Jaworski Physical Therapy, Inc.
Pediatric Medical History Form

Name of Child		Name of Parent/Legal Guardian:		SSN#
Address:		City:	State	Zip Code
Insurance Cardholder (if different)		Relationship to cardholder		Phone:
Address:		City:	State	Zip Code
Date of Birth	Age	Length of pregnancy	Sex ☐ M ☐ F	APGAR score at birth
Onset of Diagnosis	Referring Physician	Age of Siblings	Grade level	School Attending
If premature list cause if known:				
Note any complications at birth:				
Post Birth Status (oxygen, heart monitor)				
What equipment is used at home:				

Please check if your child has a history of any of the following

☐ Cancer
☐ Heart Problems
☐ Circulation Problems
☐ High Blood Pressure
☐ Nervous System Disease
☐ Cardiac Pacemaker
☐ Metal implants (rods, pins etc)
☐ Developmental Delay
☐ Cerebral palsy
☐ Autism
☐ Serious Accident
☐ Bone Fracture
☐ Stroke
☐ Muscular disease
☐ Lung Disease
☐ Kidney Disease
☐ Diabetes
☐ Hepatitis
☐ Epilepsy or Seizures
☐ Asthma
☐ Allergies
☐ Depression
☐ Mental illness
☐ Other: _____

For Therapist Use Only

Do you feel your child has feeding difficulties? ☐ Yes ☐ No
During the past month has your child been more upset or distressed than normal? ☐ Yes ☐ No
During the past month has your child been less active or playful? ☐ Yes ☐ No
Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any surgeries or hospitalizations your child has had (include dates if known): _____

_____

Please list any prescription or non prescription medications you child is taking _____

_____

Does your child have an established IEP from School? ☐ yes ☐ No

Is you child having difficulty in any of the following areas (please check all that apply)

☐ Feeding	☐ Swallowing	☐ Talking
☐ Rolling over	☐ Sitting up	☐ Sitting
☐ Crawling	☐ Kneeling	☐ Standing
☐ Balancing	☐ Walking	☐ Running

☐ Other: _____

Person to contact in case of an emergency: _____ Phone _____

Consent to Release

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Jaworski Physical Therapy, Inc. ("The Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use or disclosure. I understand that I may request a copy of the Notice of Privacy Practices at any time for my personal use. *By signing this consent, I understand and acknowledge that I have reviewed the "Privacy Notice" before signing this consent. I authorize employees of Jaworski Physical Therapy, Inc. to discuss my health information with the following persons: (Please list)*

_____ _____ _____

_____ _____ _____

General: I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said benefits. The assignment will remain in effect until revoked by me in writing.

Authorization for Treatment: I know that I am suffering from a condition(s) requiring physical/occupational/speech therapy/ massage therapy and/or athletic training. I hereby voluntarily consent to such treatment and procedures to be performed by employees of Jaworski Physical Therapy, Inc.

Permission to take Photograph: I hereby consent for Jaworski Physical Therapy, Inc. to take a photograph of me only for the purpose to use in my medical chart and will not be disclosed for any other reason without additional permission from me.

_____ _____

Patient's signature Signature other than patient (if patient is a minor)

_____ _____

Date Relationship

_____ _____

Date Witness

(rev 10/2011)

JAWORSKI PHYSICAL THERAPY, INC.

IMPORTANT- SCHEDULING AND FINANCIAL POLICIES

SCHEDULING

At Jaworski Physical Therapy, we strive to provide excellent care with treatment provided on a one- on- one basis by your therapist. The appointments you make will be reserved specifically for you. To receive the maximum benefit of treatment, it is important that you attend each of your scheduled appointments and that you arrive on time for your appointments.

Providing one- on- one care to each patient requires that we do not overbook or double book our appointments. Unfortunately, missed appointments result in open slots in our therapists' schedules and are a lost opportunity for them to help other patients. Although we understand that emergencies happen and there will be times that you have to cancel an appointment, **we reserve the right to charge a $25 fee for treatments that are not cancelled within 24 hours of the scheduled appointment time.** This fee is your responsibility and must be paid **prior** to your next scheduled treatment.

PAYMENT POLICIES

- As a courtesy we will try to verify your benefits prior to your first visit. However, experience has taught us that we can be given incorrect information. We strongly suggest that you personally contact your insurance company for verification of benefits and ask any questions you may have.
- Co-pays and co-insurances, and deductibles are dictated by your insurance company. Our contract with your insurance carrier requires that they be collected.
- Co-pays are due **prior** to the beginning of each treatment session.
- If you have a plan with a co-insurance, we will estimate your expected co-insurance and require that it be paid **prior** to the beginning of each treatment session. If you have a deductible that has not been met prior to treatment, you will be required to make a payment toward the deductible at each visit.
- You are responsible for any outstanding balance present after insurance has paid their portion and payment is due within 30 days of billing. Interest is accrued at a rate of 1.5% per month on outstanding balances.
- Payment can be made by credit card, check or cash. For your convenience, we can accept pre-authorized payments by credit card.

If you have any additional questions, please do not hesitate to ask us. Our goal is to provide you with the best possible service and to make your rehabilitation go as smoothly and successfully as possible.

Thank you for choosing Jaworski Physical Therapy, Inc.

I have read and understand the above policies.

_____ _____

Signature Date

Jaworski Physical Therapy, Inc.

Patient Name:_____Date:_____

Private Health Insurance

Name of Private Health Insurance:_____

Address:_____City:_____State:_____Zip:_____

ID#:_____Group#:_____

Cardholder Name:_____ Cardholder Date of Birth:_____

Relationship to Patient: _____ Phone: _____

Address (if different): _____

Worker's Compensation (complete the following)

Place of Employment at Time of Injury:_____

Address:_____City:_____State:_____Zip:_____

Date of Injury:_____ Claim Number: _____

If you have an attorney, please complete the following:

Attorney Name:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Liability/Motor Vehicle Accident (complete the following)

Responsible Auto Insurance Name:_____

Date of Accident:_____Claim#:_____

Address:_____City:_____State:_____Zip:_____

Adjuster Name:_____Adjuster Phone:_____

If you have an attorney, please complete the following:

Attorney Name:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

NOTICE OF PRIVACY PRACTICES
FOR HEALTH CARE PROVIDERS
[Jaworski Physical Therapy, Inc.]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR A BUSINESS ASSOCIATE.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. From time to time, the Secretary of Health and Human Services may make changes in the rules and regulations regarding the use or disclosure of PHI. We will continue to update and modify our privacy practices to remain in compliance with such regulations. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and asking for one at the time of your next appointment or by requesting that a revised copy be sent to you in the mail.

1. How We May Use and Disclose Medical Information About You.
Your Protected Health Information ("PHI") may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to collect payment for your health care services and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that is permitted:

Treatment: We will use and disclose such portions of your PHI to provide, coordinate, or manage your health care and any related services. This may include the coordination or management of your health care with a third party, including your pharmacist. We will also disclose PHI to other physicians who may be treating you or with whom we have consulted about your treatment. In addition, we may disclose your PHI to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you and may include, but are not limited to, the following: making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for medical necessity; undertaking utilization review activities; reports to credit bureaus or collection agencies; and, to our attorneys for collection, if necessary. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, the following: quality assessment activities; employee review activities; health care or financial audits; training of medical students; licensing and fundraising activities; and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to discuss your appointment. This contact will include leaving messages on your home answering machine or mailing notices to your home.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

We will take steps to reasonably secure your PHI in our custody and to have backup systems if PHI is kept in an electronic form. We will use our best efforts to secure your PHI, but cannot guarantee the information is secure from all risks or potential wrongdoers.

2. Uses and Disclosures of PHI Based Upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

3. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed and only so much information that is minimally necessary under the circumstances.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens and you have not already been provided a copy, we will try to obtain your acknowledgment of receipt of the Practice's Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

4. The Law Provides that there are Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include the following:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child or senior citizen abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing reviews, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergencies (not on the Practice's premises) where it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for organ or tissue donation purposes.

Research: We may disclose your PHI 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 PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR Section 164.500 et seq.

5. Your Rights

The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. You will be charged a reasonable fee if you are requesting copies. If we keep your medical records in an electronic form, you may request that we provide copies of your records in an electronic form such as a CD or the like. You will be charged a reasonable fee for such copies similar to the charge as if paper copies were provided. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may ask us not to disclose a part of your medical information to others if you have paid for the services related to that treatment in full when we may otherwise have billed your insurance company or other persons for such medical services. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to all restrictions that you may request other than the request not to disclose information for services for which you have already paid in full. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

We will not use or disclose your PHI for marketing purposes or sell any such information to other parties, except as expressly permitted by law.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. If we keep your PHI in electronic form, such as electronic health records, upon request, we will provide an accounting for all disclosures of PHI for any purposes beginning the later of 2011, after we implement electronic health record systems or when regulations require such disclosure in the future. This does not apply if we do not keep PHI in an electronic form.

You have the right to be notified if an unauthorized disclosure has occurred. Under certain circumstances, if an unauthorized disclosure or use of your PHI has occurred, under certain circumstances, you have the right to receive a notice from us of the circumstances and the steps taken by us to correct the circumstances or to prevent it from occurring in the future. Under certain circumstances, you would have the right to ask us to destroy any PHI in our possession, subject to our rights to retain certain copies for the protection of the physician.

You have the right to obtain a paper copy of this notice from us.

6. Complaints

You may file a complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer. We will not retaliate against you for filing a complaint. You may contact our Compliance Officer, for further information about the complaint process.

This notice was published and becomes effective on **your initial visit.**

If you have any questions about this Notice please contact: Compliance Officer
Michael Jaworski, MBA,MHS,PT

Phone: 440-366-5993

ACKNOWLEDGMENT OF RECEIPT

I, _____, acknowledge that I have received the Notice of Privacy Practices issued by Jaworski Physical Therapy, Inc. I, _____, authorize Jaworski Physical Therapy, Inc. to discuss my health information with the following persons:

Spouse _____
Children _____
_____
Parent _____
_____
Other _____
_____

_____ _____
Date Signature of Patient