PATIENT INFORMATION AND CONSENT

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ Male ☐ Female ☐

Date of Birth:_____ Age:_____ Marital Status: S M D W (circle one)

Social Security Number:_____ Occupation: _____

Left Handed ☐ Right Handed ☐ Height:_____ Weight: _____

EMERGENCY CONTACT INFORMATION:

Name:_____ Phone:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

EMPLOYER: Job Related Injury? Yes ☐ No ☐

Company:_____ Contact Person:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____Ext._____ Fax:_____

INSURANCE INFORMATION:

Payer:_____ Claim #: _____

Case Manager:_____

Payer Address:_____ City:_____ State:_____ Zip:_____

The Physical, Occupational and Speech Therapy Program has been prescribed by your physician. Your signature gives us permission to implement this treatment. I authorize the staff at Regional Therapy Services to discuss protected health information with caregivers involved in treatment of the above listed patient. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, other applicable federal and state acts, or other insurance policies is correct. I authorize to release to any insurance company or their agent, any information needed for this or related claim. I request payment of authorized benefits be made on my behalf directly to Regional Therapy Services, Inc. for any past or future services rendered to me. We will verify insurance coverage upon evaluation; however, this is not a guarantee of payment. You are responsible for reviewing your insurance plan and knowing your coverage limitations for therapy services. I understand that I will be responsible for payment of services rendered.

_____

Signature Date

_____

Relationship (if signer is not patient)

This provider of Medical Services is an equal opportunity employer and does not discriminate in its professional or employment practices of the basis of race, creed, color, sex, national origin, age, or handicap.

INJURY INFORMATION:

Your job title at time of injury:_____

Full Time ☐ **Part Time** ☐

Are you currently working?

No ☐ **(If no, last date worked:**_____**)** **Yes** ☐ **Full Duty** ☐ **Light Duty** ☐ **Hours:**_____

Date of Injury:_____ **Date(s) of Surgery:**_____

What was your injury (part of body)?:_____

Please list your prescribed medications:

Medication	Dosage	How Often Taken

Do you have any of the following?

Diabetes ☐ **Heart Problems** ☐ **High Blood Pressure** ☐ **Circulatory/Vascular Disease** ☐

Please list any restrictions from your doctor or other medical information you wish to share:

_____

_____

_____

_____

Regional Therapy SERVICES, INC.

FCE Informed Consent

Your treating physician has referred you for a Functional Capacity Evaluation or Work Capacity Evaluation. This is a voluntary test designed to measure your ability to work. It takes 3-5 hours and we need your permission to perform it. The testing consists of questionnaires, an interview, and numerous tests to measure your strength, flexibility, and ability to perform various work-related tasks such as sitting, standing, walking, stair-climbing, balancing, lifting, carrying, pushing, and pulling. You may also be asked to perform a simulation of your job. Each test will be explained to you before testing.

Do your best on *every* trial during testing in order for the results to indicate your true ability on that task. You may be asked to perform tasks that you are not used to, and your pain may increase at times during the evaluation. Because pain is so subjective and is different for every person, you will have to decide to continue or stop any particular test. We do not expect to perform activities that increase your pain to a level that you feel is unsafe for you. We will stop you if we see you doing anything that we think is unsafe for you.

This testing becomes a part of your legal medical record. Your full effort is important in order to establish your true physical capacity and what affect your injury has on your ability to work. The tests are designed to tell us if you are giving full effort within you pain tolerance, and there are indicators to determine if you are exaggerating your pain. This information will be included in the written report sent to your doctor and employer/insurance carrier (if you are here because of a work-related injury). Give your best effort at all times and do not exaggerate your pain.

We may include your picture with the report and document some of the testing with photos or videotaping for added clarity.

I understand all of the above and agree to participate in this Functional Capacity Evaluation/Work Capacity Evaluation to the best of my ability.

_____

Signature Date

_____

Witness Date

Regional Therapy SERVICES, INC.

Authorization for Release of Medical Information

This form is kept on file until the patient requests to release their medical information to a specified person/company.

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Information Released From: _____

Information Released To: _____

Relationship to Patient: _____

List any tests performed in the last year (MRI, X-Ray, etc.): _____

_____

_____

Purpose for Release: _____

_____
Signature of Patient or Representative of Patient Date

_____
Signature of Agency Date

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION

If you have questions and/or would like additional information regarding the uses and disclosures of your health information, you may contact our Privacy Officer at:

Address:	**Attn: Privacy Officer** 300 Sunset Circle Moultrie, GA 31768
Telephone:	229-985-2080
Fax:	229-890-3397

If you believe your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

_____ _____

Printed Name of Patient Date (Effective Date of Notice)

_____

Signature of Patient or Representative of Patient

_____

Printed Name of Patient's Representative (*if applicable*)

_____

Representative's Relationship to Patient (*if applicable*)

To be completed by Regional Therapy Services, Inc.:

After a good faith attempt to obtain an Acknowledgment of Receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s): _____

_____

_____

_____ _____

Signature of Regional Therapy Service, Inc. Representative Date

PATIENT RIGHTS

You may keep this page for your records.

You have the following rights concerning your Health Information:

1. **Right to Inspect and Copy Your Health Information.** Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set, maintained by or for us. A "designated record set" contains medical and billing records and other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information we maintain. For example, the right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for us in, a civil, criminal or administrative proceeding. Where permitted by the Privacy Rules, you may request that certain denials to inspect and copy your Health Information be reviewed. If you request a copy or summary of explanation of your Health Information, we may charge you a reasonable fee for copying costs, including the cost of supplies and labor, postage, and any other associated costs in preparing the summary or explanation.
2. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your Heath Information for treatment, payment and health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. We will consider, but do not have to agree to, such requests.
3. **Right to Request an Amendment of Your Health Information.** You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.
4. **Right to an Accounting of Disclosures of Your Health Information.** You have the right to receive an accounting of disclosures of your Health Information made by us within six (6) years prior to the date of your request. The accounting will not include: disclosures related to treatment, payment or health care operations; disclosures to you; disclosures based on your Authorization; disclosures that are part of a Limited Data Set; incidental disclosures; disclosures to persons involved in your care or payment for your care; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories; or disclosures that occurred prior to April 14, 2003.
5. **Right to Alternative Communications.** You have the right to receive confidential communications of your Health Information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail. On occasions we may leave a message for the patient at work, home, daycares or designated contact pertaining to your services with Regional Therapy Services, Inc.
6. **Right to Receive a Paper Copy of this Privacy Notice.** You have the right to receive a paper copy of this Privacy Notice upon request, even if you have agreed to receive this Privacy Notice electronically.