FOR YOUR APPOINTMENT
PLEASE REMEMBER TO BRING THE FOLLOWING ITEMS:

- **YOUR PRESCRIPTION** (IF YOU HAVE MEDICARE, AN HMO INSURANCE PLAN, A MOTOR VEHICLE ACCIDENT CLAIM OR A WORKER'S COMPENSATION CLAIM AND YOU DO NOT HAVE YOUR PRESCRIPTION FOR PHYSICAL THERAPY WE WILL NOT BE ABLE TO TREAT YOU.)
- YOUR INSURANCE CARDS, WORKER'S COMPENSATION CLAIM INFORMATION, OR MOTOR VEHICLE ACCIDENT CLAIM INFORMATION
- YOUR LIST OF MEDICATIONS, ALLERGIES AND SURGERIES
- **YOUR PERSONAL APPOINTMENT CALENDAR**
- THE COMPLETED PAPERWORK
- YOU MAY ALSO BRING COPIES OF ANY X-RAY, MRI, OR CT REPORTS IF YOU HAVE THEM

PLEASE ARRIVE APPROXIMATELY 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME. PLEASE CONTACT THE OFFICE IF YOU HAVE ANY QUESTIONS: 717-591-0955.

THANK YOU!

5103 Carlisle Pike, Mechanicsburg, PA

GILBERT
PHYSICAL THERAPY
The Results You Want. The Care You Deserve.

PATIENT INFORMATION

Name_____**Social Security Number**_____

Address_____**City & Zip Code**_____

Home Phone #_____**Work Phone #**_____**Birth Date**_____**Age**_____

Phone number to be used as the primary contact number_____
Email address_____

Sex M / F (circle one) **Marital Status**_____ **Spouse's Name & Work #**_____

Responsible Person's Name, Address & Phone # (for patient's under 18)_____

Date you last saw your referring and/or primary physician_____

Referring Physician_____
(First and last name) (City)

Primary Physician_____

Employer Name_____Phone Number_____

Address_____Occupation_____

Have you had physical therapy or chiropractic care in the past year?_____

Did a friend or family member refer you to Gilbert PT? (provide name) _____
Did a physician refer you? (provide name) _____
Did you hear about us through an advertisement? If so, where?_____

INSURANCE INFORMATION: *Please give your Insurance Cards to the Receptionist for verification.*

Is this accident related YES / NO AUTO / WORKERS COMP Date of INJURY _____

Primary Insurance _____ Secondary Insurance _____

Are you the Subscriber (holder) of the Insurance Policy YES / NO

If not, please complete: Subscriber's Name_____ Date of Birth _____

AUTHORIZATION AND RELEASE

I certify that the information provided on my health history has been provided as accurately as possible. I authorize the physical therapist to release any information, including diagnosis and records of any treatment or examination rendered to my child or me during the period of such physical therapy care, to third party payers and/or health practitioners. I authorize and request my insurance company, should I have insurance and if they will do so, to pay any insurance benefits directly to the treating physical therapist. I agree to be responsible for the payment of all services rendered on behalf of my dependents, or me and also for any charges, which may arise from collection of that fee.

_____

Patient Signature (or Guardian) *Date*

GILBERT PHYSICAL THERAPY

Affiliate of OPTN

MEDICAL HISTORY

Patient Name: _____ Date: _____

Medical History: Are you currently experiencing or have you had any of the following:

High Blood Pressure	Y N	Heart Disease	Y N	Numbness	Y N
Bowel/Bladder Problems	Y N	Pacemaker	Y N	Cancer	Y N
Shortness of Breath	Y N	Weakness	Y N	Pregnant	Y N
Female Problems	Y N	Diabetes	Y N	Dizziness	Y N
Night Pain	Y N	Fatigue	Y N	Osteoporosis	Y N
Irregular Heart Rate	Y N	Headaches	Y N	Stroke	Y N

Surgeries? Y N (List) _____

List any medications you are taking: _____

How would you rate your general health? (circle one) Poor Fair Good Excellent

In the past 3 months, have you experienced any significant changes in health (physical or mental) such as unexplained weight loss, depression, nausea, etc? (List)_____

List other medical problems: _____

Currently:

What is your current complaint? _____ When did it start? _____

Due to an injury? Y N (Explain) _____ Illness? _____

Did the symptoms begin: Suddenly or Gradually Previous problems in this area? Y N

Previous therapy for this condition? Y N What effect? _____

Are you getting: Better Same Worse Are you better with rest? Y N

Does activity make you worse? Y N Which activities? _____

Are you worse in the: Morning Afternoon Evening Is your pain: Continuous Occasional

Does your pain radiate? Y N Where? _____

What reduces your pain? _____

What can't you do because of your symptoms? _____

Recent tests: X-ray CT MRI EMG Myelogram Other _____

Results: _____

What did the Doctor tell you is your diagnosis? _____

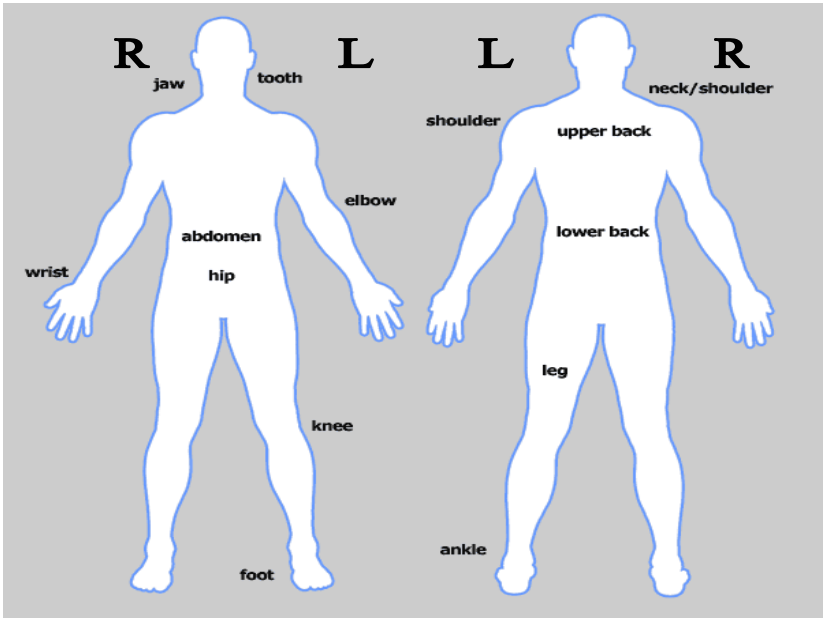
Did the physician put you on any restrictions? Y N List: _____

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain:

Right now: _____ Highest pain in past 24 hours: _____ Lowest pain in past 24 hours: _____

PLEASE COLOR YOUR AREA OF PAIN ON THE BODY DIAGRAM BELOW

FRONT



BACK

ATTENTION!

In order to provide our patients with the best possible care, we maintain scheduled appointments. If you cannot make a scheduled appointment, PLEASE contact us at least 24 hours before your scheduled time. This will allow us to adjust our schedule appropriately.

ATTENDANCE POLICY

Individuals who attend 100% of their scheduled appointments will receive a free GILBERT PHYSICAL THERAPY t-shirt.

PATIENTS WHO CANCEL 3 TIMES OR NO-SHOW 2 TIMES WILL BE DISCHARGED.

Once you have read and understood the GILBERT PHYSICAL THERAPY Attendance Policy,

Please sign here _____

Thank-You.

Gilbert Physical Therapy
Affiliate of OPTN
5103 Carlisle Pike
Mechanicsburg, PA 17050
Ph: 717-591-0955
Fax: 717-591-0956

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 this information carefully.

1.) Gilbert Physical Therapy Duties

Gilbert Physical Therapy ("Gilbert") has a legal duty to safeguard our patients' privacy in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"). Outlined below is our office policy regarding the protection of our patients' protected health information[1] ("PHI"), how this information may be used and disclosed, and how a patient obtains access to their health information.

We are required to abide by the terms of this Notice of Privacy Practice until it is superseded or amended. To that end, Gilbert reserves the right to amend the terms of its privacy practices. Any amended or new privacy provisions will be effective for all protected health information maintained by Gilbert. Should Gilbert amend its privacy practices at any time in the future, you will receive a revised notice when you next seek treatment from us.

2.) How Gilbert May Use and Disclose Patients' Protected Health Information

Treatment, Payment and Health Care Operations We will use your PHI for the purposes of treatment, payment and health care operations.

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 that 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 that 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.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility, to evaluate those providing care, and for business planning activities. For example, Gilbert may use a patient's PHI to conduct quality analyses and employee reviews.

Other Special Uses

Gilbert may use your PHI to provide appointment reminders, to inform you of our other health related products and services which may be of benefit to your, or to request a contribution to our charitable activities.

Appointment Confirmation: It is Gilbert's standard practice to call each patient regarding an upcoming appointment. In order to ensure the protection of your PHI, we must call the phone number provided by the patient. If we are prompted to leave a voice mail message, we will assume that it is secure and that we have your permission to leave a message with pertinent information. If we contact you at the home telephone number provided and we are prompted to leave a voice mail message, we will leave a message for you again assuming that it is secure that we have your permission to do so. If you, the patient provide us with a phone number and upon calling that number we reach a family member, co-worker, or other person, we will ask that person

to take a message with pertinent appointment information including but not limited to the date, time and location of the appointment.

Uses and Disclosures Required by Law

HIPAA either permits or requires 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 with your written consent.
- We may use your PHI in an emergency situation when you may not be able to express yourself.
- We will use and disclose our patients' PHI when we are required to do so by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the release requirements of the law.

Public Health Activities

We will report information to government officials that are in charge of collecting information for the purpose of:

a. Preventing or controlling disease, injury or disability;
b. Reporting child abuse and neglect;
c. Providing an employer information about an employee regarding a potential work injury or illness;
d. Notifying individuals if a product or device they may be using has been recalled;
e. Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient, including domestic violence: however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

Health Oversight Agency

We will provide information, including a patients' PHI to a Health Oversight Agency for oversight activities authorized by law. These activities can include but are not limited to, investigations, inspections, audits, surveys, licensure and disciplinary actions.

Judicial and Administrative Proceedings

We may use and disclose a patients' PHI in response to a court or administrative order, if a patient is involved in a lawsuit or similar proceeding. We also may disclose a patient's PHI in response to a discovery request, subpoena or proceeding or to obtain an order protecting the information the party has requested. However, we will only disclose such information as is expressly authorized.

Law Enforcement

We may release PHI if asked to do so by law enforcement officials:

a. In response to a warrant, summons, court order, subpoena, or similar legal process.
b. To identify/locate a suspect, material witness, fugitive or missing person.
c. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
d. Concerning a death we suspect has resulted from criminal conduct.
e. Regarding criminal conduct that occurred on our property.
f. In an emergency, to report a crime (including the location of a victim of the crime, or the description, identity or location of the perpetrator).

Serious Threats of Health or Safety

We may use or disclose a patient's PH when necessary to prevent or lessen an imminent threat to a patient's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Government Functions

We may disclose a patient's PHI if you are a member of the US or foreign military forces and if required by the appropriate authorities.

National Security
We may disclose a patient's PHI to federal officials for intelligence of national security activities authorized by law.
Correctional Institutions
We may disclose a patient's PHI to correctional institutions or law enforcement officials if the patient is an inmate or under custody of law enforcement officials.
Workers Compensation
We may release a patient's PHI to comply with workers' compensation laws and similar programs.
Your written authorization is required before your PHI may be used or disclosed by us for any other purposes. You may revoke your authorization in writing at any time, except to the extent that Madden has already made disclosures in reliance upon your prior authorization.

3.) Your Privacy Rights
Restrictions
You have the right to request certain 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 that confidential communication from us by provided in another reasonable manner 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 you a fee to cover the costs of copying and mailing these records.
Amendments
You have the right to request an amendment to be made to your PHI if you disagree with what your record says about you. This request must be made in writing. If we disagree with you, we are not required to make the change and will notify you of the same in writing. At that time, you do have the right to submit a written statement disagreeing with your denial which will become a part of your permanent record. We may not amend parts of your medical record that we did not create.
Accounting of Disclosures
You have the right to request an accounting of the disclosures of your PHI 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 prior authorization.
Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with your response, you may complain directly to the Secretary of Health and Human Services.
Request a Copy of This Notice
You have the right to obtain a copy of the Notice upon request. This notice is also published on our website: www.gilbertpt.com
Privacy Contact
If you would like more information about our privacy practice or to file a complaint, you may contact:
Susan Madden
Privacy Officer
5425 Jonestown Road, Suite 100
Harrisburg, PA 17112
717-901-9487

Effective Date This Notice will take effect on July 1, 2009.

Gilbert Physical Therapy
Affiliate of OPTN
5103 Carlisle Pike
Mechanicsburg, PA 17050
Ph: 717-591-0955
Fax: 717-591-0956

Acknowledgement Of Receipt Of Notice Of Privacy Practices

The Health Insurance Portability and Accountability Act ("HIPAA") requires that we provide you with a copy of our Privacy Notice. By signing this Acknowledgment, you are acknowledging that you have received or have been offered a copy of The Notice of Privacy Practices for Gilbert Physical Therapy.

Patient Name: _____
(Please print)

Signature of Patient: _____
(Or legally authorized representative)

Printed Name of Legally Authorized Representative: _____

If not signed by patient, please indicate your relationship to patient:_____

Date: _____

Witness: _____

For Official Use Only:

A good faith effort was made to provide the patient with a copy of the Privacy Notice but the patient refused to sign because:

_____
_____
_____
_____

Employee Signature: _____

Date: _____