HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I ACKNOWLEDGE that I have received a copy of Ryan Physical Therapy Associates notice of privacy practices. I understand that this information describes how Ryan Physical Therapy Associates may disclose and use my protected health information.

Patient's Name: _____ (please print)

Patient's Signature: _____ Date _____

Emergency Contact: _____ _____ _____

Name Relationship Phone Number

Describe your injury: Date your symptoms began:	Have you had any **prior Therapy** this year or for this condition? **Yes No**	Current Symptoms: (please circle) **Pain Stiffness Weakness Numbness Swelling**
Have you had any Diagnostic, MRI's, X-rays, etc. for this condition? **Yes No**	Surgery for this condition? **Yes, Date_____ No**	Is your injury the result of an accident at work or in a vehicle? **Yes No**

Do you have any of the following conditions? (Please circle appropriate answer)

Asthma, Bronchitis or Emphysema	Y	N	Shortness of Breath / Chest Pains	Y	N
Coronary Heart Disease / Heart Attack	Y	N	Pacemaker /Defibrillator Device	Y	N
Stroke / TIA	Y	N	Blood Clot / Embolism	Y	N
Epilepsy / Seizures	Y	N	Thyroid Problems / Goiter	Y	N
Diabetes	Y	N	Arthritis / Gout	Y	N
Varicose Veins	Y	N	Cancer / Chemo or Radiation	Y	N
Emotional / Psychological Conditions	Y	N	Bowel / Bladder Condition	Y	N
Hearing / Vision Condition	Y	N	Infectious Disease Condition	Y	N
Severe and/or Frequent Headaches	Y	N	Dizziness / Fainting	Y	N
Do you smoke?	Y	N	Alcohol Use?	Y	N
If yes, how much?	/per day		If yes, how much?	Daily / Weekly	

Please note your functional limitations when performing these activities:

Activity	NONE	Mild	Moderate	Severe	Unable	**Please list ALL medications you are currently taking:** **Name** **Dose/Frequency**
Bending / Stooping						
Climbing or Descending Stairs						
Driving / Prolonged Sitting						
Changing Positions						
Lifting / Carrying Objects						
Walking						
Dressing						
Personal Hygiene						
Yard Work / Hobbies						
Sports / Exercise						
Household Chores						
Concentrating						
Feeding Self						

I hereby agree and give my consent to medical treatment for this medical condition. I authorize the release of any medical information needed to process my insurance claim. I understand I am responsible for any charges that are not covered by my insurance carrier; I also understand that I am responsible to inform Ryan Physical Therapy Assoc. of any changes in my insurance or personal information. I authorize release of payment from my insurance carrier directly to Ryan Physical Therapy Assoc. regardless of participation in or out of network. Should I default on my financial obligation, I understand that I will be responsible for any collection costs incurred.

Patient's Signature: _____ **Date** _____