

# MRS Physical Therapy

## Patient Information Sheet

(please complete both sides of this form)

Appt Date: \_\_\_\_\_

Appt Time: \_\_\_\_\_

Account #: \_\_\_\_\_

### Patient Information

Patient FULL LEGAL name \_\_\_\_\_

Guardian name (if patient is a minor) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_ Patient's Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Marital Status: (circle) Married Single Other

Employment Status: (circle) Employed Full Time Student Part Time Student N/A

In case of an EMERGENCY, please notify \_\_\_\_\_ Phone: \_\_\_\_\_

### Physician Information

Referring Physician \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Have you had Home Health (therapy in your home) treatment in the past? YES NO Date: \_\_\_\_\_

Have you had therapy in the past 12 months? YES NO If yes, where: \_\_\_\_\_

### Insurance Information

Name of **PRIMARY** Insurance Company \_\_\_\_\_

Primary Insurance ID# \_\_\_\_\_ Primary Insurance Group# \_\_\_\_\_

Are you the POLICY HOLDER? Y or N: If you are NOT the policy holder, please complete the fields below:

Policy Holders's Name \_\_\_\_\_

Policy Holder's Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Birthdate \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

Name of **SECONDARY** Insurance Company \_\_\_\_\_

Are you the POLICY HOLDER? Y or N: If you are NOT the policy holder, please complete the fields below:

Policy Holders's Name \_\_\_\_\_

Policy Holder's Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Birthdate \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

Name of **TERTIARY** Insurance Company \_\_\_\_\_

Primary Insurance ID# \_\_\_\_\_ Primary Insurance Group# \_\_\_\_\_

Are you the POLICY HOLDER? Y or N: If you are NOT the policy holder, please complete the fields below:

Policy Holders's Name \_\_\_\_\_

Policy Holder's Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Birthdate \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

**Accident and Claim Information**

Is your injury Employment Related? YES NO Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Is your injury related to an Automobile Accident? YES NO Date of Accident: \_\_\_\_\_

Claim # \_\_\_\_\_ Adjustors Name: \_\_\_\_\_ Adjustor Phone: \_\_\_\_\_

Are you represented by an ATTORNEY? YES NO

Name, Address and Phone of Attorney \_\_\_\_\_

**Marketing Information**

How did you choose MRS PHYSICAL THERAPY:

Past patient  Friend  Radio  Newspaper  Doctor  Other

**TREATMENT CONSENT AND INFORMATION RELEASE**

The undersigned hereby authorizes consent of treatment and the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to render my treatment, submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed this particular claim.

I, (PATIENT) \_\_\_\_\_ hereby authorize and/or/all of the insurance companies identified above to pay and I hereby assign directly to MRS all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred including any no show fees. I further acknowledge that any insurance benefits, when received by and paid to MRS will be credited to my account in accordance with the above said assignment.

NOTE \*\* patient information is transmitted and shared via email between company entities and email is not always secure\*\*

(Signature) \_\_\_\_\_ Date: \_\_\_\_\_

**MRS Physical Therapy  
Past Medical History Questionnaire**

Patient Name \_\_\_\_\_ Reason for Therapy: \_\_\_\_\_

Have you ever received therapy for the condition mentioned above? Yes No  
If so, when? \_\_\_\_\_ Treatment Received: \_\_\_\_\_

Previous Treatment: Successful Unsuccessful ***Have you been vaccinated for COVID-19? Yes No***

Could you be or are you pregnant? Yes No

Do you now or have you ever had any of the following? Please check all those that apply.

Arthritis \_\_\_\_\_ Diabetes \_\_\_\_\_ Thyroid Problems \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Anemia \_\_\_\_\_  
Headaches \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Hypersensitivity to Heat/Cold \_\_\_\_\_ Concussion \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Swelling in Ankles \_\_\_\_\_ Hernia \_\_\_\_\_ Heart Attack \_\_\_\_\_ Deep Vein Thrombosis \_\_\_\_\_  
Kidney/Bladder Problems \_\_\_\_\_ Pacemaker \_\_\_\_\_ Seizures/Epilepsy \_\_\_\_\_ Previous Fractures \_\_\_\_\_  
Vascular Disease \_\_\_\_\_ Metal in Body/Surgical Implants \_\_\_\_\_ Previous Surgeries \_\_\_\_\_ Stroke \_\_\_\_\_  
Cancer/Tumor \_\_\_\_\_ Hearing Loss \_\_\_\_\_ Asthma \_\_\_\_\_ Recent Weight Loss or Gain \_\_\_\_\_ Depression \_\_\_\_\_  
Shortness of Breath \_\_\_\_\_ Current Infections \_\_\_\_\_ Anxiety \_\_\_\_\_ Chronic Cough \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
Substance Abuse \_\_\_\_\_ Fainting Spells \_\_\_\_\_ Hepatitis \_\_\_\_\_ Other: \_\_\_\_\_

If you answered "yes" to any of the above, please explain and give approximate date(s):  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies? No Yes If yes, please list \_\_\_\_\_

Are you presently taking any medications? No Yes  
If yes, please list medications, frequency and specify condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***This information is correct to the best of my knowledge.***

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Notice of Protected Health Information Practices (Privacy Policy)

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.

## Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), MRS Physical Therapy ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

## Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:
  - a. **Treatment.** We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.
  - b. **Payment.** We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.
  - c. **Health Care Operations.** We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.
2. **Uses and Disclosures With Patient Authorization.** Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.
3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.
4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:
  - a. **Uses and Disclosures Required by Law.** We will disclose your health information when required to do so by law.
  - b. **Public Health Activities.** We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.
  - c. **Abuse and Neglect.** We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.
  - d. **Regulatory Agencies.** We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.
  - e. **Judicial and Administrative Proceedings.** We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.
  - f. **Law Enforcement Purposes.** We may disclose your health information to law enforcement officials when required to do so by law.
  - g. **Coroners, Medical Examiners, Funeral Directors.** We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.
  - h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.
  - i. **Threats to Health and Safety.** We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
  - j. **Military/Veterans.** If you are a member of the armed forces, we may disclose your health information as required by military command authorities.
  - k. **Workers' Compensation.** We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
  - l. **Marketing.** We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

- m. **Appointment Reminders.** We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.
  - n. **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.
5. **Uses and Disclosures to Business Associates.** With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

## Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.
2. **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.
3. **Right to Verbally Object.** You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.
4. **Right to Seek an Amendment of Your Health Information.** You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.
5. **Right to an Accounting of Disclosure of Your Health information.** You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.
6. **Right to Confidential Communications.** You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.
7. **When Authorizations are Required.** An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.
8. **Right to Revoke Your Authorization.** You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.
9. **Right to Opt-Out of Fundraising Communications.** We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by calling the Compliance Officer at [814-864-6650](tel:814-864-6650) or sending an email to [h.bender@mrsphysicaltherapy.com](mailto:h.bender@mrsphysicaltherapy.com) with your instructions to opt out of fundraising communications.
10. **Right to be Notified Following a Breach of Your Information.** If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.
11. **Right to Receive Copy of this Notice.** You have the right to receive a copy of this Notice.

## Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at [814-864-6650](tel:814-864-6650). Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at [814-864-6650](tel:814-864-6650). All complaints must be submitted to the Practice in writing at [4538 Peach Street, Erie, PA 16509](mailto:4538 Peach Street, Erie, PA 16509). There will be no retaliation for filing a complaint.

## Effective Date

The effective date of this Notice is 08/22/2013.

---

## Acknowledgement of Receipt of Privacy Notice

### Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

***Please read the following information carefully:***

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by MRS Physical Therapy (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 4538 Peach Street, Erie, PA 16509, Attention: Compliance Officer
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): \_\_\_\_\_

\_\_\_\_\_

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient

---

### **To Be Completed by the Practice**

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

\_\_\_\_\_ Accepted      \_\_\_\_\_ Denied      \_\_\_\_\_ Not Applicable

\_\_\_\_\_ Other (explain) \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Practice Representative

\_\_\_\_\_  
Date

---

## Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes MRS Physical Therapy (the "Practice") to obtain, use and disclose the personally identifiable health information specifically referenced in this Authorization.

**Please read the following information carefully:**

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information:  
\_\_\_\_\_
2. I authorize the following person(s) or class of persons to receive the information:  
\_\_\_\_\_
3. The following is a description of the information that I authorize to be used and/or disclosed:  
\_\_\_\_\_  
\_\_\_\_\_
4. The information will be used and/or disclosed only for the following purposes:  
\_\_\_\_\_  
\_\_\_\_\_
5. I understand and acknowledge that if the person or entity that receives the information is not a health care provider, health plan, or other entity covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
6. **(If applicable)** I understand that the Practice will receive compensation for its use and/or disclosure of the information.
7. I understand and acknowledge that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that I may inspect or copy any information used and/or disclosed under this Authorization.
8. I understand and acknowledge that I may revoke this Authorization at any time by sending a written revocation to the Practice at the following address: 4538 Peach Street, Erie, PA 16509, Attention: Compliance Officer. However, I also understand and acknowledge that if I revoke this Authorization, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Authorization.
9. This Authorization expires \_\_\_\_\_  
(insert applicable date or event).

I understand all of the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION**

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient

---

A copy of the completed and signed Authorization form has been provided to the patient or representative:

\_\_\_\_\_ Yes

\_\_\_\_\_ No

\_\_\_\_\_  
Signature of Authorized Practice Representative

\_\_\_\_\_  
Date