4832 S. 24th Street, Omaha, NE Office:
402-502-1819
Fax: 402-502-2057
www.OmahaIntegratedRehab.com

New Patient Information

Employer Name: _____

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Social Security Number: _____-_____-_____ Marital Status (circle one): Single Married Divorced Widowed

Date of Birth: _____ Preferred Language: English Spanish Other: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email address: _____

Emergency Contact Data:

Contact Name: _____Home Phone: (_____) _____-_____

Patient Health Information Consent Form and Acknowledgment of Privacy Practices

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Please refer to Notice of Privacy Practices of Integrated Rehab, LLC for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physical therapist and/or chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient or Parent/Guardian of Minor Patient Date