WESTVIEW HEALTH CARE CENTER

PATIENT INFORMATION

PATIENT INFORMATION: (Please Print)				
NAME (Last Name, First Name, Middle Name)		DATE OF BIRTH		□MALE □FEMALE
MAILING ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	EMPLOYER	Social Security #	MARITAL STATUS Sing. Mar. Other
IF UNDER 18, PARENT OR GUARDIAN'S NAME				
EMERGENCY CONTACT				
NAME	RELATIONSHIP		PHONE NUMBER	
INSURANCE INFORMATION				
PRIMARY INSURANCE COMPANY NAME	MEMBER ID #		GROUP #	
SUBSCRIBER'S NAME	DATE OF BIRTH	MALE FEMALE	EMPLOYER	
SECONDARY INSURANCE COMPANY NAME	MEMBER ID #		GROUP #	
SUBSCRIBER'S NAME	DATE OF BIRTH	MALE FEMALE	EMPLOYER	
HOW DID YOU HEAR ABOUT US? ☐PHYSICIAN ☐FRIEND/RELATIVE ☐WEBSITE ☐NEWSPAPER ☐RADIO ☐OTHER				
PRESENTING PROBLEM(S):		REFERRED BY PHYSICIAN:		
IS CONDITION AUTO RELATED? □ Y □ N	WORK RELATED? □ Y □ N	OTHER ACCIDENT? (Please explain)		

I hereby authorize WESTVIEW HEALTH CARE CENTER to leave answering machine/voicemail messages or give messages regarding my visit to (NAME OF PERSON) _____

PATIENT SIGNATURE x_____ DATE _____

PATIENTS WITH MEDICARE	
NAME OF BENEFICIARY	ID #

I request that payment of the authorized Medicare benefits be made either to me on my behalf or to WESTVIEW HEALTH CARE CENTER for any services furnished me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services.

I understand my signature requests that payment be made and authorizes release if medical information necessary to pay the claims. If item 12 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, though physician and supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE OF BENEFICIARY x_____ DATE _____

ASSIGNMENT OF BENEFITS

I, _____ hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled to: WESTVIEW HEALTH CARE CENTER. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize as said assignee to release all information necessary to secure payment of said benefits.

SIGNATURE x_____	DATE _____	WITNESS _____

WESTVIEW HEALTH CARE CENTER

PATIENT HISTORY & OUTPATIENT ADMISSION FORM

NAME (Last Name, First Name, Middle Name)	DATE OF BIRTH	TODAY'S DATE
PRESENTING PROBLEM(S):	REFERRED BY PHYSICIAN:	
HAVE YOU HAD PREVIOUS PHYSICAL THERAPY? WHERE? WHEN?		

CURRENT MEDICATIONS (including OTC's and vitamins)

DRUG NAME	DOSE	PERSCRIBING MD	TAKEN FOR	DATE Rx

MEDICATION ALLERGIES ( )No Known Allergies

DRUG	REACTION	DATE OF REACTION

SENSITIVITIES TO LATEX AND PAIN MEDICATION

	YES	NO	REACTION
Sensitivity to Latex			
Anti-Inflammatory			
Vicodin			
Other:			

OTHER DOCTORS (including Primary Care Physician)

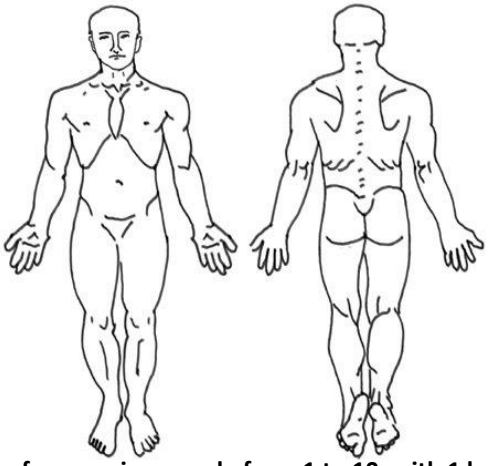
NAME	SPECIALTY	ADDRESS	PHONE #	FAX #

PAST ORTHOPEDIC OPERATIONS	RIGHT, LEFT, OR BOTH	DATE OF SURGERY

OTHER ORTHOPEDIC PROBLEMS	RIGHT, LEFT, OR BOTH	DATE OF ONSET

WESTVIEW HEALTH CARE CENTER

Please show us where your pain is on the illustration below



Rate the intensity of your pain on scale from 1 to 10, with 1 being very little pain

MEDICAL HISTORY (Check all that apply)

PULMONARY	
□ COPD/Emphysema	□ Pulmonary Embolism
□ Asthma	□ Use of O2
□ Tuberculosis	□ Sleep Apnea
□ Pneumonia	□ Shortness of Breath at Rest/Exertion
□ CPAP/BiPAP machine	□ Other:

NEUROLOGICAL	
□ CVA / Stroke / TIA	□ Seizures / Epilepsy
□ Dementia / Alzheimer's	□ Head Trauma
□ Parkinson's	□ Dizziness / Vertigo
□ Multiple Sclerosis	□ Fainting
□ Peripheral Neuropathy	□ Headaches
□ Muscular Dystrophy	□ ALS
□ Cerebral Palsy	□ Other:

EYES, EARS, NOSE & THROAT	
□ Cataracts	□ Peripheral Vision Problems
□ Macular Degeneration	□ Glasses/Contact Lenses
□ Legally Blind	□ Prosthesis (electrolarynx)
□ Enucleation □ L □ R	□ Tinnitus
□ Glaucoma □ L □ R	□ Vestibular
□ Hearing Loss □ L □ R	□ Hearing Aids □ L □ R
□ Sign Language	□ Dentures
□ Vocal Cord Polyps/Nodules	Other:

CARDIAC	
□ Congestive Heart Failure	□ Heart Valve Problems
□ High Blood Pressure	□Heart Murmur
□ High Cholesterol	□ Heart Attack
□ Angina/Chest Pain	□ Peripheral Vascular Disease
□ Coronary Heart Disease	□ Cardiomyopathy
□ Endocarditis	□ Pacemaker. When?
□ DVT (Deep Vein Thrombosis)	□ Defibrillator. When?
Normal Blood Pressure (if Known)?	

GENITOURINARY	
□ Kidney Stones	□ Urinary Incontinence
□ Pelvic Floor Dysfunction	□ Prostrate Problems
□ Yes □ No Are you Pregnant?	□ Other:

ENDOCRINE	
□ Hypothyroidism	□ Hyperthyroidsm
□ Diabetes: Type:	□ Insulin □ Non-Insulin

SKIN	
□ Rash	□ Edema
□ Open Wounds	□ Cellulitis
□ Shingles	□ Other:

AUTOIMMUNE	
□ Lupus	□ RA
□ Other:	

HEMATOLOGIC	
□ Anemia	□ HIV / AIDS
□ Clotting Problems	□ Neutropenia Precautions
□ Other:	

MUSCULOSKELETAL	
□ Fracture	□ Fibromyalgia
□ Arthritis	□ Back / Neck Pain
□ Disk Disease	□ Unsteady Gait
□ Osteoporosis	□ Limited movement
□ Gout	□ Tick Borne Disease
□ Lyme disease	□ Other:

GASTROINTESTINAL	
□ Hepatitis: Type	□ GERD / Acid reflux
□ Liver Disease	□ Hiatal Hernia
□ Peptic Ulcer	□ Pancreatitis
□ IBS / Crohn's	□ Other:

CANCER	
□ Cancer Type	
□ Radiation	□ Chemotherapy

OTHER MEDICAL CONDITION(S):

SOCIAL HISTORY (Check all that apply)

Alcohol: □ None □ Heavy □ Moderate □ Occasionally

Tobacco: □ Non Smoker □ <1 PPD □ 1-3 PPD □ >3 PPD □ Quit: _____

Drug Use: □ No □ Yes

Employment: □ Full time □ Part time □ Retired □ Disabled □ Student □ Other

FAMILY HISTORY (Check all that apply)

□ Alzheimer's	□ Arthritis	□ Bleeding Disorder	□ Blood Clots	□ Breast Cancer	□ Cancer, other
□ Circulatory Problems	□ Diabetes	□ Genetic/Hereditary Disorder	□ GI Disease/Ulcer	□ Gout	□ Heart Disease
□ High Cholesterol	□ Hypertension	□ Leukemia	□ Obesity	□ Stroke	□ Seizure Disorder
□ Psychiatric Disorder	□ Tuberculosis	□ Kidney Disease	□ Other:		

150 Ware Road, Dayville, CT 06241 ▫ Tel (860) 774-8574 ▫ Fax (860) 412-7661

WESTVIEW HEALTH CARE CENTER

Authorization to Release Healthcare Information

Note to Patient: A signed authorization form is required by some healthcare providers & attorneys to have permission by the patient to legally release documentation to our clinic; i.e. Radiology Reports, MRI Reports, Operative Reports, & other related documentation

Patient Name: _____ Date of Birth: _____
First M.I. Last

Maiden Name: _____
(if applicable)

I herein authorize **Westview Outpatient Therapy & Aquatic Center/Westview Sports Medicine** the right to obtain and receive the following information:

Please check the following documents / reports authorized to be obtained

- ☐ X-Ray Images / Radiological Reports / MRI Reports
- ☐ Surgical / Operative Reports (recommended if you are a post-operative patient)
- ☐ Office Visit Chart Documentations
- ☐ Treatment & Discharge Summaries from previous physical therapy clinic(s) and/or emergency room visits
- ☐ Other: _____

Signature: _____ **Date:** _____
Patient, Parent/Guardian, or Authorized Representative of Patient

Cancellation Policy

Exceptional care is our goal and we strive to make it possible for all patients to maintain appointments and achieve an optimal level of health. Because our patients truly value their outpatient therapy program, we ask that you please honor our **attendance policy**. Please sign below to confirm you've **acknowledged & accept all aspects of this policy**.

PLEASE READ & INITIAL THE FOLLOWING

1. Westview Sports Medicine requires **24 hour notice** prior to the cancellation or reschedule of any appointment. (Excluding: emergencies, serious illness, & severe weather conditions). If you cancel without 24 hours' notice, you will be charged $25 that must be paid on your next visit

   ⇨ Initial: _____

2. If you are more than **15 minutes late** for your scheduled appointment, we reserve the right to cancel the appointment or decrease treatment time per therapist's discretion.

   ⇨ Initial: _____

3. Westview Sports Medicine has scheduled appointments. If you fail to provide notice of cancellation, a no-show fee will be charged. We understand oversights do occur, which is why there is no penalty for the first no-show; however, there is a **$25 charge for every no-show after.** The $25 must be collected on your next visit. Please understand that scheduled visit(s) precludes other patients from access to services in your time slot.

   ⇨ Initial: _____

Patient Name (Print): _____

Signature: _____ **Date:** _____
Patient, Parent/Guardian, or Authorized Representative of Patient

WESTVIEW HEALTH CARE CENTER

Acknowledge of Receipt of Privacy Notice

Documentation of Attempt to Obtain Written Acknowledgement

As required by the Health Insurance Portability and Accountability Act of 1996, we document compliance by retaining copies of our privacy notices and any written acknowledgements of receipt of the privacy notice or documentation of good faith efforts to obtain such written acknowledgement in accordance with our obligation to provide the privacy notice at first service after compliance date, or, when an emergency occurs, as soon as possible after emergency treatment

_______ I have received the Privacy Notice

Signature: ____ **Date:** ____________________________

Patient, Parent/Guardian, or Authorized Representative of Patient

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_______ We have made a good faith effort to deliver a copy of our Privacy Notice to:

Patient Name: ____

Signed: ______________________________________ Date: ____________________

WESTVIEW HEALTH CARE CENTER

A NOTICE ABOUT OUR PRIVACY POLICY

We are providing you with this notice of our Privacy Policy in accordance with the Federal Health Insurance Portability and Accountability (HIPAA) Act of 1996. This Act regulates how we use and disclose your protected health information. Your protected health information, or PHI, is personal information that concerns your past, present or future physical and mental health condition. This notice explains your right to access and control your PHI.

Your Rights:

- You have the right to request restrictions on certain uses and disclosures of your PHI
- You have the right to choose how and where we contact you
- You have the right to inspect or copy your medical records
- You have the right to request amendments to your records
- You have the right to receive an accounting of some disclosures of your PHI

All requests must be in writing. We will provide you with the appropriate request form. We are required to agree to your requests.

Uses and Disclosures for Treatment, Payment, or Operations:

Treatment: We will use and disclose your PHI to provide, coordinate, and manage your health care. For example, if you were referred by another physician for treatment, we will provide that physician with part or all of your medical records.
Payment: We will use your PHI to obtain payment for our services. For example, we may submit claims on your behalf to your insurance company, or disclose selected PHI to a company which performs billing or collection services for us.
Operations: We may use your PHI to carry out other operations of our medical practice. Our practice may share minimal PHI with business associates, which perform services for us. Our business associates are pledged to safeguard your privacy.
Reminders or Treatment Options: We may contact you and remind you of your next appointment. We may provide information to you about treatment alternatives or other services that may be of interest.
Uses and Disclosures without your authorization: We may use and disclose your PHI for public health purposes, for health oversight activities, to report abuse or neglect, for Workers' Compensation programs, or for national security and intelligence.

Our Duties:

We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI. We will follow the terms of the notice currently in effect. We reserve the right to change the terms of our privacy notice at any time, and any revised notices/provisions effective for all PHI that were created or received prior to issuing the revised notice. We will not implement any change prior to its effective date. Any revised notice will be posted in the lobby and be available from our Privacy Officer.

Privacy Complaints:

You may complain to our Privacy Officer if you believe your rights have been violated. You may also complain to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.