

HIPAA Consent Form

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by TheraMatrix Physical Therapy (TheraMatrix) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of TheraMatrix. I understand that diagnosis or treatment of me by TheraMatrix may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. TheraMatrix is not required to agree to the restrictions that I may request. However, if TheraMatrix agrees to a restriction that I request, the restriction is binding on TheraMatrix and any TheraMatrix clinician.

I have the right to revoke this consent, in writing, at any time, except to the extent that TheraMatrix has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review TheraMatrix’s Notice of Privacy Practices prior to signing this document. TheraMatrix’s Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of TheraMatrix. The Notice of Privacy Practices for TheraMatrix is also provided in the waiting area of each clinic and on the TheraMatrix website at www.theramatrix.com. This notice of Privacy Practices also describes my rights and TheraMatrix’s duties with respect to my protected health information.

TheraMatrix reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the TheraMatrix website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Relationship to Patient

THERAMATRIX PHYSICAL REHABILITATION MEDICAL HISTORY

Patient Name: _____

Acct #: _____

Clinic: _____

Have you ever been treated or are you now being treated for any of the following conditions:

<u>Condition</u>	Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems, Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness, Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder, Arm, Hand Problems	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Leg Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Blood Count	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Tumors/Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Metal Implants (screws, plates. etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or is there a possibility that you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

List all surgeries and medications you are currently taking along with any information you feel this clinic should know. If you answered "YES" to any of the above, please explain below:

**THERAMATRIX PHYSICAL REHABILITATION
MEDICARE FORM**

Acct #:

Clinic:

Please complete this form in its entirety so that your insurance may be billed.

Name:

MC#

(from Medicare Card)

1. Are you currently receiving Home Health Service? Yes No

2. Have you received Home Health Services within the last 6 months? Yes No

3. Date of Injury?

4. Please check the following that apply to you:

Entitled to ESRD Benefits

Auto Accident

Entitled to Black Lung Benefits

Worker's Comp.

5. If your injury was an accident, where did this happen? (Please be specific)

Place:

Address:

6. Are you filing a lawsuit or do you intend to in the future? Yes No

If yes, who is the responsible party?

Attorney Name:

7. Are you or your spouse currently employed? Yes No

8. Are you retired? Yes No If yes, retirement date:

9. Are you covered by a Group Health Plan? Yes No

Name of Plan:

Contract Number:

This information is important in filing your Medicare claims to insure proper payment.

Thank you for your cooperation.

Signature

Date