



Northeastern Rehabilitation
A S S O C I A T E S , P . C .

Arrival Time vs Appointment Time for EMGs

You will be given an Appointment Time for the EMG and an *Arrival Time* of **30 minutes prior.**

EMGs require a minimum of 30 minutes to complete. Our goal is to have you in the exam room as close to your appointment time as possible. By arriving 30 minutes prior, this allows us to complete the check in process and provide the physician the time he/she needs to complete the EMG study.

If you are not here 30 minutes prior to the EMG appointment time, we may need to reschedule your appointment.

Thank you.

The Staff and Physicians of Northeast Rehab

Patient Information Sheet (Please Print)



Patient Name: _____ **Date of Birth:** ____ / ____ / ____
Last First Middle I.

Soc. Sec. # : _____ / _____ / _____ **Sex:** M F

Race: White Black/African American American Indian/Alaska native Asian
 Native Hawaiian/other Pacific Islander Other _____

Ethnicity: Not of Spanish/Hispanic descent Spanish/Hispanic **Primary Language:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact _____ **Phone:** _____

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: _____ **Relation:** _____

■ **Primary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** ____ / ____ / ____
Last First Middle I.

Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Work Phone** _____

Employer: _____

■ **Secondary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** ____ / ____ / ____
Last First Middle I.

Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone _____ Work Phone _____

Employer: _____

Please complete this section if this is a Work Related Injury or Auto Accident:

Patient Name: _____

■ **Work Related Injuries**

Date of Injury: _____ / _____ / _____ Claim #: _____

Employer: _____ County located in: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Contact Name: _____ Phone: _____

■ **Auto Accident**

Date of Injury: _____ / _____ / _____ Claim #: _____

Auto Insurance Carrier: _____

Insurance ID #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Contact Name: _____ Phone: _____

■ **Attorney Information - if Applicable**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Patient Name: _____

MEDICATION INTAKE SHEET

Please list **all** medications taken on a daily basis, including **vitamins, herbals and over-the-counter** medications. Please list all **medication allergies**. Please list pharmacy name and telephone number.

For Office Use Only: Initial: _____ Ht: _____ Wt: _____ BP: _____ Pulse: _____

Medication Name	Dose/Strength	Times taken per Day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

ALLERGIES: _____

Pharmacy Name _____ Phone Number _____



NOTICE OF PRIVACY PRACTICES

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

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Please note that Northeastern Rehabilitation Associates, PC (NERA) is affiliated with TLC Medical Fitness, TLC Physical Therapy, Healing Arts Center, and NE Rehabilitation Chiropractic Center. All office sites of NERA may share information for the purposes of treatment, payment, or healthcare operations as described in this notice.

YOUR RIGHTS UNDER THE PRIVACY RULE

*Following is a statement of your rights, under the Privacy Rule, in reference to your PHI.
Please feel free to discuss any questions with our staff.*

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken on action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone) and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We

have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization, to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security;

workers' compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us.

*You may file a complaint with us by notifying the Privacy Manager at 570-344-3788.
NERA will not retaliate against you for filing a complaint.*

Effective Date:
June 18, 2013

Publication Date:
June 18, 2013

Your choice: Making your health information available to health care professionals

A guide for patients



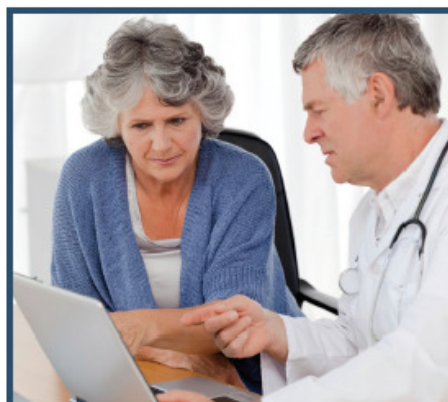
Providing doctors and nurses who care for you with quick access to your health information when and where it is needed ensures you get the best possible health care. A health information exchange, or HIE, is a service that allows health information to securely move electronically between doctors, nurses and other health care professionals who care for you so it can be accessed when it is needed for treatment purposes. That's why we participate in the Keystone Health Information Exchange.

How is my health information exchanged?

Doctors, nurses and other health care professionals participating in an HIE have nearly immediate access to a patient's health information from another HIE participating health care professional. Otherwise, a patient's health information is transmitted between health care professionals via telephone or fax, which often causes treatment delays.

Is my health information being exchanged today?

Yes, health information from this facility is being exchanged electronically with other health care professionals to help coordinate your care.



What health care information is available?

Only health care information that is relevant to providing care is exchanged between health care professionals. This includes lab/test results, medications, allergies and medical history. Mental health, HIV and substance abuse information is managed following state and federal guidelines.

Is my health information protected?

Yes, privacy and security safeguards are in place to meet and exceed federal, state and local requirements, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) act. Access to this system is regularly audited to ensure health information is accessed appropriately.

What if I don't want to make my health information available?

Your participation is voluntary—you can choose not to allow your health information to be exchanged. This is called opting out. By doing so, your health information from this facility will not be made electronically available to other health care professionals. If you do not wish to have your health information

available through the health information exchange, you must opt out at each participating health care facility you visit. There is not a universal opt-out option.

If you do not want this health care professional and/or facility to make your health information available through the HIE, please notify the staff at our registration desk.



570-214-9438

KeyHIESupport@KeyHIE.org

Who do I contact if I have additional questions?

If you have additional questions about KeyHIE or opting out that are not covered in this brochure, please contact KeyHIE Support at KeyHIESupport@KeyHIE.org or 570-214-9438.