CORNERSTONE REHABILITATION
Patient Information Sheet

PATIENT INFORMATION

Patient Name	Date of Birth	Age	Home Phone No.	Bus or Cell Phone No.

Address	City	State	Zip Code

Soc. Sec. No.	☐ Male ☐ Female	☐ Married ☐ Single	☐ Divorced ☐ Widowed	☐ Separated	Spouse's Name

PATIENT EMPLOYMENT INFORMATION

Currently Employed ☐ Yes ☐ No	Retired ☐ Yes ☐ No	Date Retired	Current employer or retired from

Employer Address	City	State	Zip Code

INSURANCE INFORMATION (Please complete all information)

Primary Insurance Co. Name and Address

Policy No.	Group No.	**Name of Insured (☐ same as patient)**

Relationship to Patient (☐ self) **Address of Insured (☐ same as patient)** **DOB of Insured (☐ same as patient)**

Secondary Insurance Co. Name & Address

Policy No.	Group No.	**Name of Insured (☐ same as patient)**

Relationship to Patient (☐ self) **Address of Insured (☐ same as patient)** **DOB of Insured (☐ same as patient)**

INJURY INFORMATION

Date of injury:	**Type of Injury (Check all that apply):** **Motor vehicle accident** ☐ **Work-related** ☐ **Other than MVA** ☐
Attorney? ☐ Yes ☐ No	Attorney Name/Phone:
State in which accident occurred _______	Are you Black Lung Entitled? ☐ Yes ☐ No

WORKER'S COMPENSATION INFORMATION

Employer	Employer Contact Person/Claim Number	Employer Phone Number	
Address	City	State	Zip

EMERGENCY INFORMATION

Person to contact in case of emergency	Phone Number	Relation to Patient

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses ☐ Self ☐ Other:	Relation to Patient	Phone Number	
Address	City	State	Zip Code

CONSENT – RELEASE – PAYMENT POLICY

I authorize Cornerstone Rehabilitation to render treatment to me as ordered by my physician and grant permission to Cornerstone Rehabilitation to obtain my medical records from my physician.

I authorize Cornerstone Rehabilitation to furnish information to insurance carriers and/or Medicare.

I authorize Cornerstone Rehabilitation to contact my attorney and release information to my attorney.

I hereby assign to Cornerstone Rehabilitation all benefits paid on my behalf from insurance carriers and/or Medicare.

I understand that in the absence of payable benefits from my insurance carrier and/or Medicare and/or attorney, I am responsible for all charges incurred for my care.

_______________________________ _______________________

Patient Signature Date

Physical Therapy
Occupational Therapy
Speech Therapy

Consent to Confirm Your Physical Therapy Appointment

Health Insurance Portability & Accountability Act (HIPAA) is a federal law passed in 1996 which requires healthcare organizations comply with specific rules. One of these rules governs the disclosure of your medical information. Because of these regulations, we must have your permission to release any medical information to someone other than yourself.

It is our policy not to release confidential and/or unauthorized information via home telephones, answering machines, work telephone numbers, voice mail, cell phones and/or pagers until you have authorized such. When we return your telephone calls or call to confirm your appointment, we can only leave messages in methods you have authorized and with people you have authorized. An authorized person is one to whom you have given us permission to speak. The following information you provide is our authorized information for you:

I authorize Cornerstone Physical Therapy & Rehabilitation and/or representatives of this company to leave medical information pertaining to my care by the following methods at the numbers listed and will assume responsibility to notify them whenever this information changes:

	No (√)	Yes (√)	If yes, please give Phone Number	Preferred (√)
Home Telephone				
Work Telephone				
Voice Mail				
Cell Phone				
Pager				

Please list the names and relationships of authorized people below:

____

____

____

____

____

Patient Name (Please print): ______________________________

Patient Signature __________________________________

Date ______________________

463 Ashley Ridge Blvd, Suite 100 ♦ Shreveport, LA 71106 ♦ Phone: 318-671-8772 ♦ Fax: 318-671-8776
P.O. Box 8370 ♦ Shreveport, LA 71148

Notice of Privacy Practices for Cornerstone Rehabilitation

PLEASE REVIEW THIS NOTICE CAREFULLY.

THIS NOTICE DESCRIBES (1) HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND (2) HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, documentation about the therapy you receive will be available in your medical record to all health professionals who may provide treatment to you or who may be consulted on your behalf by staff members.

Payment. Your health information may be used to file your health insurance or from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request information on dates of service, services provided, and the medical condition being treated.

Health Care Operations. Your health information may be disclosed as necessary to support the day-to-day activities and management of Cornerstone Rehabilitation. For example, information on the services you receive may be used to support budgeting and financial reporting and/or activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the Louisiana Department of Public Health.

Other Uses and Disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred prior to notifying us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the Federal privacy standards. These include:

- ☑ the right to request restrictions on the use and disclosure of your protected health information
- ☑ the right to receive confidential communications concerning your medical condition and treatment
- ☑ the right to inspect and copy your protected health information (see below)
- ☑ the right to amend or submit corrections to your protected health information
- ☑ the right to receive an accounting of how and to whom your protected health information has been disclosed
- ☑ the right to receive a copy of this notice

Requests to Inspect Protected Health Information. You may generally inspect or copy the protected health information we maintain on you. As permitted by federal regulation, we require that a request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Cornerstone Rehabilitation Duties

We are required to abide by the privacy policies and practices that are outlined in this Notice and to maintain the privacy of your protected health information. It is our responsibility to provide you with this Notice of Privacy Practices.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon your request at any visit, you will be provided with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Complaints

If you believe that your privacy rights have been violated, please call the matter to our attention by sending a letter describing the cause of your concern to Jenny Mulig at the address listed below. You will not be penalized or otherwise retaliated against in any way for filing a complaint.

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Jenny Mulig, Privacy Officer
Cornerstone Rehabilitation
463 Ashley Ridge Boulevard, Suite 100
Shreveport, LA 71106

Contact Person

For further information concerning our privacy practices, please contact:

Cherie Leone, Privacy Official
Cornerstone Rehabilitation
463 Ashley Ridge Blvd Suite 100
Shreveport, LA 71106

Effective Date

This Privacy Practices Notice is effective on and after April 14, 2003. You will be provided with the Notice each time you begin a new course of treatment.

Acknowledgement of Receipt Of Notice of Privacy Practices

(PF-2000)

Cornerstone Rehabilitation reserves the right to modify the privacy practices outlined in the notice.

Patient's Signature

I have received a copy of the Notice of Privacy Practices for Cornerstone Rehabilitation.

Printed Name:

____
(Patient's Name – Please Print)

Signature:

____
(Patient's Signature)

Date:

____
(Date)

Signature of Patient's Representative

If patient is a minor or an adult who is unable to sign this form, patient's representative will sign below:

Patient's Representative:

____
(Signature of Patient's Representative)

Relationship to Patient:

____
(Relationship to Patient)

My Medicines

List in the first column the medications you are currently taking. In the second column write in briefly why you are taking it. For example, Tiazac in the first column and high blood pressure in the second.

Medication Name	Reason

Patient's Name: ______________________ Date Completed: ____________________

Cornerstone Rehabilitation

Physical Therapy
Occupational Therapy
Speech Therapy

OUR PATIENTS' RIGHTS

You have the right to:

be fully informed about your rights and responsibilities as a patient and about services available and charges for those services.

be treated with dignity and respect.

privacy in your treatment and confidentiality of your medical records.

know about your physical condition and to receive information necessary to give informed consent prior to the start of treatment.

voice opinions, recommendations, and grievances in relation to services offered by the facility and policies without fear of discrimination or reprisal.

refuse treatment to the extent permitted by law and to be informed of the consequences of your refusal.

refuse participation in research conducted in the RehabCare Program.

refuse to have photographs taken during your clinical visits.

OUR PATIENTS' RESPONSIBILITIES

You will be responsible for:

providing accurate and complete information about your health and about your health insurance and/or other applicable information, such as attorney or MVA information.

active participation in the development of your treatment plan and in your treatment plan, such as a home exercise program.

consideration of the rights of others while in the clinic area.

regular and prompt attendance at the appointed times.

I have read the patient's rights and responsibilities as noted above.

______________________________ _______________

Patient Signature Date