

# MEDICAL HISTORY

**Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Are you working?     Full Duty     Light Duty     Retired     N/A  
 Off due to this problem.    First lost day of work: \_\_\_\_\_

What is your main goal for therapy? \_\_\_\_\_

1. Date of injury / onset: \_\_\_\_\_ 2. Please indicate where your problem is

3. How were you injured? \_\_\_\_\_ located on the body chart below:

\_\_\_\_\_

4. Please check if you have had any of the following:

X-rays     MRI     CT scan

Other: \_\_\_\_\_

5. Have you ever had these symptoms before?     Yes     No

6. What makes your pain better? \_\_\_\_\_

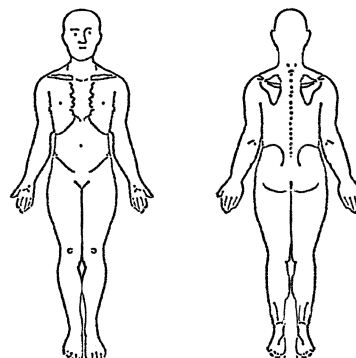
\_\_\_\_\_

7. What makes your pain worse? \_\_\_\_\_

\_\_\_\_\_

8. Have you had a related injury?     Yes     No

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



Using the symbols below, please draw in the location of your symptoms on the diagrams.

**XXX – Pain**                      **000 – Numbness**  
**//// – Aching**                      **... – Pins and Needles**

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / angina	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Metal implants	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / fainting	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<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"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Urine leakage	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Liver / gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (type ___ )	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: list _____	<input type="checkbox"/>	<input type="checkbox"/>	Contacts	<input type="checkbox"/>	<input type="checkbox"/>

Please list anything else you feel we should know about your problem or medical history: \_\_\_\_\_

\_\_\_\_\_

10. What medications are you currently taking?     Anti-inflammatory     Pain     Blood thinner

Blood pressure     Steroid     Other: \_\_\_\_\_

11. The services of a social worker are available. Please indicate if you have need of such services:

Yes     No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# WESTERN RESERVE SPINE & SPORT

**Patient:** \_\_\_\_\_

## STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY:

Western Reserve Spine & Sport appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your primary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible, co-payment and/or co-insurance, as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may effect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elect to continue therapy past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Western Reserve Spine & Sport for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay Western Reserve Spine & Sport the full and entire amount of the bill incurred by me or the above named patient.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Western Reserve Spine & Sport, through its appropriate personnel, to perform on me, or the above named patient, appropriate assessment and treatment procedures relating to:

\_\_\_\_\_

I further authorize Western Reserve Spine & Sport to release to appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(or parent if patient is a minor)

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## NO SHOW POLICY:

Your therapist allocates specific time for your appointment to meet the needs of your rehabilitation program. We understand that there may be times when you miss an appointment, but we request that you give us a **24 hour notice** to cancel or change your appointment time or date. You should schedule a make-up appointment as soon as possible to help meet your rehabilitation goals.

If you fail to cancel your appointment, within a 24 hours, you may be charged a \$25.00 administrative fee. Since insurance companies will not cover this fee, you will be personally responsible.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Western Reserve Spine and Pain Institute**  
**WESTERN RESERVE PROFESSIONAL GROUP**  
307 West Main St. • Kent OH 44240  
Ph. 330-677-3628 • Fax 330-677-3626

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute, "Company", is required to maintain the privacy of your health information and to provide you with this Notice about our privacy practices, legal duties and your rights concerning your protected health information ("PHI"). If you have questions about any part of this Notice or if you want more information about the privacy practices at this Company, please contact:

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute  
307 West Main St., Kent OH 44240  
Kelly Semancik, Privacy Officer

Effective date of this Notice: April 14, 2003

**I. HOW THIS COMPANY MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION ("PHI").**

This Company collects protected health information ("PHI") from you and stores it in one or more ways including, but not limited to, paper charts and files, electronic media, and computer storage. This is your medical record. The medical record is the property of this Company, but the PHI in the medical record belongs to you. This Company protects the privacy of your PHI. This Company is legally permitted to use or disclose your PHI for the following purposes:

TREATMENT. This company may use and disclose your PHI when you need a prescription, lab work, x-ray, or other health care service. In addition, we may use and disclose your PHI about you when referring you to another health care provider. For example, if you are referred to another physician, we may disclose your PHI to your new physician regarding whether you are allergic to any medications. We may also disclose your PHI about you for the treatment activities of another health care provider. For example, we may send a report about your care from us to a physician to whom we are referring you to so that the other physician may treat you.

PAYMENT. This company may use and disclose your PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are scheduled to receive. For example, we may ask for payment approval for your health plan before we provide care or services. We may use and disclose your PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose your PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose your PHI to insurance companies providing you with additional coverage. We may disclose limited parts of your PHI to consumer reporting agencies relating to collection of payments owed to use.

This Company may also disclose your PHI to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company or health plan. For example, we may allow a health insurance company to review your PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

HEALTH CARE OPERATIONS. This Company may use your PHI in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professions, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and credentialing activities.

YOUR AUTHORIZATION. In addition to this Company's use of your PHI for treatment, payment and health care operations, you may give us written authorization to use or disclose your PHI to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure of your PHI permitted while the authorization was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI except as set forth in this NOTICE.

DISCLOSURES TO YOU, YOUR FAMILY AND FRIENDS. This Company will disclose your PHI to you as described in the Patient Rights section of this NOTICE. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your health care, but only if you agree that we may do so.

NOTIFICATION AND COMMUNICATION WITH FAMILY. This Company may disclose your PHI to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family or others.

REQUIRED BY LAW. This Company may use and disclose your PHI information when required to do so by Law.

PUBLIC HEALTH. This Company may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration, problems with products and reactions to medications; and reporting disease or infection exposure.

HEALTH OVERSIGHT ACTIVITIES. This Company may disclose your health information to health agencies for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

DECEASED PERSON INFORMATION. This Company may disclose your health information to coroners, medical examiner and funeral directors.

ORGAN DONATION. This Company may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

PUBLIC SAFETY. This Company may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

WORKERS' COMPENSATION. This Company may disclose your health information as necessary to comply with Workers' Compensation laws.

APPOINTMENT REMINDERS, TEST RESULTS AND TREATMENT INFORMATION. This Company may contact you to provide appointment reminders, test results or to give your information about other treatments or health-related services that may be of interest to you. This may include voice mail messages, postcards, letters, e-mail and other forms of communications.

**II. WHEN THIS COMPANY MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION.** Except as described in this Notice of Privacy Practices, this Company will not use or disclose your health information without your written authorization. If you do authorize this Company to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**III. YOUR HEALTH INFORMATION RIGHTS.**

1. You have the right to request restrictions on certain uses and disclosures of your health information. This Company is not required to agree to the restriction that you request.
2. You have the right to receive your health information through reasonable alternative means or at an alternative location.

3. You have the right to inspect and copy your health information. This Company may impose a charge for copying expenses.
4. You have a right to request that this Company amend your health information that is incorrect or incomplete. This Company is not required to change your health information and will provide you with information about Company denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by this Company, except that this Company does not have to account for the disclosures for treatment, payment, health care operations, information provided to you, or certain government functions described above.
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute  
307 West Main St., Kent OH 44240  
Kelly Semancik, Privacy Officer

**IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES.** This Company reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, this Company is required by law to comply with this Notice.

**V. COMPLAINTS.** Complaints about this Notice of Privacy Practices or how this Company handles your health information should be directed to:

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute  
307 West Main St., Kent OH 44240  
Kelly Semancik, Privacy Officer

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services  
Office of Civil Rights  
Hubert H. Humphrey Bldg.  
200 Independence Ave, S.W.  
Room 509F HHH Bldg.  
Washington DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found on-line at <http://www.hhs.gov/ocr/regmail.html>.

If you are not satisfied with this Company's response, you may file a complaint with:

Regional V, Office for Civil Rights	Ph: 312-886-2359
U.S. Department of Health and Human Services	Fax: 312-886-1807
233 N. Michigan Ave., Suite 240	TDD: 312-353-5693
Chicago IL 60601	

Alternatively, you may e-mail a complaint to: [OCRComplain@hhs.gov](mailto:OCRComplain@hhs.gov) . For further information, contact:

Office for Civil Rights	Ph: 202-205-8725
Department of Health and Human Services	
Mail Stop Room 506F	
Hubert H. Humphrey Building	
200 Independence Ave, SW	
Washington DC 20201	

**COMPANY WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute  
307 West Main St., Kent OH 44240  
Kelly Semancik, Privacy officer

I hereby acknowledge that I received or was provided the opportunity to receive a copy of Western Reserve Professional Group, d.b.a. Western Reserve Spine and Pain Institute's Notice of Privacy Practices.

PATIENT INFORMATION:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone: \_\_\_\_\_

PERSONAL REPRESENTATIVE INFORMATION (IF APPLICABLE):

Print Name: \_\_\_\_\_

Nature of Relationship: \_\_\_\_\_  
(i.e. - Parent, Guardian, Beneficiary or Personal Representative of Deceased Patient, etc.)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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***For Office Use Only:***

- Signed form received.
- Acknowledgment Not Obtained.
- Patient Refused.
- Emergency -
- Other - \_\_\_\_\_

Print Staff Member's Name: \_\_\_\_\_

Staff Member's Signature: \_\_\_\_\_

Date: \_\_\_\_\_