Confidential Medical History/Evaluation

Kernersville Rehab Specialists, LLC
Physical and Occupational Therapy Center
Orthopedics• Spine and Sports Rehab• Pediatrics• Geriatrics

Name:_____Today's Date:___/___/___

Address:_____State:_____Zip Code:_____

Date of Birth:___/___/___ Home Phone:_____Cell Phone:_____ SS#:_____

Referring MD:_____Facility:_____Phone:_____

Patient E-mail Address:_____ Sex: M F

Emergency Contact Name:_____Relationship:_____Phone:_____

Marital Status: Single Married Divorced Other Are you currently receiving Home Health PT/ OT? Yes No

Are you employed? Yes No Occupation:_____Name of Employer_____

Is this injury: Work Related Auto Accident Liability Other

Date of Onset **OR** Injury:____/____/____

Condition: Acute Chronic Chief Complaint:_____

Have you had surgery or injections for this injury/illness?: Yes No Number of surgeries/injections 1 2 3 4 ____

Date of Surgery:___/___/___Type of Surgery:_____All other surgeries:_____

Have you had any of the following Medical or Rehab services for this injury/episode? YES/NO, Date: _____

	Yes	No		Yes	No
Chiropractor	__	__	CT Scan	__	__
EMG/NCV	__	__	General Practitioner	__	__
Massage Therapy	__	__	MRI	__	__
Myelogram	__	__	Neurologist	__	__
Occupational Therapy	__	__	Orthopedist	__	__
Physical Therapy	__	__	Podiatrist	__	__
Emergency Room Care	__	__	X-Rays	__	__

Other:_____

Are your symptoms: □Constant □Intermittent □Getting Better □Getting Worse □Staying the Same

What makes your symptoms better?:_____

What makes your symptoms worse?:_____

Job Requirements?:_____

Maximum weight you must lift at work?:_____Last date worked?:___/___/___

What do you want to accomplish from therapy (i.e. goal)?:_____

When is your next doctor visit?:_____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Kernersville Rehab Specialists, regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature:_____Date:____/____/____

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Confidential Medication List

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Due to insurance requirements Medication list MUST be completed. Please complete below medication/supplement list **prior to evaluation.**

Name of Medication	**Dosage/mg**	**Frequency**	**Application**
(*example*) *Asprin*	*325mg*	*2x/day*	*Oral*
Supplements			

□ I do not currently take any medications/supplements.

I acknowledge that I have provided a complete list of my current medications/supplements. If any additional changes to my current medications/supplements arise I will inform my Kernersville Rehab Specialists of these changes.

Patient/Parent/Guardian Signature:_____Date:____/____/____

Kernersville Rehab Specialists

1031 E Mountain Street ◆ Bldg 318, Suite 101 ◆ Kernersville, NC 27284
336-996-4980 ◆ Fax: 336-996-3521

Notice of Patient Information Privacy Practices

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

Legal Duty

Kernersville Rehab Specialists, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Kernersville Rehab Specialists, LLC (hereafter known as KRS) uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, KRS may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

KRS may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, KRS policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

KRS may change its policy at any time. When changes are made, a new Notice of Patient Information Privacy Practices will be posted in the waiting room and will be provided to you at your next visit. You may also request an updated copy at any time by calling our office, or by printing a copy from our website.

Patients 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 any 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 treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, or when required by law or in emergency circumstances. KRS will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints

For further information regarding our health information practices, or if you have a complaint or are concerned that KRS may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address on this Notice. You may also send a written complaint to the US Department of Health and Human Services.

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Patient Information Privacy Practices Acknowledgement Form

I have read and fully understand Kernersville Rehab Specialists LLC's **Notice of Patient Information Privacy Practices.** I understand that Kernersville Rehab Specialists may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of services provided. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Kernersville Rehab Specialists will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge and agree to the use and disclosure of my personal health information for purposes as noted in Kernersville Rehab Specialists LLC's **Notice of Patient Information Privacy Practices**. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient's Printed Name

_____
Patient's Signature

_____
Date

Kernersville Rehab Specialists, LLC
KRS
1031 E Mountain St
Bldg 318, Suite 101
Kernersville, NC 27284
336-996-4980
info@KRSTherapy.com
Aquatic & Land Based Physical/Occupational Therapy

PATIENT SURVEY

Name:

_____

Thank you for taking a moment to tell us how you chose Kernersville Rehab for your therapy services!

Please check all of the following sources in which you heard about our clinic:

- ☐ Telephone Book (Yellow Pages Listing)
- ☐ Internet Advertisement
- ☐ Our Webpage (www.krstherapy.com)
- ☐ Physician Referral
- ☐ Recommendation from family, friend, co-worker, etc.
- ☐ Workers' Compensation Insurance
- ☐ Previous Patient