Blue Ridge Physical Therapy, Inc.
3915 Bristol Highway, Suite 301
Johnson City, TN 37601

Kimberly A. Contryman, PT, DPT, NCS, OCS
Doctor of Physical Therapy

Patient Information Forms Instructions

The following forms are included with the Patient Information Package:

1. **Patient Information**

   Please complete all fields. Signatures are required for "Other Insurance" and "Financial" fields. Medicare patients: Please sign all three fields.

2. **Brief Medical History**

   Please complete all relevant information.

3. **Privacy Practices Acknowledgement**

   In the packet is our Notice of Privacy Practices. Completion of this form signifies you have read the notice. In addition, if you would like to allow anyone else access to your Protected Health Information, please complete the authorization form included. These may be relatives or friends that we would otherwise not release your information to. You do not need to return the Notice of Privacy Practices, just the acknowledgement.

4. **Patient Agreement**

   Please read the notice and include your name, signature and date.

5. **Patient Rights and Responsibilities**

   Please read. You need not return the information.

Thank you! We look forward to seeing you. Please arrive for your first appointment 15 – 20 minutes ahead of time so that we may check you in. If you need to reschedule, call 423-262-0020 as soon as possible so that someone else my use the time.

Blue Ridge Physical Therapy, Inc.
3915 Bristol Highway, Suite 301
Johnson City, TN 37601
Ph. 423-262-0020/Fax 423-262-0057

PATIENT INFORMATION

Name:_____ Age: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ Social Security #: _____

Home Telephone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

Marital Status: (Single, Married, Separated, Divorced, Widowed) _____

Email Address: _____

Guarantor Name (If patient is under 18 years of age): _____

Guarantor Address: _____

Guarantor City/State/Zip: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Spouse: _____ Birth date: _____

Spouse's Employer: _____ Phone: _____

Relative or friend not living with you: _____ Phone: _____

Referred to us by: _____

In your admission packet, you were provided with information regarding your rights and responsibilities and a patient agreement. Do you have any questions regarding this information? (_____) Yes (_____) No

CONTINUED ON OTHER SIDE

Insurance Information

(Please list all carriers)

Primary Insurance Name: _____

Claims Address: _____

City/State/Zip: _____

ID# _____ Group# _____ Phone: _____

Subscriber Name: _____ Date of Birth: _____

Employer: _____

Secondary Insurance Name: _____

Claims Address: _____

City/State/Zip: _____

ID# _____ Group# _____ Phone: _____

Subscriber Name: _____ Date of Birth: _____

Employer: _____

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made to Blue Ridge Physical Therapy, Inc. (or Kimberly A. Contryman, DPT), 3915 Bristol Highway, Suite 301, Johnson City, TN 37601, for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____

(Note: This is a one-time authorization for Medicare patients; No other signatures will be required unless patient also carries supplemental insurance.)

Other Insurance: I authorize the release of medical information necessary to process insurance claims and authorize payment of medical benefits to Blue Ridge Physical Therapy, Inc. and/or Kimberly A. Contryman, DPT.

Signed: _____ Date: _____

Financial: I understand and agree to pay in full any portion not covered by my insurance company (ies). I consent to receive services provided by Blue Ridge Physical Therapy, Inc.

Signed: _____ Date: _____

Blue Ridge Physical Therapy, Inc.

Brief Medical History

Name: _____ Date: _____

Nature of your illness or injury:_____

Date of onset: _____ Referring Physician: _____

Have you ever had any major surgery or injury? YES _____ NO _____

1. If "YES," what kind and when?

   Date: _____ Type: _____

   Date: _____ Type: _____

   Date: _____ Type: _____

2. Have you ever been diagnosed as having any of the following conditions?

   Yes _____ No _____ Cancer. If "Yes," describe what kind and when:

   _____

   Yes _____ No _____ Heart problems. If "Yes," describe:

   _____

   Yes _____ No _____ Do you have a pacemaker?

   Yes _____ No _____ High Blood Pressure?

   Yes _____ No _____ Diabetes?

   Yes _____ No _____ Depression?

   Yes _____ No _____ Hepatitis?

   Yes _____ No _____ Tuberculosis?

   Yes _____ No _____ Other. If "Yes," please explain:

   _____

3. Have you recently noticed:

   Yes _____ No _____ Dizziness?

   Yes _____ No _____ Numbness or tingling?

   Yes _____ No _____ Nausea or vomiting?

   Yes _____ No _____ Weight loss or gain?

   Yes _____ No _____ Fatigue?

   Yes _____ No _____ Weakness?

   Yes _____ No _____ Fever, chills or sweats?

4. Do you have any skin allergies to latex, lotions, body creams, oils, etc.?

   Yes _____ No _____

5. Please list any other allergies we should know about:

   _____

   _____

6. Is there any other important information that you feel we should know about?

   _____

   _____

   _____

Please list all medications that you are currently taking:

Name	Route	Dosage	Frequency

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 takes effect on April 26, 2004 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at **Blue Ridge Physical Therapy, Inc.**. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

The Law Requires Us to:

Keep your medical information private.

Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

Follow the terms of the current notice.

We Have the Right to:

Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information or a person who has died with a coroner, medical examiner, funeral director, or organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical treatment of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, or to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS You

Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make the request in writing. You may get the form to request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $20.00 for each record or partial record we provide.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency.)
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U. S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Blue Ridge Physical Therapy, Inc.
3915 Bristol Highway, Suite 301
Johnson City, TN 37601
ATTN: Kevin R. Costello

We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Blue Ridge Physical Therapy, Inc.

PRIVACY PRACTICES ACKNOWLEGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____Birthdate_____

Signature _____

Date _____

Protected Health Information Release Authorization

I understand that my Protected Health Information is private and my only be distributed or divulged as specified in the Privacy Practices Acknowledgement. However, I would like to specifically allow the following individuals access to my information:

Blue Ridge Physical Therapy, Inc.

PATIENT RIGHTS AND RESPONSIBILITIES

Your Rights:

To receive information about office policies/procedures; to be informed, in advance, about the care to be furnished as well as any changes in the care to be furnished;

To be informed before care is initiated, orally and in writing, if requested, of the (1) Extent to which payment may be expected from Medicare, Medicaid, of other federally-funded programs; (2) Charges not covered by Medicare; (3) Charges the patient may have to pay; (4) Cost of care; (5) Charges covered by private insurance;

To receive services without regard to race, creed, color, religion, sex, national origin, sexual orientation, handicap or age;

To receive information needed to assure your informed consent for treatment; receive reasonable and appropriate information concerning your condition and treatment unless the therapist determines the knowledge would harm the patient and records such determination in the patient's record;

To receive reasonable continuity in staffing;

To receive the full name and title of any staff involved in your care;

To receive courtesy and respect from all staff at all times;

To decline services after having received reasonable information;

To be informed of your rights through written notice of rights prior to or during the initial evaluation visit;

To exercise your rights as a patient; family or guardian may exercise your rights if you are judged incompetent;

To participate in decisions concerning your care; right to participate in the planning of care;

To voice a problem, complaint, grievance, or recommend a change, please call or write to clinic's business manager;

To confidentiality of the clinical records maintained by this clinic and not released with the patient's and or legal guardian's permission.

YOUR RESPONSIBILITIES:

To provide accurate, complete information regarding illnesses, hospitalizations, medications, allergies, and other pertinent issues;

Provide notice of your inability to keep an appointment;

Participate in the development and update of your care plan;

Adhere to your individualized care plan;

Notify clinic of any changes in your care or condition;

Voice any questions you have regarding your care;

Assure that financial obligations are fulfilled as promptly as possible;

Relay information regarding concerns and problems you may have to a clinic staff member.

Cancellation and No-Show Policy

It is important for patients to make their appointments, not only because the prescribed visits help to ensure positive results, but missed appointments mean that the time slot is not available for someone else. Barring a true emergency, if a patient cancels his/her appointment with less than twenty-four (24) hours notice, they will be subject to a $25.00 cancellation fee.

If a patient no-shows their appointment, they will be charged a $50.00 no-show fee.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____