

HIPAA NOTIFICATION

REHAB PARTNERS, INC. IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AND TO PROVIDE YOU NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES AND ADHERE TO THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE DO CHANGE OUR INFORMATION PRACTICES, WE WILL POST A NOTICE THAT THE NOTICE HAS CHANGED AND THE EFFECTIVE DATE OF THE CHANGE. COPIES WILL BE MADE AVAILABLE UPON REQUEST.

I UNDERSTAND THAT REHAB PARTNERS, INC. HAD MADE AVAILABLE TO ME A COPY OF THE NOTICE OF PRIVACY PRACTICES. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE: _____

DATE: _____

Because of the nature of this practice, it may be necessary to contact you by telephone for examination results, scheduling, appointments, billing, etc. HIPAA requires that we obtain specific consent from our patients allowing us to speak with others on your behalf should you not be available. Please indicate below the names, relationships, and date of birth of those you will allow us to speak with on your behalf. This would include your SPOUSE, FAMILY MEMBERS, CARE GIVERS, ETC.

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

If you **DO NOT** want us to speak with anyone with regards to your treatment, appointments, billing, etc. please indicate so by signing below.

NAME: _____

DATE: _____

Rehab Partners, Inc.
Health History Questionnaire

Date_____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name: _____ DOB: _____ Age: _____

What medical concerns bring you to our office? _____

How did you hear about our office? Doctor Friend/Family Advertisement Web
Insurance

If disabled, check here: Nature of disability: _____

Do you exercise routinely? (*circle*) Yes No If yes, what exercise/how often? _____

Have you used tobacco products one or more times within the last 24 months? (*circle*) Yes No
If yes, was cessation counseling intervention received? (*circle*) Yes No

Have you completed Advanced Directives or do you have a Living Will? (*circle*) Yes No Which? _____

Tell us about your home environment: (*e.g. live alone or with family; house or apt; stairs? pets?*)

Have you had 2 or more falls in the past year, or any one fall with injury in the past year? (*circle*) Yes
No

Medical Information:

Allergies: _____

Have you ever been diagnosed with or treated for the following conditions? Check all that apply:

- | | | | | |
|---|---|--|---|-------------------------------------|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid Disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> TB/Lung Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Digestive Disorder | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | |
| <input type="checkbox"/> Cancer (please specify type and year diagnosed): _____ | | | | |

Please list all illnesses, medical conditions and surgeries not discussed above:

Personal Safety: (circle your answer)

Are you under a lot of pressure at work or home? Yes No If yes, which? _____

Do you have any safety concerns? Yes No

Do you have any difficulty obtaining or preparing 2 meals per day? Yes No

I certify that I have read and understand the above. I will not hold Rehab Partners, Inc. or any of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's/Guardian's signature (or individual completing form for patient)

Date