RHODE ISLAND
Physical Therapy
& Sports Medicine

Assignment of Benefits and Consent for Release of Information

Patient Name:_____

Assignment of Benefits

I hereby instruct and direct Insurance Company to pay by check which should be made out and mailed to: Rhode Island Physical Therapy and Sports Medicine 621 Pound Hill Rd, Suite 101 North Smithfield, RI 02896.

However, if my current insurance policy does not allow direct payment to my provider, I hereby instruct you to make out the check to me and mail it to the following address: Rhode Island Physical Therapy and Sports Medicine 621 Pound Hill Rd, Suite 101 North Smithfield, RI 02896.

This is for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy for the services rendered. I authorize Rhode Island Physical Therapy and Sports Medicine to deposit checks received on my account when made out to me. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as valid and effective as the original.

Consent for Release of Information

I also authorize the release of any information pertinent to my case to any physicians, rehabilitation consultants, insurance company, adjuster, or attorney involved in this case, except as follows:

Signature of Policyholder:_____ Date_____

Signature of Claimant, if other than Policyholder:_____

Please list persons with whom we may leave confidential information:

Name:_____ Phone:_____

Name:_____ Phone:_____

How may we leave confidential information with you?

• Email • Cell Phone Voicemail • Home Voicemail • Work Voicemail

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Intramuscular Manual Therapy(IMT)/Trigger Point Dry Needling Consent

IMT/TDN involves placing a small needle into a muscle or other soft tissue structure of the body in order to improve flexibility and decrease symptoms. When indicated, IMT/TDN is a valuable treatment for musculoskeletal pain. Like any treatment, there are risks to consider.

The most serious risk associated with IMT/TDN is accidental puncture of a lung resulting in pneumothorax. If this were to occur, a chest X-ray is required for diagnosis. No treatment is performed with partial lung collapse findings. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and, in skilled hands, should not be a concern. Other risks include bruising, infection, soreness, and nerve injury.

Please discuss any concerns with your therapist during your treatment.

Do you have any known diseases or infections that can be transmitted through bodily fluids?

Yes • No •

- **I understand the risks involved and consent to this treatment as medically necessary.**
- **No, thank you. I have read the information above and I do not want this treatment.**

Patient/Guardian Name (Print):_____

Patient/Guardian Signature:_____

Date:_____

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Patient Name:_____ Date:

_____

Please list all medications you currently take:_____

_____

__

Please check "yes" or "no":

Condition	Yes	No	Condition	Yes	No
Arthritis	•	•	Headache/Migraine	•	•
Asthma/Lung Problems	•	•	Head Injury	•	•
Bladder Problems	•	•	Heart Problems	•	•
Blood Clots/Vascular Problems	•	•	High Blood Pressure	•	•
Cancer	•	•	Neuromuscular Problems	•	•
Chest Pain w/ Exertion	•	•	Numbness/Tingling	•	•
Diabetes	•	•	Osteoporosis	•	•
Difficulty w/ Balance/Coordination	•	•	Parkinson's Disease	•	•
Difficulty w/ Hearing/Vision	•	•	Seizures	•	•
Dizziness/Blackouts	•	•	Shortness of Breath	•	•
Fractured/Broken Bones	•	•	Stroke/CVA/TIA	•	•
Frequent Joint Strains/Sprains	•	•	Swollen Arms/Hands/Legs/Feet	•	•
			Weakness in Arms/Legs	•	•

Do you have any history of the following?:_____

Smoking • •

Using a pacemaker • •

Falls • • If so, how many times?_____Were you injured?_____

Pins/Metal Implants • • If so, where?

_____

Infectious Disease • • If so, please explain

_____

Pregnancy • • If so, how many times? And when?

_____

Allergies (Including latex) • • If so, please list

_____

Please check "yes" or "no":

Procedure	Yes	No	Date	Specifics (Which side/part of body)

Have you had surgery for your current injury/episode? • Yes • No

When?_____

Joint Replacement • • _____
_____
Orthopedic Surgery • • _____ _____
Heart Surgery • • _____
_____
Fracture Reduction • • _____
_____
Joint Manipulation • • _____
_____
Spinal Surgery • • _____
_____
Other
Surgeries_____
Please list your current
limitations/restrictions_____

Complete the following based on your current injury/episode:_____
Have you had any of the following Medical or Rehabilitative Care? If yes, when?_____

•Physician _____ •X-Ray _____
•Chiropractor _____ •MRI _____
•Physical Therapist _____ •CT Scan _____
•Occupational Therapist _____ •Bone Scan _____
•Massage Therapist _____ •EMG/NCV _____
•Orthopedist _____ •Myelogram _____
•Neurologist _____ •Blood Chemistry _____
•Podiatrist _____
•Other:_____

What are you currently seeking treatment for? (Please include which side of your body is affected)

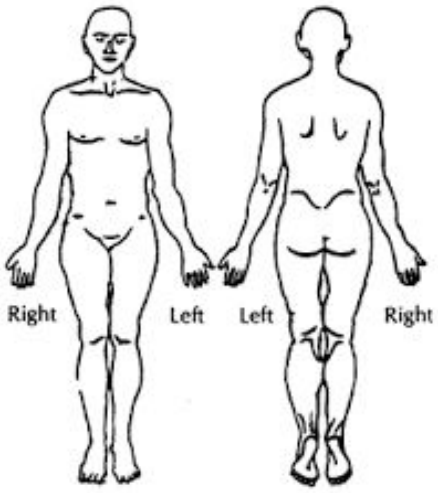
_____
_____
____

Please rate your pain from 1-10 (1= no pain; 10= the worst pain you have experienced)_____

0 5 10

Using the diagram below, describe your symptoms with the following symbols:_____

(X) Sharp pain (+) Numbness/Tingling (#) Ache (B) Burning



I believe all the information included in this form to be correct to the best of my knowledge.

Patient/Guardian Signature:_____ Date:_____

Patient Consent to Treatment

The physical therapist has discussed the proposed treatment, the material risks, expected benefits, and reasonable alternatives of the proposed treatments. My questions have been answered to my satisfaction and I hereby consent to the proposed treatment.

Patient/Guardian Signature:_____Date:_____

Acknowledgement of Receipt of Our Notice of Privacy Practices/HIPPA

I,_____, have been provided with a copy of the Notice of Privacy Practices from Rhode Island Physical Therapy and Sports Medicine.

Patient/Guardian Signature:_____Date:_____

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& Sports Medicine

Registration Form

Today's Date:_____ Therapist:_____ Eval Date:_____

Patient Information

First Name:	Last Name:	Date of Birth:	Male Female	Married Single
Street Address:	City:		State:	Zip Code:
Home Phone:	Cell Phone:	Email:		
Emergency Contact:	Relationship:	Phone:		

Condition Information

Diagnosis:	Doctor:	Worker's Comp Auto Neither	
Surgery: Yes No	Date:	Facility:	
Physical Therapy: Yes No	Dates:	Facility:	

Payment Information

WC/Auto:	Date Injured:	Claim #:	Claim Rep:
Rep's Phone:	Insurance:	Ins. Phone:	
Ins. Address:	City:	State:	Zip Code:
WC Only:	Employer:	Work Phone:	
Work Address:	City:	State:	Zip Code:
Manager:	Manager Phone:		
Primary Insurance:	Carrier:	ID #:	
	Subscriber Name:	Subscriber Birth Date:	
	Deductible:	Copay:	
Secondary Insurance:	Carrier:	ID#:	
	Subscriber Name:	Subscriber Birth Date:	
	Deductible:	Copay:	

How Did You Hear About Us?

Friend/Family
Internet Search
Newspaper
Brochure
Insurance
Website
Clinic Sign
My Doctor

Your Signature

I have verified that the information above is correct to the best of my knowledge.

Signature:_____ Date:_____

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Notice of Privacy Practices

Effective June 17, 2013

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

Our Commitment

Rhode Island Physical Therapy and Sports Medicine is committed to uphold all professional, ethical, and legal standards for safe guarding patients' health information. This notice is provided to you in accordance with federal law, to explain our privacy practices. Federal law requires us to abide by the terms of this notice.

How We Use and Share Your Health Information

When you receive care at Rhode Island Physical Therapy and Sports Medicine, we use and share health information to treat you, to obtain payment of services, and to conduct normal business activities and health care operations. The following describe the ways we may use and share your health information.

Treatment: We will share your health information with other health care providers to provide, coordinate, and manage your care. For example, your primary physical therapist will share information with assistants and physicians directly involved in your care. All staff at Rhode Island Physical Therapy and Sports Medicine follows the privacy practices described in this notice.
Payment: We may use and share your health information to obtain payment for services we provide to you. For example, we send a bill to your insurance company which identifies you, your diagnosis, and your treatment procedures.
Workers' Compensation: We may use or share health information in connection with claims for workers' compensation benefits.
Family, Friends, and Caregivers: Unless you object, we may use or share your health information to communicate with another person who is involved in your care.
Legal Obligations and Law Enforcement: We will disclose health information about you when required to do so by federal or state law or as may be required for legal proceedings or for law enforcement.
Threats to Safety and Health: We may share your health information with police or others when necessary to avoid harm to the health and safety of you, another person, or the general public.
Incidental Disclosures: Certain incidental disclosures of your health information may occur as a byproduct of lawful and permitted use and disclosure of health information. Such incidental disclosure is permitted as long as we apply reasonable safeguards to protect medical information. For example, another patient may overhear a conversation between you and your physical therapist in the gym area. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law.

Your Health Information Rights

Although your health record is the physical property of Rhode Island Physical Therapy and Sports Medicine, the information belongs to you. You have the right to:

- Request us to restrict the health information we use or share about you for treatment, payment, or health care operations. However we are not required to agree to this request.
- A paper copy of this notice upon request.
- View or receive a copy of health information about you that we have. We may charge a fee for copying.
- Ask for amendments if you believe your health information is incorrect or incomplete. You must submit the request in writing and supply the reason. This request may be denied if applicable laws requires or permits us to deny it or if you information is correct and complete.
- Request an accounting, or list of instances in which we disclosed your health information to others. This right is subject to certain exceptions, restrictions, and limitations. Such requests must be submitted in writing to the Privacy Officer.
- Request communications of your health information by alternative means or alternative locations. For example, you may ask us to only contact you at work. Such requests must be submitted in writing to the Privacy Officer.

We reserve the right to change our privacy practices and the terms of this notice at any time. Any revised version of this notice will be effective for all health information that we maintain about you at that time, including information gathered prior to the effective date of the revision. Upon your request, we will provide you with a copy of the most up to date version of this notice.

For more information, requests, questions and complaints:
Rhode Island Physical Therapy and Sports Medicine: 621 Pound Hill Rd N Smithfield RI 02896. (Phone): 401-356-1447 (Fax): 401-356-1448
Office of Civil Rights, US Department of Health and Human Services Government Center: J.F. Kennedy Federal Building- Room 1875 Boston MA 02203
(Phone): 617-565-1340 (Fax): 617-565-3809 Email: OCRCOMPLAINT@hhs.gov