DEVELOPMENTAL &
REHABILITATIVE SERVICES

Date_____/ _____/ _____

Patient Information

Name_____ _____
Last First Middle SS#

Street Address_____

City, State, ZIP_____

Phone # (home)_____(work)_____(cell)_____

Can we call you at work? ___Yes ___No DOB_____/_____/_____ Age_____ Sex: ___Female ___Male

E-Mail Address:_____

Occupation: _____Employer_____

How did you hear about our practice?_____

Emergency contact: _____Relation: _____

Emergency contact phone #: Primary _____ Secondary _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self) _____

Do you have health insurance? ____Yes ____No Do you have secondary insurance ____Yes ____No

Primary Insurance_____

Secondary Insurance _____

*Please Provide This Office With A Copy of Your Insurance Card (s) and Drivers License

Assignment and Release (insured patients)

I certify that I have insurance with _____ and I authorize my insurance company to pay directly to Developmental & Rehabilitative Service, Inc. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize Developmental & Rehabilitative Service, Inc to release my medical records to the insurance company in order to secure payment for services rendered. I authorize the use of this signature on all insurance claims, including electronic submissions.

_____ _____

Signature Date

Developmental & Rehabilitative Service, Inc.
5295 Highway 78 – Stone mountain Highway
Suite I
Stone Mountain, GA 30087
(770) 879-5646 Fax: (770) 981-2024

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. It is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. Your medical information may be used by the business office to process you payment for the services rendered and by administrative personnel reviewing the quality of care you receive.

Examples of uses of your health information for treatment purposes are:

- Referral information is taken from the client, the family of the client, a service coordinator, or a physician's office and this information will be given to your treating therapist and may obtain treatment information about you and records it in a health record.
- We may contact you to provide appointment reminders.
- During the course of your treatment the therapist determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input in providing assistance with your healthcare diagnosis or treatment.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. Payment for your healthcare services may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we will render. Examples include, making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Example of use of Your Information for Health Care Operations:

- We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, transcription services and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office- we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record - you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request (The physician or other health care provider is not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Receive communications from us in a confidential manner.
- Request that communications of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give I you upon request; and
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights please notify your treating therapist.

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You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment and health care operations purposes,

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice".

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling or your information, please feel free to discuss this with me and we will work together to rectify the situation promptly

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to me. You may also file a complaint by mailing or e-mailing the Secretary of Health and Human Services.

- I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from me.
- I cannot, and will not, retaliate against you for filing a complaint with Secretary of Health and Human Services.

Other Disclosures and Uses

Notification - Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a fa'"11ily member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family - Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, heath information relevant to that person's involvement In your care or in payment for such care if you do not object or in an emergency.

Research - We may disclose information to researchers when an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved their research.

Marketing - We may contact you to provide you with appointment reminders, with information
about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

Fund Raising - We may contact you as part of a fund raising effort.

Public Health - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect - We may disclose your protected health information to public authorities as allowed by law to report abuse and neglect.
Law Enforcement - We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight - Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings - We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses - Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with written authorization and you may revoke the authorization as previously provided.

Website - This Notice is also located on DevRehabPT.com

Effective Date: February 1st, 2014

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Review of Systems

Have you had or do you experience?

Cardiovascular System	YES	NO
Elevated cholesterol	___	___
Sweating associated with pain	___	___
Palpitations	___	___
Swelling of extremities	___	___
History of smoking	___	___
Orthopnea (difficulty breathing)	___	___
Pacemaker	___	___
Hypertension	___	___

G.I. System	YES	NO
Difficulty swallowing	___	___
Heartburn	___	___
Jaundice (yellow appearance)	___	___
Specific food intolerance	___	___
Constipation	___	___
Diarrhea	___	___
Change in color of stool	___	___
Rectal bleeding	___	___
Gall bladder problems	___	___
Liver problems	___	___

G.U. System	YES	NO
Dysuria (painful urination)	___	___
Hematuria (blood in urine)	___	___
Incontinence	___	___
Frequency of urination	___	___
Urinary urgency	___	___
Post menopausal vaginal bleeding	___	___
Painful intercourse	___	___
Hx of STD	___	___
Date of Last Period ___/___/___		

Pulmonary System	YES	NO
Dyspne a (labored breathing)	___	___
Wheezing	___	___
Prolonged cough	___	___
Sputum production	___	___
Amount/Color:		
_____		

Endocrine System	YES	NO
Excessive thirst	___	___
Excessive hunger	___	___
Polyuria (large volume of urine)	___	___
Excessive sweating	___	___
Fatigue	___	___
Weakness	___	___
Thyroid problems	___	___

Neurological System	YES	NO
Ataxia (poor muscle coordination)	___	___
Memory lapses	___	___
Confusion	___	___
Head Trauma	___	___
Neurological disorder	___	___
Tremors	___	___
Slurred speech patterns	___	___
Hearing/Visual disturbances	___	___

Other Systems	YES	NO
ENT (ears, nose, throat)	___	___
Integumentary (skin)	___	___
Lymphatic	___	___
Psychiatric	___	___
Musculoskeletal	__ _	___
Cancer	___	___
Type: _____		

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