Patient:_____

Westgate Physical Therapy & Exercise
PATIENT HIPAA CONSENT FORM

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I herby assign all medical benefits to which I am entitled from any and all insurance/health plan to Westgate Orthopaedic Physical Therapy & Exercise. This assignment of benefits will remain in effect until revoke in writing by me. I herby authorize Westgate Orthopaedic Physical Therapy & Exercise to release all information necessary to secure payment. I agree that I am financially responsible for all charges incurred by my dependents or me for the services rendered, regardless of insurance coverage or lack thereof. Any outstanding balance may be subject to a 1.5% service fee if not paid in full within 90 days from the date of service. **I also understand that 24 hour notice is required for cancellation of appointments. If 24 hour notice is not provided I understand I will be billed for missed appointments ($10 charge for a late cancellation and $20 charge for "no show"/missed appointment).**

I authorize that your office may contact me in the following manner (check all that apply)
HOME TELEPHONE: _____
❑ OK to leave message on machine with detailed message
❑ OK to leave message with call-back number only
❑ OK to leave message with family member (Who?_____)

CELLULAR TELEPHONE:_____
❑ OK to leave message on voicemail with detailed message
❑ OK to leave message with call-back number only

EMERGENCY CONTACT:_____ Phone:_____

_____ _____
Signature of Patient or Guardian Date

Updated 7/15/13

Medical History

Allergies	❑ Yes ❑ No	Dizzy Spells	❑ Yes ❑ No	MRSA	❑ Yes ❑No
Anemia	❑ Yes ❑ No	Emphysema/Bronchitis	❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑No
Anxiety	❑ Yes ❑ No	Fibromyalgia	❑ Yes ❑ No	Muscular Disease	❑ Yes ❑No
Arthritis	❑ Yes ❑ No	Fractures	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Gallbladder Problems	❑ Yes ❑ No	Parkinson's	❑ Yes ❑ No
Autoimmune Disorder	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hearing Impairment	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Cardiac Conditions	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Smoking	❑ Yes ❑No
Cardiac Pacemaker	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Speech Problems	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Strokes	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	HIV/AIDS	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Currently Pregnant	❑ Yes ❑ No	Incontinence	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Depression	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Vision Problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Metal Implants	❑ Yes ❑ No		

Describe any other conditions or precautions

If "yes" to any of the above, Please explain and give approximate dates/Describe any other conditions

Fall History

Injury as a result of a fall in the past year? ❑ Yes ❑ No
Two or more falls in the past year? ❑ Yes ❑ No

Surgical history

Body Region: _____ Surgery Type:_____ Date: ____/____/_____

Body Region: _____ Surgery Type:_____ Date: ____/____/_____

Body Region: _____ Surgery Type:_____ Date: ____/____/_____

Body Region: _____ Surgery Type:_____ Date: ____/____/_____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason taking:_____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason taking:_____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason taking:_____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason taking:_____

❑ Currently not taking any medications