



Notice of Patient Information Practices

This notice describes how medical and personal information about you may be used or disclosed and how you can obtain access to this information. Please review this form carefully.

OUR LEGAL DUTY

Mullaney & Associates, LLC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION

Mullaney & Associates, LLC uses personal health information primarily for treatment, obtaining payment for treatment, conducting administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing, tracking, and research studies. In any other situation, Mullaney & Associates, LLC will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease further disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be provided to you. You may request a copy of our Notice of Information Practices at any time. Our HIPPA Compliance Officer is Christine Mullaney. She can be reached at 732-970-4974.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes. You may request in writing that we not disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Mullaney & Associates, LLC will consider requests on a case-by-case basis. The company is not legally required to accept the requests.

Acknowledgement of Receipt of Practice's Notice of HIPAA Privacy:

I have received the Notice of Patient Information Practices for Mullaney & Associates Physical Therapy, LLC.

Patient Name	Date	Patient Signature	Date
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If this is a sporting related injury, can we speak to your coach regarding this injury and plan of care? **Y / N**

Please read the information below.
Initial the cancellation policy, initial the type of insurance you will be utilizing, and choose a payment option.

_____ **Cancellation/No Show Policy:** We have a strict Cancellation/No Show Policy. All Cancellations must be within 24 hours of your appointment. You are allowed 2 cancellations in less than a 24 hour time period without a charge to your account. Your third cancellation in less than 24 hours will result in a charge of \$85 to your account. Therapy will not resume until all cancellation charges are paid. You are allowed one “no show” appointment. If we do not hear from you within 24 hours after your “no show” all future visits will be cancelled.

_____ **Primary Insurance/Secondary Insurance:** We will bill your primary insurance as a courtesy to you. We assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved. Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as “above usual and customary,” is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your benefits. While we take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. **Please become familiar with your benefit plan before beginning treatment.**

_____ **Medicare:** We will bill Medicare for you. In most cases, Medicare will pay 80% of the allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

_____ **Self Pay:** Please pay the balance in full at the time of service or upon the receipt of monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Mullaney & Associates, LLC is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection.

_____ **Workers’ Comp:** We will bill your workers’ comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

Authorization For Communication

Name _____

Check off list of all allowable methods of contact:

___ Home phone _(____)_____ - _____

___ Cell phone _(____)_____ - _____

___ Work phone _(____)_____ - _____

___ Mail to home address

Can personal health information be left on your voice mail ? ___yes ___ no

comments _____

Can personal health information be left with a family member or significant other ?

___yes ___no

If yes please fill in information below:

Name _____

Telephone _(____)_____

Patient Signature _____

Print Name: _____ Date: _____

Height: _____ ft _____ in

Weight: _____ lbs

Are you presently working? Yes No Date of next physician's visit: ____/____/____ Date of

injury/onset: ____/____/____ Have you ever had these symptoms before? Yes No

Check which apply to your symptoms?

- Work related injury Recurrence of previous injury
 Motor vehicle accident Injury related to lifting Injury related to falling
 Cause unknown Athletic / recreational injury Other: _____

Have you had a related surgery? Yes No Date of surgery? _____

Do you have, or have you had any of the following?

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Poor tolerance to Cold <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / CVA	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Vision:					
Do you wear glasses/contacts? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Visual Disturbances? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____		
Macular Degeneration? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If yes on any of the above please briefly explain and give approximated date: _____

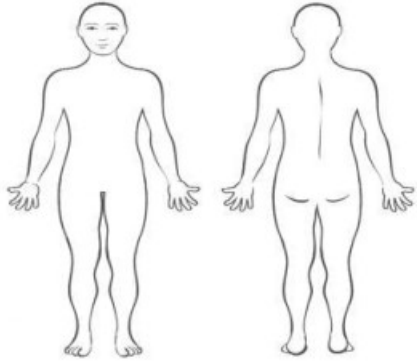
Is there any other information regarding your past medical history that we should know about? _____

Are you presently taking Medications? If yes please list what medication and for what condition?

When did your symptoms begin? _____

What are your symptoms? Please circle any that apply. Pain Numbness Tingling Other _____

Where do you feel your symptoms?



If you have pain, what type is it? Please circle any that apply. Dull Ache Sharp Throbbing Shooting
Burning?

On a scale of 0---10, what is worst your pain gets? _____

How is your pain at its best? _____

How is your pain today? _____

What activities, positions etc make your pain better? _____

What activities, positions etc make your pain worse? _____

If applicable, How long can you sit before your pain increases? _____

If applicable, How long can you stand before your pain increases? _____

If applicable, How long can you walk/run before your pain increases? _____

Have you undergone any diagnostic tests related to your symptoms (x---ray, mri, emg)? _____

Are you currently working? _____, if so what do your job duties include (sitting, standing,
lifting?) _____

Do you have difficulty with any of the following (circle all that apply) :

Sleeping Stairs transferring sit---stand lifting, carrying, pushing

Sports Activity Other _____

