Patient Information Sheet

Date: __________

Last Name: ________________________ First Name: _________________________________ Middle Initial: ___

Guardian 's Name: _____________________________________ (if any) SSN: ____-____-___

Date of Birth: ____-____-____ Marital Status: M/S/W/D

Address:____

City: ____ State: ____ Zip Code: ____________________

Home Phone: _____________________________ Email: _______________________________________

Cell#:_____________________________________ Work#: _____________________________________

Employer: ______________________________ Occupation: _________________________________

Emergency Contact: ______________________ Relationship: ______________________________

Address:____

City: ____ State: ________ Zip Code: _______________

Primary Physician: ____________________________ Specialty: ____

Address:____

City: ____ State: ____ Zip Code: __________________

Phone: ____________________________________ Fax: ____

Referring Physician: _____________________ Specialty: ____

Address:____

City: ____ State: ____ Zip Code: __________________

Phone: ___________________________________ Fax: ____

Name: ____________________________   Date: ____________________________

Patient's Privacy Policy

A. We have a legal duty to protect health information about all patients.

B. We may use and disclose Personal health information (PHI) about the patient in the following circumstances:

1. **We may use and disclose PHI about patients to provide healthcare treatment to them.**
2. **We may use and disclose PHI about patient to obtain payment for services.**
3. **We may use and disclose PHI about patients to healthcare operations.**
4. **We may use and disclose PHI under other circumstances without their authorization.**
5. **Patients can object to certain and disclosures.**
6. **We may contact patients to provide appointment reminders.**
7. **We may contact patients with information about treatment services, products or healthcare providers.**
8. **We may contact patients for fund-raising activities.**

C. Patients have several rights regarding PHI about themselves.

1. **Patients have the right to request restrictions on uses and disclosures of PHI about themselves.**
2. **Patients have the right to request different ways to communicate with them.**
3. **Patients have the right to see and copy PHI about themselves.**
4. **Patient have the right to request amendments of PHI about themselves.**
5. **Patients have the right to a listing of the disclosures we have made.**
6. **Patients have a right to copy this notice.**

D. Patient may file a complaint about our privacy practices.

E. Effective date of this notice

Initials: __________

Realhab, Inc.
Physical Therapy & Rehabilitation Services
12159 US Hwy 301 North
Parrish, Florida 34219

ACKNOWLEDGMENT: Receipt of notice of Privacy Practices

I have received a copy of the Realhab, Inc. Notice of Privacy Practices effective __________.

Name: (please print): ______________________________
Signature: _______________________________________
Date: ____

I am a parent/legal guardian of __________________ (patient name). I have received a copy of the Realhab, Inc. Notice of Privacy Practices effective _________________.

Name: (please print): ______________________________
Signature: _______________________________________
Date: ____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective and given to the individual on (date): _______________

_____ In person _____ Mailing _____ Email _____ Other: ___________

Reason individual or parent/legal guardian did not sign this form:

_____ Did not want to
_____Did not respond after more than one attempt.
_____ Other:______________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

_____ In person conversation: ______________ _____ Telephone contact: __________________
_____ Mailing:___________________________ _____ Email: ____________________________
_____ Other: _____________________________

Staff Name: (please print) ____

Signature: _______________________________________ Date: ______________________________