

Robbins Rehabilitation
2895 Hamilton Blvd. suite 105
Allentown, PA 18103
Phone: (610) 841-3555 Fax: (610) 841-3558

HIPPA Notice of Privacy Practices

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 of health care operations 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 health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and disclosures of Protected Health Information

Your protected health information may be used and disclosed by you physician, 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.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business of activities of your physical therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting and arranging for other business activities. We may use a sign-in sheet at the registration desk where you will be asked to sign your name. 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 an appointment.

We may use or disclose your protected health information in the following situations without your authorization: These situations may 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; Worker's 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 physicians 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.

You may request in writing or by telephone a copy of your medical records. All requests will be processed and prepared for pick up within 10 days. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or in 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 of 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 purposes 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 described in the Notice of Privacy Practices. Your request must state that specific restriction requested 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 your 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 of disagreement with us and we may prepare a rebuttal to your statement and we will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures 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 file a complaint with us by notifying our privacy contact of your complaint.
Privacy contact: Todd Robbins

Or you may complain to the Secretary of Health and Human Services, telephone 800-792-9770.

DATE: _____

MEDICAL SCREENING FORM

Circle YES or NO...

Have you or any immediate family member ever been told you have:

Self	Family
Cancer ?.....Yes ..No	YesNo
Diabetes ?Yes ..No	YesNo
High blood pressure ?.....Yes ..No	YesNo
Heart disease ?.....Yes ..No	YesNo
Angina/chest pain ?Yes ..No	YesNo
Stroke ?.....Yes ..No	YesNo
Osteoporosis ?Yes ..No	YesNo
Osteoarthritis ?Yes ..No	YesNo
Rheumatoid arthritis ?Yes ..No	YesNo
Head/Neck Trauma ?.....Yes ..No	

In the past 3 months have you had or do you experience:

- A change in your health ?.....Yes.....No
- Nausea/Vomiting ?.....Yes.....No
- Fever/chills/sweats ?Yes.....No
- Unexplained weight loss ?.....Yes.....No
- Numbness or tingling ?.....Yes.....No
- Changes in appetite ?.....Yes.....No
- Difficulty swallowing ?.....Yes.....No
- Changes in bowel or bladder function ?Yes.....No
- Shortness of breath ?Yes ..No
- Dizziness ?.....Yes.....No
- Upper respiratory infection ?.....Yes.....No
- Urinary tract infection ?Yes.....No

In the past year have you had 2 weeks or more during which you felt sad, blue, depressed or when you lost all interest in things that you usually cared about or enjoyed?.....Yes....No

Have you felt sad or depressed much of the time in the past year?.....Yes....No

Have you had any trauma to your head and neck (i.e blunt trauma, fall, ejection from auto etc) Yes...No

Circle YES or NO...

Do you have a history of:

- Allergies/Asthma ?.....Yes No
- Headaches ?Yes No
- Bronchitis ?Yes No
- Kidney disease ?Yes No
- Rheumatic fever ?Yes No
- Ulcers ?Yes No
- Sexually transmitted disease ? . Yes No
- Seizures ?Yes No

Are you currently:

- Pregnant ?.....Yes No
- Under Stress ?Yes No

Are your symptoms: (check one)

- Getting worse The same Improving

How are you able to sleep at night? (check one)

- Fine Moderate difficulty Only with medication

Check all that apply...

Do you have a problem with ... (check all that apply)

- Hearing Vision
- Speech Communication

Do you or have you in the past smoked tobacco?

YES NO

If yes, _____Packs **X** _____Years.

Last tobacco use _____

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____

List medications currently using:

2895 Hamilton Blvd. suite 105
Allentown, PA 18103
Phone: 610.841.3555



51 N. Broad Street
Phillipsburg, NJ 08886
Phone: 908.454.2404

RobbinsRehabilitation.com

PATIENT INFORMATION RELEASE

The HIPPA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their health information (PHI). The individual has the right to request confidential communication, such as calling the individual's office instead of the home. Please check below where we can contact you regarding your PHI or if we need to let you know of changes in our clinical schedule.

It is very important that we have accurate information in which to contact you should we need to move or cancel your appointment in the case of an emergency.

I wish to be contacted in the following manner:

Home Telephone: # _____ **Work Number: #** _____
 O.K. to leave a message with detailed information O.K. to leave a message with detailed information
 Leave message with call back number only Leave message with call back number only

Cell Phone Number: # _____ **What is the best number to reach you on?** _____
 O.K. to leave message with detailed information
 Leave message with call back number only

Emergency Contact's name _____ Phone# _____ Relation _____

Email address _____

We occasionally contact patients via email to update them on upcoming events exclusively offered to our patients. We also send a quarterly newsletter with helpful health tips and prizes for contests. Your address **will not** be shared with third parties and you will not receive large amounts of messages. We only wish to keep our patients informed and offer them opportunities to improve their health.

O.K. to send me information via email Please do not send me any email

It is very important for us to know how you **FIRST** learned about Robbins Rehabilitation. Please check the appropriate line

<input type="checkbox"/> Dr. referred you	<input type="checkbox"/> Friend/family member referred you	<input type="checkbox"/> Phone book
<input type="checkbox"/> Drove by our office	<input type="checkbox"/> Radio advertisement	<input type="checkbox"/> Television advertisement
<input type="checkbox"/> Internet search	<input type="checkbox"/> Saw us at a community event/ lecture	<input type="checkbox"/> Received and email from us
<input type="checkbox"/> Twiter.com	<input type="checkbox"/> Blog (robbinsrehab.wordpress.com)	<input type="checkbox"/> Facebook.com
<input type="checkbox"/> Other _____	If friend/family, who? _____	

Patient Information Release Agreement

I hereby authorize direct payment to Robbins Rehabilitation. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any Dr., insurance company, adjuster, or attorney involved in this case.

I understand and agree that my insurance company will be billed directly and I am ultimately responsible for the balance of my account for any professional services rendered at Robbins Rehabilitation.

SIGNATURE OF PATIENT: _____ DATE: _____

PRINT NAME: _____

Changing Physical Therapy in the Lehigh Valley