

# Herrick Physical Therapy Orthopedic & Pediatric Services P.C.



Fax # 862-666-9662  
Phone # 973-800-4050

## Patient Medical History Form

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Date of 1st Doctor's Visit for this Injury/ or next follow-up appointment: \_\_\_\_\_

Have you had surgery for this injury? ☐ YES ☐ NO

Type of Surgery(ies)? \_\_\_\_\_

### Are you currently taking any medications (prescriptions and/or over the counter medications):

Anti-Inflammatories	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, please specify: _____
Muscle Relaxers	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, please specify: _____
Pain Medication	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, please specify: _____
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, please specify: _____

### Diagnostic, Medical, or Rehabilitative services for this Injury/episode?

EMG/NCV	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other: _____
MRI	<input type="checkbox"/> YES <input type="checkbox"/> NO	
X-Ray	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CT Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	

### What is your Chief Complaint?

\_\_\_\_\_  
\_\_\_\_\_

### Rate your chief complaint in order of severity from worst (5) to least (1)

Pain\_\_\_\_ Decreased Motion\_\_\_\_ Swelling/edema\_\_\_\_ Stiffness\_\_\_\_  
Loss of function\_\_\_\_\_ Numbness: \_\_\_\_\_ Tingling \_\_\_\_\_

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**Indicate the nature of your pain and symptoms:** \_\_\_Sharp \_\_\_Dull \_\_\_Piercing\_\_\_Shooting \_\_\_Aching  
\_\_\_Deep \_\_\_Superficial \_\_\_Tingling \_\_\_Numbness \_\_\_Intermittent \_\_\_Burning \_\_\_Stabbing \_\_\_\_\_

**When and how did this problem begin?**

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Has this problem affected your daily life or routine? Briefly describe in what ways. \_\_\_\_\_

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Have you had past similar episodes of this current problem? If yes, were you treated with; (circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other, Did they help to alleviate your symptoms? \_\_\_\_\_

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**Do you now or have you ever had any of the following?**

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hand Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Heart Disease or Angina	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Vision or Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Energy Loss	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Problems/Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Ankle/Foot Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Trouble/Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Any Pins or Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Back Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>

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Blood Clot/ Embolism	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/>
Knee Injury/Surgery	<input type="checkbox"/> <input type="checkbox"/>	Varicose Veins	<input type="checkbox"/> <input type="checkbox"/>
Infectious Diseases	<input type="checkbox"/> <input type="checkbox"/>	Are you Pregnant	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack or Surgery	<input type="checkbox"/> <input type="checkbox"/>	Joint Replacement	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Do you smoke	<input type="checkbox"/> <input type="checkbox"/>
Severe or frequent headaches	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>
Shoulder Injury/Surgery	<input type="checkbox"/> <input type="checkbox"/>	Allergies	<input type="checkbox"/> <input type="checkbox"/>

If “YES” to any of the above please explain in more detail here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you presently working? \_\_\_\_\_ Yes, \_\_\_\_\_ No, since: \_\_\_\_\_  
Physical/Emotional demands of present occupation? (High, moderate, minimal) \_\_\_\_\_

\_\_\_\_\_

Overall activity level: \_\_\_\_\_ Sedentary, \_\_\_\_\_ Light, \_\_\_\_\_ Moderate, \_\_\_\_\_ Heavy, \_\_\_\_\_ Very heavy. Sports  
and Exercise (Type, Frequency, Duration)

\_\_\_\_\_

What are your goals? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who can we thank for this referral?

\_\_\_\_\_

**Thank You for Your Patience!**

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*I authorize that the information listed above is true to my knowledge.*

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Patient Signature/ Legal Guardian

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Date

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Therapist's Signature

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Date

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## Informed Consent for Physical Therapy Services

### Welcome to Herrick Physical Therapy!

Physical Therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of Physical Therapy is: to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention. Intervention is provided throughout the use of rehabilitative procedures, mobilization, massage, exercise, and physical agents to aide the patient in achieving their maximum potential within their capacities and to accelerate convalescence and reduce the length of functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, modification or strategy. Herrick Physical Therapy Orthopedic & Pediatric Services PC does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for.

**It is your right** to decline any part of your treatment at any time before or during treatment, should you feel it necessary or have other unresolved concerns. It is your right to ask your Physical Therapist about the treatment they have planned based on your individual history, diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand my rights with regards to treatment and evaluation in a physical therapy setting, and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

\*I understand the discussed out of pocket rate, and I agree to this amount per service date.

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Estimated Responsibility: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Emergency Contact/ Relation: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Additional Consent:

I certify/acknowledge that the release of my information be provided to the following personal representative:

Person/Relation: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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## Assignment of Insurance Benefits

I, hereby authorize my insurance carrier to DIRECTLY pay Herrick Physical Therapy Orthopedic & Pediatric Services PC any and all insurance payments, benefits, reimbursements or monies that my insurance carrier may pay in connection with the Speech-Language Therapy (SLP) Services rendered. I voluntarily and knowingly assign my insurance payments to Herrick Physical Therapy Orthopedic & Pediatric Services PC. I understand that if my insurance carrier sends payments directly to me, I shall give these payments to Herrick Physical Therapy Orthopedic & Pediatric Services PC within five business days or I will legally responsible for the full amount of the Speech-Language Therapy services rendered under those dates.

I certify that the health insurance information that I provided to this provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

**HSA:** YES or NO (circle one)

If "yes" do you plan on using your HSA?

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Special Remarks regarding your HSA, with  
explanation: \_\_\_\_\_

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## Notice of Privacy Policies: HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CONTENT BELOW CAREFULLY.

Introduction: Herrick Physical Therapy Orthopedic & Pediatric Services PC is committed to treating and using your protected health information in a responsible manner. Federal and state laws require me to maintain the privacy of your protected health information. This Notice of Health Information Practices describes the personal information that I collect, and how and when I use or disclose this information. It also describes your rights as they relate to your protected health information (PHI). This Notice is effective as of April 14, 2003, and applies to all protected health information as defined by federal guidelines and regulations. Understanding Your Health Record/Information: Every time you are treated at Herrick Physical Therapy Orthopedic & Pediatric Services PC a typed record of your visit is made. This note contains your symptoms, examination findings, and test results, treatment, and a plan of care for future visits. This information, is referred to as your health or medical record, and it serves as: \* Basis for planning your care and treatment, \* Means of communication among many healthcare professionals that work as a team to deliver care, \* Legal document described the care you received, \* Means by which a third party payer can verify that services billed were actually provided, \* A tool in educating health professionals \* A source of information for public health officials charged with improving the health of this state and nation, \* A source of data for planning and marketing, \* A tool with which I can assess and continually work to improve the care I render and the outcomes I achieve understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand, who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights: Although your health record is the physical property of Herrick Physical Therapy Orthopedic & Pediatric Services PC, the information belongs to you. You have the right to: \* Obtain a copy of this notice of information practices on request, \* Inspect and receive a copy of your health record as provided for in 45 CFR 164.524, \* Amend your health record as provided in 45 CFR 164.528, \* Obtain an accounting of disclosures of your health information other than for treatment, payment and healthcare operations as provided in 45 CFR 164.528, \* Request communications of your health information by alternative means or at alternative locations, \* Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and \* Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Herrick Physical Therapy Orthopedic & Pediatric Services PC is required to: \* Maintain the privacy of your health information, \* Provide you with this notice as to our legal duties and privacy practices with respect to



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information that is collected and maintained about you, \* Abide by the terms of this notice, \* Notify you if I am unable to agree to a requested restriction, and \* Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Herrick Physical Therapy Orthopedic & Pediatric Services PC reserves the right to change practices and to make the new provisions effective for all protected health information that is maintained.

Should information practices change, Herrick Physical Therapy Orthopedic & Pediatric Services PC will mail a revised notice to the address you provided on file, or based on agreement, a copy will be emailed to you.

Herrick Physical Therapy Orthopedic & Pediatric Services PC will not use or disclose your health information without your authorization, except as described in this notice. Furthermore, Herrick Physical Therapy Orthopedic & Pediatric Services PC will discontinue using/disclosing your health information after written revocation of the authorization according to the procedures included in authorization is received.

## Uses and Disclosures of Protected Health Information.

Herrick Physical Therapy Orthopedic & Pediatric Services PC may use or disclose PHI about you for treatment, payment, and health care operations. Following are examples of types of uses and disclosures that the company is permitted to make. Herrick Physical Therapy Orthopedic & Pediatric Services PC will disclose health information for treatment. Example: Information obtained: by the physical therapist, speech therapist or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you.

Herrick Physical Therapy Orthopedic & Pediatric Services PC will document in your record: your plan of care, treatment and interventions, observations, symptoms, tests, and measurements and your response to treatment. Herrick Physical Therapy Orthopedic & Pediatric Services PC will provide your physician, case manager or subsequent health care provider with copies of various reports that should assist him or her in your treatment and care. Herrick Physical Therapy Orthopedic & Pediatric Services PC will use and disclose your health information for payment. Example: A bill may be sent to you or a third-party payer. Herrick Physical Therapy Orthopedic & Pediatric Services PC may use and disclose your PHI to submit bills to you or a third-party payer for health care services provided to you.

Herrick Physical Therapy Orthopedic & Pediatric Services PC may disclose your PHI to another health plan, health care provider; or other entity subject to the federal Privacy Rules for their payment purposes: Payment activities may include processing claims, determining eligibility or coverage for benefits, reviewing services for medical necessity, and performing utilization review of your account. Herrick Physical Therapy Orthopedic & Pediatric Services PC will use and disclose health information for regular health care operations. Example: Health care operations include the business functions conducted by a health care provider. Members of the healthcare staff may use information in your health record to perform transcription duties, as well as assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services that

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Herrick Physical Therapy Orthopedic & Pediatric Services: PC provides. These activities may include providing customer services, transcription duties, responding to complaints, conducting review of accounts and other quality assessment and improvement activities.

Business associates: There are some services provided through contacts with business' associates with whom Herrick Physical Therapy Orthopedic & Pediatric Services PC as written agreements containing terms to protect the privacy of your PHI. When these services are contacted, Herrick Physical Therapy Orthopedic & Pediatric Services PC may disclose your health information to my business associates so that they can perform the job Herrick Physical Therapy Orthopedic & Pediatric Services PC has appointed them to do, which may include billing you or your third-party payer for services rendered. In order to protect your health information Herrick Physical Therapy Orthopedic & Pediatric Services PC requires the business associates to appropriately safeguard your information.

Notification: Herrick Physical Therapy Orthopedic & Pediatric Services PC may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. As a means of communication Herrick Physical Therapy Orthopedic & Pediatric Services may: leave a message on your answering machine or on voicemail, mail you a postcard or written notice, email you, your healthcare provider, or case manager.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify; health information relevant to that person's involvement in your care or payment related to your care. Research: Herrick Physical Therapy Orthopedic & Pediatric Services PC may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Workers Compensation: Herrick Physical Therapy Orthopedic & Pediatric Services PC may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. This may include communication either in writing, email, or by telephone with a case manager in charge of your case.

Public Health: As required by law, Herrick Physical Therapy Orthopedic & Pediatric Services PC may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: Herrick Physical Therapy Orthopedic & Pediatric Services PC may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

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On Your Authorization: You may give Herrick Physical Therapy Orthopedic & Pediatric Services PC written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give Herrick Physical Therapy Orthopedic & Pediatric Services PC the authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give Herrick Physical Therapy Orthopedic & Pediatric Services PC a written authorization, this company cannot use or disclose your PHI for any reason except those described in this notice.

For More Information or to Report a Problem: \* If you have any further questions and would like additional information you may contact Herrick Physical Therapy Orthopedic & Pediatric Services PC call 862.330.3185.

If you believe your privacy rights have been violated, you can file a complaint with Herrick Physical Therapy Orthopedic & Pediatric Services, or with the Office for Civil Rights, U.S. Department of Health and Human Resources. The address for the Office for Civil Rights is listed below:

Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W.  
Room 509F, HHH Building. Washington, D.C. 20201

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that Herrick Physical Therapy Orthopedic & Pediatric Services PC has engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or in the public. I consent to the use or disclosure of my protected health information (PHI) Herrick Physical Therapy Orthopedic & Pediatric Services PC for the purpose of Treatment, Payment, and Health Care Operations.

I have read a copy of the Notice of Privacy Practices: HIPAA and understand I have a right to review it prior to signing this document.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_