Blood Clot			Do you have a pacemaker?		
Epilepsy /Seizures			Pins or Metal Implants			Varicose Veins		
Excessive Weight Loss / Gain			Are You Pregnant?			Joint Replacement		
Do you smoke? Qty_____			Do you Drink? Qty_____					

Therapist Reviewed PMH _____ (Initials) _____ (Date)

Please list any additional information that would assist us in your care:
_____
_____

Are you aware of what your diagnosis is? YES NO
Based upon your awareness, what are your goals/expectations of this program:
_____

Patient / Guardian Signature:_____Date:_____

SYMMETRY PT DISCLAIMER FOR CARE AND TREATMENT

I, _____, hereby request admission to a physical therapy / personal training / massage therapy / Graston Technique program with Symmetry Physical Therapy & Wellness, LLC. I hereby certify that I voluntarily consent to engage in the program and that I have passed a medical examination given by my medical doctor for the purpose of determining my ability to participate in the program.

I further certify that I make the above request and give the above consent with full knowledge of the potential risks of the program, and in particular those risks due to the physiological changes that can occur during exercise. I understand that such changes may include, by way of example and not limitation, abnormal blood pressure and disorders of the heartbeat (ie: too rapid, too slow, or ineffective), which could result in fainting or possibly, in some cases, heart attack or death.

In consideration of my admission to the program, I agree to release, save harmless, and keep indemnified Symmetry Physical Therapy & Wellness, LLC, each and everyone of their organizers, agents, servants, and representatives from and against all claims, actions, costs, expenses and demands with respect to death, injury, loss or damages to my person or property howsoever caused, arising out of or in connection with my taking part in this program. It is understood and agreed that this agreement is to be binding on heirs, my executors, assigns, and myself.

I certify that I have read the foregoing and understand it. I acknowledge that I have had the opportunity to ask questions regarding this agreement and the program, and any such questions, which I have asked, have been answered to my satisfaction.

Intending to be legally bound hereby, I make this agreement this ____ day of _____2017.
(Day) (Month)

_____ _____

Participant's / Patient's Signature **Date**

_____ _____

Witness's Signature / Parent or Guardian **Date**
(If person is under the age of 18 years)

Symmetry Physical Therapy & Wellness, LLC

Statement of Privacy Notice

Effective June 1, 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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child 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.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may 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 or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary 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 to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (914)738-1748. If our Privacy Officer (office manager) is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (914)738-1748. If our Privacy Officer (office manager) is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Symmetry Physical Therapy & Wellness, LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____

Patient's Name (print)

_____

Patient's Signature Date