PATIENT INFORMATION – *Please Print*

Name____
Last First Middle Initial

Address_____________________________________
Street

______________________________ __________
City Zip Code

Phone Number ______________ ______________
Home Work

____
Cell

Date of Birth ______________ Age __________
Marital Status__________ Male/Female ____
Employer ___________________________________
Employer Address ___________________________
____

GUARANTOR INFORMATION

Relationship to Patient____________________________
Name____
Last First Middle Initial

Address____
Street

____________________ ______________________
City Zip Code

Phone Number ______________ ______________
Home Work

____
Cell

Date of Birth ________________ Age __________
Marital Status _____________ Male/Female_____
Employer ____
Employer Address __________________________________
____

ADDITIONAL INFORMATION

Emergency Contact ________________________ ________________________ ____________________
Name Relationship Phone Number

Referring Doctor ______________________________ Primary Doctor________________________________

Is this visit related to an accident? Yes / No Work / Auto / Other _________________ Date ____________
Have you been to physical therapy this year? Yes / No Number of Visits ________

How did you find us? Doctor / Advertisement / Friend or Family / Sports / Other ___________________________

To the best of my knowledge, the above information is correct. I consent to the assessment, treatment, and review of treatment options with the Physical Therapist.

Signature ____ Date ___________________
Patient or Representative

FINANCIAL/PRIVACY PRACTICES/CONSENT ACKNOWLEDGEMENTS

Please initial each line:

____ I understand that I am financially responsible for all applicable treatment fees whether or not paid by an insurance company.

____ I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____ I consent to the use and disclosure of my personal health information as noted in this office's Notice of Privacy Practices.

____I consent to the use and disclosure of my personal health information (with name removed) for the training of student Physical Therapists and/or participation in research studies.

____I consent to any of the designated parties below to request and receive any personal health information:
Name/Relationship: (Doctor, Specialist, Family Member, Caregiver, etc.)

____
____
____

Signature ____ Date ______________________

Rev: 1/2017
Forms: Patient Information

Dery Physical Therapy Services, P.C.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY

Dery Physical Therapy Services, P. C. is required by State and Federal Laws to maintain the privacy of your personal health information and provide this notice about out legal duties and information on our practices. We will follow the information practices that are described in this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Dery Physical Therapy Services, P.C. uses your personal health information primarily for treatment, obtaining payment, conducting internal administrative activities, and evaluating the quality of the care that we provide. Your health information is not shared with anyone who does not "need to know". For example, Dery Physical Therapy Services, P.C. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Your health information is released when required by insurance companies to receive payment for our services.

Dery Physical Therapy Services, P.C. may also use or disclose your personal health information without prior authorization when it is required by law. For example, your personal health information may be released for public health purposes, if an agency that audits health care requires it for investigation, inspection and licensing of healthcare providers, the U.S. Or another country's armed forces require it, or a court of law requires it.

In any other situation, it is the policy of Dery Physical Therapy Services, P.C. to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke this authorization to stop future disclosures. A parent, legal guardian or properly named patient advocate may represent you if you are unable to provide authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to review or obtain a copy of your personal health information. If you request a copy of your information, we may charge a fee for the cost of copying and mailing.

You have a right to request that we correct any inaccurate or incomplete information in your records. You must put your request in writing to our Privacy Officer and include a reason to support this change. Dery Physical Therapy Services, P.C. will not amend any records it did not create or that it deemed accurate.

You have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You have a right to request restricted use of your health information. You must put your request in writing to our Privacy Officer and include what information you want to limit, whether you wish to limit our use, disclosure or both, to whom these limits apply. Dery Physical Therapy Services, P.C. will consider all requests on a case by case basis, but we are not legally obligated to accept them.

You have the right to request that we communicate with you about medical matters in certain ways (home phone/cell phone) or at certain locations. This request will be accepted in writing and should be as specific as how and where you wish to be contacted. WE do not need to know the reason for your request.

You have the right to request a copy of this notice.

Dery Physical Therapy Services, P.C. may change its policy regarding the use of your personal health information at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room. A new Notice of Information Practices will be provided to you on your next visit. You may also request a current copy of our Notice of Information Practices at any time.

CONCERNS AND COMPLAINTS

If you are concerned that Dery Physical Therapy Services, P.C. may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Dery Physical Therapy Services, P.C.'s health information practices or if you have a complaint, please contact the following person:

Dale A. Kilyanek, BSN Privacy Officer
Dery Physical Therapy Services, P.C.
901 West Main St.
Lowell, MI 49331

REVISED: January, 2017

Dery Rehabilitation Services, P.C.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY

Dery Rehabilitation Services, P. C. is required by State and Federal Laws to maintain the privacy of your personal health information and provide this notice about out legal duties and information on our practices. We will follow the information practices that are described in this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Dery Rehabilitation Services, P.C. uses your personal health information primarily for treatment, obtaining payment, conducting internal administrative activities, and evaluating the quality of the care that we provide. Your health information is not shared with anyone who does not "need to know". For example, Dery Rehabilitation Services, P.C. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Your health information is released when required by insurance companies to receive payment for our services.

Dery Rehabilitation Services, P.C. may also use or disclose your personal health information without prior authorization when it is required by law. For example, your personal health information may be released for public health purposes, if an agency that audits health care requires it for investigation, inspection and licensing of healthcare providers, the U.S. Or another country's armed forces require it, or a court of law requires it.

In any other situation, it is the policy of Dery Rehabilitation Services, P.C. to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke this authorization to stop future disclosures. A parent, legal guardian or properly named patient advocate may represent you if you are unable to provide authorization.

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CONCERNS AND COMPLAINTS

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Dale A. Kilyanek, BSN Privacy Officer
Dery* Rehabilitation *Services, P.C.
P.O. Box 268
Lowell, MI 49331

REVISED: January, 2017

SOCIAL /VOCATIONAL FORM

We are interested in the total well being of all of our patients. With this in mind ,we feel on occassion referal to additional community resources may assist in the rehabilitation process.

Please answer the following questions as completely as possible. The information you provide will be helpful to our team in determining an approriate treatment plan.

ARE YOU CURRENTLY

Working full time_______ Off on short term disability______ Homemaker_______
Working part time_______ On disability_______ Student_______
On light/restricted duty_____ Retired_______

At this time can you complete normal daily activities? Yes No

On a scale of 1 – 10 how much physical pain are you experiencing?

None 1 2 3 4 5 6 7 8 9 10 A great deal

LIFE STRESS INFORMATION

Which areas in your life do you presently find stressfull?

Personal issues______ Health Concerns______ Depression______
Family Concerns______ Financial Issues______ Chronic Pain______
Work Related Issues______ Stress Management______ Other______

On a scale of 1 – 10 rate your current stress level:

Relaxed, at ease 1 2 3 4 5 6 7 8 9 10 Out of control

Signature________________________________ Date_______________

Office Use Only: Notes:

Therapist: