METTLE PHYSICAL THERAPY
Function Restored

www.mettlept.com

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Email Address:			
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	

Chose Clinic Because/ Referred to Clinic by Dr.: ☐ Insurance Plan ☐ Word of Mouth:

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Phone: ( ) -
Regular Dr./PCP	Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:		
Subscriber's Name (If different):		Birth Date: / /
ID. #:	Group/Policy #:	Policy Holder's SSN:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth Date: / /
ID. #:	Group/Policy #	
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto:	☐ Labor & Industries:		
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

IN CASE OF EMERGENCY

Name of Local Relative or Friend:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -
Please provide the name of the person(s) to whom Mettle Physical Therapy may disclose health information		
Name:	Relationship to Patient:	Phone: ( ) -
May we send an email or leave messages regarding appointments or treatment on your answering machine? ☐ Yes ☐ No		

I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s). Additionally, I authorize my insurance benefits be paid directly to Mettle Physical Therapy and authorize said practice to release any information required to process my claim. I understand that I am financially responsible for any remaining balance.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM **Patient Name** _____

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
Other:		

EXERCISE
- ☐ None
- ☐ 1-2 x Week
- ☐ 3-4 x Week
- ☐ 5+ x Week

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ Other

STRESS LEVEL
- ☐ Low
- ☐ Medium
- ☐ High

HABITS
- ☐ Smoking — Packs a Day _____
- ☐ Alcohol — Drinks a Week _____
- ☐ Coffee/Soda — Cups a Week _____

What types of exercise do you perform? _____

What things cause stress in your life?

Are you taking any seizure medication? ☐ Yes ☐ No If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ Yes ☐ No If yes list name: _____

List all medications you are currently taking: _____

List all surgeries (including dates): _____

Are you pregnant? ☐ Yes ☐ No What week? _____

Have you had any injuries related to work? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had any auto accidents? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ Yes ☐ No Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

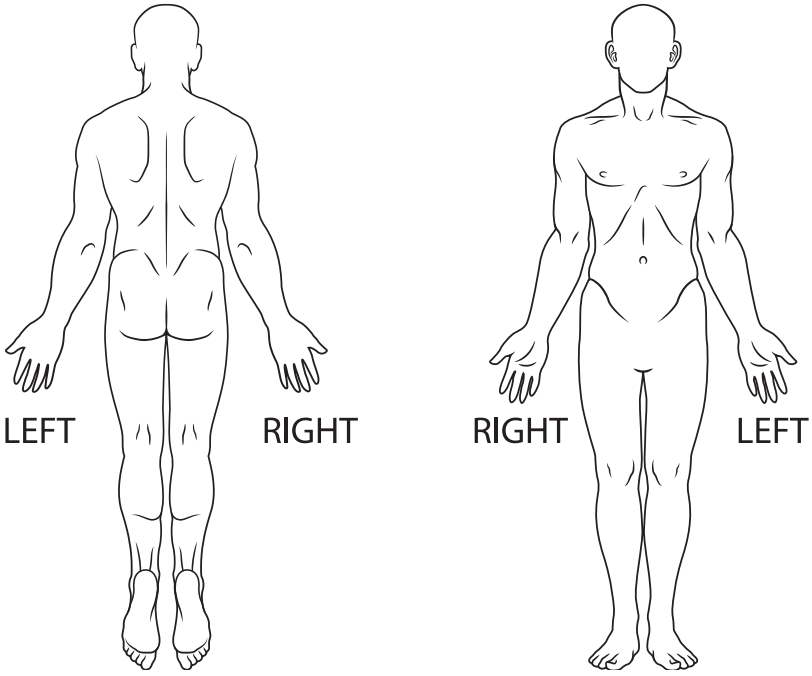
Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMM	— — —	0 0 0 0
M	— —	0 0 0

Pins and Needles	Stabbing	Other
□ □ □ □ □ □	/////	x x x x
□ □ □ □	////	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>LOWEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>HIGEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

What goals do you wish to achieve in physical therapy? _____

_____

_____

_____

_____

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Mettle Physical Therapy or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____

Name of Patient (Print Clearly)

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

www.mettlept.com

NOTICE OF PRIVACY PRACTICES

Effective date of this notice: 8 /1/11

Please Note: YOUR BENEFITS OR ELIGIBILITY WILL NOT BE AFFECTED BY THIS NOTICE*

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.

SUMMARY

To provide you with benefits, METTLE PHYSICAL THERAPY will receive personal information about your health, from you, your physicians, hospitals, and others who provide you with health care and social services. Your health information is private. This notice of our privacy practices is intended to inform you of the ways we may use your information and when we may disclose this information to others. It also describes your rights related to this information as well as our responsibility.

KINDS OF INFORMATION THAT THIS NOTICE APPLIES TO

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains anything that could reasonably be used to identify you, (otherwise known as de-identified data).

WHO MUST ABIDE BY THIS NOTICE?

METTLE PHYSICAL THERAPY

1. All workforce members (employees, staff, students, volunteers and other personnel whose work is under the direct control of METTLE PHYSICAL THERAPY).
2. The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

Reasons Your Health Information May be Used or Disclosed by METTLE PHYSICAL THERAPY.

1. **Treatment.** We may use your health information to provide you with benefits (medical or social) related to METTLE PHYSICAL THERAPY programs. This means that our employees, staff, students, volunteers and others whose work is under our direct control, may read your health information to learn about your medical condition or social service needs, and use it to help you make decisions about your care. For instance, a workers' comp evaluator may read your medical chart in the hospital as part of your assessment for your claim. We will also disclose your information to others to provide you with medical treatment or services. For instance, we may use health information to identify clients with certain chronic illnesses and send information tothem regarding treatment alternatives.
2. **Payment.** We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our accounting department may use your health information to pay your claims (for benefits provided). And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). We may also disclose some of your health information to the county or other organizations with whom we contract for payment- related services. This entity will be known as a business associate. We may respond to Legislative requests via our Offices of Commissioner. We will not use or disclose more information for payment purposes than is necessary. This is known as using only the minimum necessary amount to accomplish the purpose of use or disclosure. However, the business associate is held accountable to the Secretary of Health and Human Services to safeguard (keep secure) and protect (keep private) your information.

   New types of organizations have been formed to facilitate the electronic exchange of health information. These organizations did not exist when the HIPAA regulations were initially passed. The American Recovery and Reinvestment Act of 2009 has been highly sensitive to the protection of health information and is therefore requiring business associate agreements with the following other types of organizations: Health Information Exchanges, Regional Health Information Exchanges and E-prescribing Gateways that support electronic health record exchange.
3. **Health Care Operations.** We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other clients to plan what services we need to provide, expand, or reduce. We may use your information to communicate with you about a drug or biologic that is currently being prescribed.Any other

marketing communication involving payment requires us to obtain an authorization from you prior to releasing such communication.

4. **Legal Requirement to Disclose Information.** We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by the State insurance department. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.
5. **Public Health Activities.** We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, deaths, and reactions to certain medications.
6. **To Report Abuse.** We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.
7. **Law Enforcement.** We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.
8. **Specialized Purposes.** We may disclose the health information of clients of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president.
9. **To Avert a Serious Threat.** We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.
10. **Family and Friends.** We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.
11. **Research.** We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.
12. **Information to Clients.** We may use your health information to provide you with additional information. This may include sending appointment reminders to your address. This may also include giving you information about treatment options, alternative setting for care, or other health-related services that we provide.

13. **Notification in the Case of a Breach**. We are required by law to notify you in the case of a breach of your unsecured (not encrypted or masked by some technology) protected health information when it has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach.

YOUR RIGHTS

1. **Authorization**. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization.
2. **Request Restrictions.** You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree except to restrict your health information from going to a health plan for purposes of carrying out payment or health plan operations if you have first paid for the health care service or item out of pocket in full. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law or for treatment purposes.
3. **Confidential Communication**. You have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send program application information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.
4. **Inspect And Receive a Copy of Health Information.** You have a right to inspect the health information about you that we have in our records, and to receive a copy of it (hard copy or electronic). This includes your request for us to send your health information to an entity or person designated by you such as a Personal Health Record. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes application, enrollment and payment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying, reproducing in electronic media, and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.
5. **Amend Health Information.** You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, it is not part of the records we use to make decisions about you, the

information is something you would not be permitted to inspect or copy, or if the information is incomplete or otherwise inaccurate.

6. **Accounting of Disclosures.** You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures relating to a disaster; disclosures that you have authorized; and disclosures made directly to you. If the request for accounting for disclosure is applicable to electronic records, you may not request a time period longer than three years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons may not be included on the list: disclosures of information in a facility directory [if applicable]; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.
7. **Paper Copy of this Privacy Notice.** You have a right to receive a paper copy this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.
8. **Complaints.** You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Secretary of the U. S. Department of Health and Human Services, at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR LEGAL DUTIES

1. We are required by law to keep your health information private.
2. We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
3. We are required to abide by the terms of this notice until we officially adopt a new notice.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all existing clients within 60 days of the effective date.

WHOM TO CONTACT

For more information about this notice, about our privacy policies, to exercise your rights as listed on this notice, or to request a copy of our current notice of privacy practices, contact the person listed below:

METTLE PHYSICAL THERAPY PRIVACY OFFICER
Sahil Brahmbhatt
Mettle Physical Therapy
552 Allen Rd
Basking Ridge, NJ 07920
(516) 508-0086

Copies of this notice are also available at all METTLE PHYSICAL THERAPY.