Danville Orthopedic & Athletic Rehabilitation (DOAR)
New Patient Information

Patient's Full Name _____ Sex: Male / Female

Age: _____ Date of Birth _____ Social Security # (Required) _____

Home Phone (_____) _____ Cell Phone (_____) _____

Email_____ □ Opt-in to receive our occasional emails from us

Address (if P.O. Box, must also include street address)

_____

City_____ State _____ Zip_____

Marital Status: Single/Married/Divorced/Widowed Spouse's Name _____

Responsible Party (if different from patient) _____

Address (if different from patient) _____

Employer _____ Active/Retired

Employer's Address _____ Phone (____) _____

City_____ State _____ Zip_____

Referring Physician: _____

Primary Care Provider: _____

Why did you choose us as your outpatient therapy provider? (Please check all that apply)

□ Physician Recommendation
□ Insurance Participation
□ Friend/Family Recommendation: _____
□ Internet Search
□ Facebook
□ Email
□ Phone Book
□ Other: _____

OFFICE USE: Eval Date _____Therapist: _____ Ins Category: _____ Acct #_____Exec / 41N / 48E / Chatham / SoBo

Danville Orthopedic & Athletic Rehabilitation
New Evaluation Paperwork

Insurance Information

Please provide your driver's license and insurance cards to the Front Office Coordinator.

Patient's Full Name _____

Insurance Carrier Name _____ Group Name _____

Policy Holder's Full Name: _____ Date of Birth _____

Address (if different from patient) _____

City_____ State _____ Zip Code _____

Date of Birth _____ Social Security # _____-_____-_____ Sex: Male/Female

Employer _____

Identification # _____ Claim # _____

Lit/Liability Patient: If the injury was caused by an **auto accident**, are you filing a Legal Claim? Yes/No
Attorney's Name (if applicable) _____

Worker's Comp Patient: Are you currently working? Yes/No
If so, are you on regular duty/light duty? Is this due to your injury? Yes/No

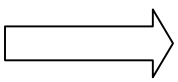
Medicare Patient
Were you recently discharged from home health? Yes/No
If yes, agency name: _____

Signatures

Consent for treatment: Consent for treatment is authorized to Danville Orthopedic & Athletic Rehabilitation, Inc. to provide physical and/or occupational therapy.

Payment: Medical Insurance is a private contract between you and the carrier. We bill your insurance as a courtesy. It is your responsibility to ensure that payment is made for your care.

Release Information: I authorize Danville Orthopedic and Athletic Rehabilitation, Inc. to release medical information to my insurance carrier for direct payment to Danville Orthopedic and Athletic Rehabilitation, Inc. . for services rendered. I also authorize any company to whom a signed photocopy of this release is sent, to release information to Danville Orthopedic and Athletic Rehabilitation, Inc. for the collection of payment for services rendered.



_____ _____
Signature of Patient or Responsible Party Date

OFFICE USE: Patient Name _____ *Account #* _____

Danville Orthopedic & Athletic Rehabilitation
New Evaluation Paperwork

Functionality & Symptom Questionnaire – Page 1 of 3

Name _____ Age _____ Date _____

Please complete the following questionnaire so we can have a better understanding of your current condition.

When and how did your problem start? _____

_____

_____

Rate your major area of current pain on a scale of 1-10. Circle the number that best describes your pain. Use the descriptions as a guide.

0 1 2 3 4 5 6 7 8 9 10

No Pain | Very Weak | Weak | Moderate | Somewhat Strong | Strong | Very Strong | Very Very Strong

What are you unable to do because of this problem? _____

_____

What makes the pain worse? What makes it better? _____

_____

Have you had this pain or problem in the past? Yes/No

If yes, what made it better? _____

_____

Does the pain wake you up at night? Yes/No
Does the pain go away with position change or activity? Yes/No
Does the pain get *better* or *worse* as the day goes on? Better/Worse
Does activity *increase* or *decrease* your pain? Increase/Decrease

Are you limited in what you can do during work, recreation, or with home activities? If yes, please describe.

_____

Date of onset of illness/injury/accident _____

Pain caused by: Illness/auto accident/work related/other: _____

OFFICE USE: Patient Name _____ *Account #* _____

Danville Orthopedic & Athletic Rehabilitation
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Functionality & Symptom Questionnaire – Page 2 of 3

Have you or any immediate family members ever had the following…

	Self	Family
Cancer	Yes/No	Yes/No
Diabetes	Yes/No	Yes/No
High Blood Pressure	Yes/No	Yes/No
Heart Disease	Yes/No	Yes/No
Anginal/Chest Pain	Yes/No	Yes/No
Stroke	Yes/No	Yes/No
Blood Clots	Yes/No	Yes/No
Osteoporosis	Yes/No	Yes/No
Osteoarthritis	Yes/No	Yes/No
Rheumatoid Arthritis	Yes/No	Yes/No
AIDS or HIV Positive	Yes/No	Yes/No

Do you have a history of…

Allergies/Asthma	Yes/No
Headaches	Yes/No
Bronchitis	Yes/No
Kidney Disease	Yes/No
Rheumatic Fever	Yes/No
Ulcers	Yes/No
Sexually Transmitted Disease	Yes/No
Seizures	Yes/No
Tuberculosis	Yes/No
Hepatitis	Yes/No
Jaundice/Liver Disease	Yes/No
Stroke or Blood Clots	Yes/No
Lung or Pulmonary Problems	Yes/No
Incontinence	Yes/No
Anemia or Blood Disorder	Yes/No

In the past three months have you had or have you experienced…

Nausea/Vomiting	Yes/No
Fever/Chills/Sweats	Yes/No
Unexplained Weight Change	Yes/No
Numbness or Tingling	Yes/No
Changes in Appetite	Yes/No
Difficulty Swallowing	Yes/No
Change in Bowel/Bladder Habits	Yes/No
Urinary Tract Infection	Yes/No
Coughing Up Blood	Yes/No
Upper Respiratory Infection	Yes/No
Dizziness	Yes/No
Shortness of Breath	Yes/No

Check All that Apply

I currently have difficulty with…

_____Walking _____Getting up from a seat
_____Driving _____Bending at the waist
_____Standing _____Lifting
_____Running _____Playing sports

I am wearing or have…

_____Glasses/Contacts _____Pacemaker
_____Metal/Foreign Object Implant _____Dentures

I have a problem with…

_____Hearing _____Vision
_____Speech _____Communication

How do you learn best?

_____Seeing _____Doing
_____Listening

Do you currently or have you in the past, used tobacco products? Yes/No

If yes, describe how many packs per week? _____
How many years? _____
Last tobacco use was _____

List of medications currently being taken:

_____
_____
_____
_____

List any operations you have had:

_____
_____
_____
_____

Date of last physical examination _____

Weight_____lbs **Height** ____ft ____in

OFFICE USE: Patient Name _____ *Account #* _____

Danville Orthopedic & Athletic Rehabilitation
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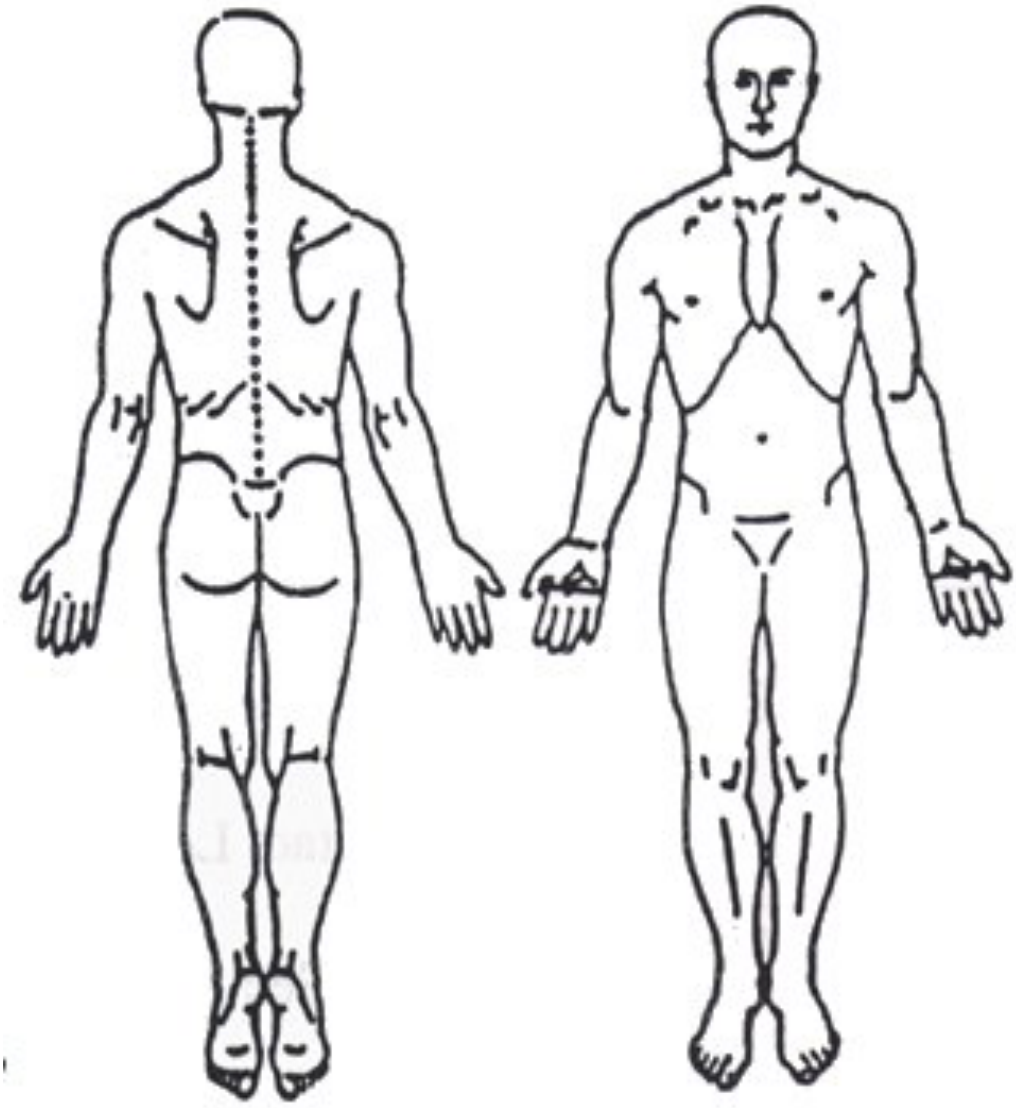
Functionality & Symptom Questionnaire – Page 3 of 3

Circle any of the following words or phrases that describe your pain:

Shooting	Pounding	Pressure	Scalding	Burning
Tingling	Stinging	Stabbing	Cold	Deep Ache
Tearing	Sharp Ache	Touchy	Cramping	Swollen
Numbness	Loss of Sensation.			

Please indicate where your pain is located and what type of pain you are experiencing at the present time. Use the symbols below to describe your pain.

\# Stabbing X Burning ~ Tingling * Numbness



OFFICE USE: *Patient Name* _____ *Account #* _____

Danville Orthopedic & Athletic Rehabilitation
New Evaluation Paperwork

Notice of Privacy Practices – Patient Copy

This notice describes how your medical information may be sued and disclosed and how you can gain access to this information

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential.

All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and amend it.

We are required by law to maintain privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPPA

Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a neurologist referral to an orthopedist.

Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.

Health care operations are any activity related to covered functions in which we participate in the function or our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be an evaluation of customer service given to patients.

We may, without prior consent, use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all identifiable health information.

All other uses and disclosers will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you to provide appointment reminders or t inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising purposes.

Under HIPPA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or from us by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information, however, this request may be denied under certain circumstances;
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request.

If you feel your privacy rights or the provisions of this notice of privacy policies have been violated, you have the right to file a formal written complaint. Please address questions or concerns to the Clinic Manager.

The Notice of Privacy Practices is effective 4/14/03. We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the specified purposes, as defined under the Act.

OFFICE USE: Patient Name _____ *Account #* _____

Danville Orthopedic & Athletic Rehabilitation
New Evaluation Paperwork

Acknowledgement of Privacy Practices

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you, including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date of this Privacy Notice
The effective date of this Privacy Notice is April 14, 2003.

Changes or Revisions to our Privacy Notice
We reserve the right to change the Privacy Notice at any time and to make the revised notice effective for your current and previously received health information. Should we change the Privacy Notice, we will post a copy of the new notice in the main lobby and on the website. You may obtain a copy of the new/revised Privacy Notice from the business office.

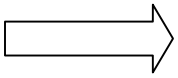
Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking an Authorized, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our privacy practices or would like to: obtain copies of our Privacy Notice, request restrictions on the release of your medical information, revoke an authorization, amend or correct your health information, obtain a listing of the information we disclosed concerning your health information, request to inspect a copy of your medical information, request that we communication information about your health in any way, deny or make accessible to your health information, filing complaints, or any other concerns you may have regarding our privacy practices, please contact:

Administrator
2140 Franklin Turnpike
Danville, VA 24540

You may also file complaints with:
U.S. Department of Health & Human Services
200 Independence Avenue, South West
Washington, DC 20201
Phone: 1-202-619-0257 Fax: 1-877-6966775

I certify that I have received a copy of the Privacy Notice and that I have had an opportunity to review and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that this facility is committed to protecting my health information.



_____ _____
Signature of Patient or Responsible Party Date

_____
Printed Name

_____ _____
Signature of Witness Date

OFFICE USE: Patient Name _____ *Account #* _____