Medication Form

Patient's Name: _____ Date: _____

Please fill out required information regarding **ALL MEDICATIONS: PRESCRIPTION, OVER THE COUNTER, VITAMINS, AND DIETARY/ HERBAL SUPPLEMENTS** below **COMPLETELY:**

☐ I am currently **NOT** taking any of the above

Medication: Prescription, Over the Counter, Vitamins, Herbals, Dietary Supplements	**Dosage**	**Frequency (times per day)**	**Route (Oral, Injectable, Transdermal, Inhale) Patients with Medicare MUST complete**	**Reason for Medication**

I acknowledge I have reviewed the above listed information noted with patient.

Clinician Signature: _____ Date: _____

MEDICAL HISTORY	YES	NO	ONSET DATE
Anemia			
Chest pain/Heart Attack/Coronary Artery Disease			
High Blood Pressure			
Arthritis			
Pulmonary Condition			
Cancer			
Diabetes			
Abnormal Bleeding/Clotting			
Vision Deficits			
Depression/Anxiety			
Hearing Problems			
Kidney Disease			
Osteoporosis			
Falls			
Fractures			
Seizures			
Incontinence			
Thyroid Disorder			
Strokes/TIA			
Active Infection			
Other Neurologic Disorder			
Loss of Consciousness			
MRSA/VRE/C-Diff			
Headaches			
Skin Disorders			
Other:			

Surgical History: List and Date

1. _____ 3. _____

2. _____ 4. _____

I acknowledge I have reviewed the above listed information noted with patient.

Clinician Signature: _____ Date: _____

PRIMARY MEDICAL CONDITION REQUIRING REHABILITATION:

_____

Allergies:

☐ **Yes** ☐ **No**

Allergic Reaction: _____

Special Tests Performed:

X-Ray ____ CAT scan ____ MRI ____ Bone Scan ____ Other ____

Date and result: _____

Have you ever had therapy for this problem? Yes ____ No ____

Are you under anyone else's care for this problem now? Yes ____ No ____

Have you had Physical Therapy before? Yes ____ No ____

If yes, please explain:

Social History:

Home Status:

Your current living arrangement is:

Live alone ____ Live with partner ____ Live with family/friend ____ Other ____

Do you live with children 18 years or younger? Yes ____ No ____

Do you have stairs going into your home/building? Yes ____ No ____

If yes, how many? ____

Smoking History:

Current smoker ____ Packs per day ____

Former smoker (Quit Date: _____)

Never smoked ____

Use of Alcohol:

Social ____ Weekly ____ 1 to 2 glasses per day ____ 2+ per day ____

Occupation:

_____

Are you currently working? Yes ____ No ____

Cultural Needs:

What is the primary language spoken in your home?

_____

Do you require an interpreter? (Bilingual patients may need an interpreter)

Yes ____ No ____

Are there any cultural/religious practices that you would like us to be aware of before treatment?

Yes ____ No ____

If yes, please explain: _____

PAIN

Do you have persistent or frequent Pain? Yes ____ No ____

If **YES**, complete the following:

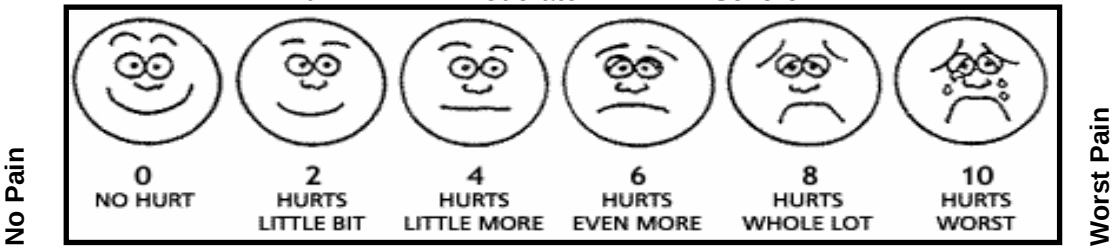
Location on body: _____

Does pain affect your daily activities? Yes ____ No ____

Does pain wake you at night? Yes ____ No ____

Circle one:

Mild **Moderate** **Severe**



Do you have durable medical equipment? (i.e. walker, wheelchair, etc.) _____

What exercises or sports do you participate in? _____

List your three major **FUNCTIONAL** difficulties/problems
(i.e. Self Care, Household Chores, Changing Positions, Shopping, Transportation, Walking, Work)

1. _____
2. _____
3. _____

List your three major **SYMPTOM** complaints

1. _____
2. _____
3. _____

List your **SPECIFIC GOALS** for rehabilitation

1. _____
2. _____
3. _____

I acknowledge I have reviewed the above listed information noted with patient.

Clinician Signature: _____ Date: _____

Acknowledgement of Company Policies and Procedures

Financial Policy MOTION Sports Medicine is partnered with Park Slope Medicine, P.C. and affiliated with New York Methodist Hospital. Your clinical care will be provided by our physical and occupational therapy staff at MOTION Sports Medicine. Your billing will be managed by Park Slope Medicine. All billing statements from MOTION Sports Medicine will come under the heading of Park Slope Medicine. Please make all checks payable to Park Slope Medicine, P.C.

Park Slope Medicine is contracted with most insurance companies. All bills for treatment services will be submitted directly to your insurance carrier. I authorize payment of medical benefits directly to Park Slope Medicine, PC and understand I am responsible for payments of all services rendered. If I belong to an HMO/ Managed Care Organization that Park Slope Medicine participates with, I agree to be responsible for securing necessary referrals and making direct payments as required by my policy. As a courtesy, MOTION Sports Medicine will submit to insurance for physical and occupational therapy authorizations.

MOTION Sports Medicine is bound by Federal and State Law to comply with the payment policies set forth by each insurance plan. These regulations prevent MOTION Sports Medicine from uniformly waiving co-payments and/or deductibles. Copayments must be paid in full before each treatment session. If you choose to issue your co-payments on a weekly basis, payment is due prior to your first treatment session of the week. If you wish to cancel or reschedule an appointment, we require a minimum of 24-hour advance notice. Less than 24-hour notice will result in a $50 cancellation fee. If you have frequent cancellations or fail to keep two appointments without notice, you may be discharged from the program. Applicable cancellation fees may be charged to your account. If you are experiencing financial hardship, you may qualify for financial assistance with the cost of your services. Please ask to speak to a member of our Patient Accounts Department. In the event it becomes necessary to refer your account for collection, you will be held responsible for the attorney fees and collection costs."

Consent For Care and Treatment I, the undersigned, do hereby agree and give my consent for MOTION Sports Medicine to provide me with effective rehabilitative treatment as considered necessary and proper in treating my physical condition. No guarantees have been made regarding the projected outcome of care. I have been given the opportunity to ask questions, and all my questions have been answered satisfactorily.

A Legal Guardian must accompany patients under 18 years of age to their Initial Evaluation. Said Legal Guardian is not required to attend follow up treatment sessions provided that the *"Consent to Treat a Minor"* document has been completed.

Disclosure to Individuals Involved in Patient's Case I acknowledge I have been offered a copy of MOTION Sports Medicine HIPAA Notice of Privacy and Security Practices. I authorize MOTION Sports Medicine to use and/ or disclose my Protected Health information (PHI) to carry out and arrange for my treatment, seek and receive payments for my treatments, and carry out business operations of the office. I give permission to MOTION Sports Medicine's providers and/or their authorized representatives to communicate medical information to me via any or all of the following methods as checked below:

☐ Voicemail: Phone #_____ ☐ Fax: #_____

☐ Email: Email address: _____ ☐ Writing

I give permission to MOTION Sports Medicine's providers and/or their authorized representatives to discuss my personal healthcare information only with the following individual(s) whom I have listed below:

Name:	Relationship to Patient
1. _____	_____
2. _____	_____

Motor Vehicle Collision/No Fault Policy/Worker's Compensation Policy If you were involved in a motor vehicle accident, you must complete and submit your No Fault application to your carrier within 30 days of your accident date and comply with any Independent Medical Examination (IME) requests. If you fail to do so, you will be held responsible for all payments until the time of settlement, judgment, or payment by attorney or the automobile insurance company. If you sustained an injury on the job and are receiving Physical and/or Occupational Therapy under Worker's Compensation you must comply with all requests set forth by Worker's Compensation.

I have read all company policies, procedures and guidelines. I hereby agree to treatment under the above stated terms.

Patient Signature: _____Printed Name: _____ Date: _____

WELCOME TO MOTION Sports Medicine

Partnering Together to Achieve Your Goals!

Company Policies and Guidelines to a Successful Relationship

Thank you for choosing MOTION Sports Medicine for your Physical and Occupational Therapy treatment services. MOTION Sports Medicine is dedicated to providing you with the best in personalized care. Outlined below are a few company policies designed to serve our mutual needs.

Before you begin your treatment sessions, the following is required:

1. A prescription or referral from your physician (Direct Access within 30 days or 10 visits, first occurrence)
2. Verification of your insurance benefits
3. A copy of your insurance card (Front and Back)
4. Co-payments required by your insurance company
5. Photo ID
6. Completion of Acknowledgements Form

Appointment Policy

We recommend that you arrive 10 minutes before your scheduled appointment time. This will allow time for you to address scheduling and/or insurance needs prior to your therapy session. If you arrive more than 10 minutes after your scheduled start time you may not receive a full treatment session. If you arrive more than 20 minutes after your scheduled start time every attempt will be made to accommodate you. You may be asked to wait for the next opening with an available therapist or to reschedule your appointment, as last minute openings may not be available.

Medical Records Policy

Medical records are available upon request once you have completed a "*Medical Release Form"* and applicable fees have been satisfied. Should your insurance company request copies of your records in order to process your claim, we will provide all requested documentation. We will not release your medical records to a third party without a signed "*Medical Release Form"* or unless the law authorizes or compels us to do so.

Dress Code Guidelines

It is recommended that you wear comfortable footwear (sneakers) and clothing to your therapy sessions.

Cell Phone Policy

Please set cell phones and pagers to vibrate or silent when in the therapy area. Please use cell phones for emergencies only. Please find a private area to make your call so as not to disturb other treatment sessions in progress.

Waiting Room Policy

Young children who are not receiving therapy are not permitted in the therapy area. Children must remain supervised in the waiting area.

Effective April 14, 2003

Revised September 23, 2013

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We are committed to protecting medical information about you. This includes all records of your care generated by the office, whether made by your therapists or by office personnel.

We are required by law to make sure that medical information that identifies you is kept private. We are required by law to provide you with this notice of our legal duties and privacy practices with respect to medical information about you. This notice describes your rights and certain obligations we have regarding the use and disclosure of medical information.

USES AND DISCLOSURES

The following categories describe different ways that we may use or disclose your protected health information (PHI). Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories:

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Business Operations includes the uses and disclosures necessary to run the office and make sure all our patients receive quality care. For example, we may use your medical information to monitor our staff's performance in caring for you and educate them as to how to improve the care they provide to you.

Business Associates: We may share your medical information with our "business associates," such as our billing service and other vendors who perform administrative services for us. We have a written contract with each of these business associates that requires them to protect the confidentiality of your medical information.

Other Special Uses: We may use your PHI for other reasons including: contacting you with an appointment reminder, calling out your name in the waiting room when we are ready to see you, informing you of other health and recreational therapy related services that may be of interest to you, or requesting a contribution to our charitable activities.

Breach Notification: In the case of a breach of unsecured PHI, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances one of our business associates may provide the notification. We may also provide notification by other methods as appropriate.

Uses and Disclosures Required by Law: The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or health of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

YOUR PRIVACY RIGHTS

Restrictions: You have the right to request restrictions on how your PHI is used; however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications: You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI: You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments: You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures: You have the right to request, in writing, an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Changes to this Notice: We reserve the right to amend this notice at any time in the future. After an amendment is made, the revised Notice of Privacy will apply to all protected health information we maintain, regardless of when it was created or received. A copy of our current notice will be posted in our waiting area.

Complaints: If you feel that your privacy rights have been violated, you have the right to make a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Office at MOTION Sports Medicine, at 263 7th Avenue #2A, Brooklyn, NY 11215. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services. OCRComplaint@hhs.gov

The complaint form may be found at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

TREATMENT CONSENT FORM FOR MINORS

(Form to be completed by Parent or Legal Guardian for any patients under the age of 18)

MOTION Sports Medicine is required to protect the rights of our patients and ensure the safety of minors. Any new patient under the age of 18 must be evaluated in the presence of their Parent/Legal Guardian. It is important that the Parent/Legal Guardian be aware of the minor's condition(s) and informs the treating clinician.

Patient Name: _____

Patient Age: _____

Parent/Legal Guardian: _____

Relationship to Patient: _____

I, "Parent/Legal Guardian" do hereby authorize the staff of MOTION Sports Medicine (licensed Physical and Occupational Therapists) to provide "Patient" with effective rehabilitative treatment pursuant to the prescription from his/her physician as deemed advisable by MOTION Sports Medicine staff for his/her care and well-being.

Please select one of the following (A OR B):

- ❑ A. I, hereby grant MOTION Sports Medicine permission to treat "Patient" whether or not "Patient" is accompanied to treatment session.

OR

- ❑ B. I, "Parent/Legal Guardian" hereby authorize the rendering of Physical and/or Occupational Therapy treatment exclusively in my presence or in the presence of the below designated representative(s). In the absence of "Parent/Legal Guardian" or the representative(s) listed below, treatment shall NOT be rendered.

Name of Representative(s): _____

Relationship to Patient: _____

I confirm that I have read and fully understand the above.

Parent /Legal Guardian: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Emergency Contact Information

Parent/Legal Guardian: _____	Alternate Contact: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____