Notice of Privacy Practices

Material that is shared in therapy/rehabilitation is considered confidential to the extent provided by the law. Patient information, including case records, is confidential and will be released only under the following conditions:

1. The therapist is using case records for purpose of supervision, treatment team consultation, professional development, or training and research. In such cases, to preserve confidentially, clients will be identified by first names only; the clinical staff determines that the client is a danger to himself/herself or to someone else such as being suicidal or homicidal;
2. The client discloses a personal history/knowledge of any physical, sexual or emotional abuse, neglect, or exploitation of a child, elderly, or disabled person whether it be the past or present; the client discloses sexual contact with a mental health professional with whom the client had/has a professional relationship;
3. The therapist or the clinic is ordered by a court to disclose information;
4. The client directs the therapist or clinic to release the client's records;
5. The therapist or clinic is otherwise required by law to disclose information.

In family and/or group settings, individual privacies are maintained to the best extent possible. However, due to the interaction of the group therapy process per se, it is not always possible to maintain strict confidentiality. It is your responsibility to understand this prior to disclosing personal information or participating in group therapy.

All of the therapists associated with the clinic have proper training and credentialing for the provision of services that they provide. All therapists have either appropriate licensure, are provisionally licensed and are receiving supervision from a licensed medical director or are students in a therapy program and are receiving supervision by a licensed therapist.

If you have a complaint regarding any of the treatment that you receive here at Rehabilities, please inform the therapist that you are working with and the patient coordinator. If you wish to go beyond this level of complaint, please ask the office staff for higher remedies.

I understand that in order to undergo testing/evaluation and/or participate in therapy/rehabilitation, I am required to sign a Consent for Release of Information form giving the treatment team permission to communicate with my doctors, mental health professionals who have seen me previously and/or obtain copies of records of my previous treatment, and or any individual or entity directly involved in the payment of my care. I agree to disclose previous treatment and will reimburse Rehabilities Partners LLC for any expenses charged for supplying copies of my records. I understand my right to review a notice of privacy practices, to request restrictions, and to revoke consent.

With an understanding of the above requirements, I agree to participate in evaluation/testing and/or therapy/treatment and release the therapists and Rehabilities Partners LLC from liability for the same.

I authorize the representatives of Rehabilities Partners LLC to contact me to provide appointment reminders.

YES _____ NO _____

_____ _____

Patient Signature Date

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I authorize the representatives of Rehabilities Partners LLC to contact me to provide appointment reminders.

YES _____ NO _____

_____ _____

Patient Signature Date

Rehabilities

Notice Of Privacy Practices

1208 McRae Blvd
El Paso, TX 79925
Tel. (915) 595-4500 Fax (915) 595-4502

WRITTEN ACKNOWLEDGMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices,** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date

Rehabilities

Authorization to Release Medical Records

Patient Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State:_____ Zip Code: _____

I hereby authorize _____ to provide a copy, summary or a narrative of my medical records as indicated below:

- ❑ Complete Records
- ❑ Radiological Reports
- ❑ Records of care concerning the following conditions:

  _____
  _____
  _____

Release to the following:

Rehabilities
1208 McRae Blvd
El Paso, Texas 79925
(915) 595-4500
Fax (915) 595-4502

This authorization extends to copies of any and all records, reports, or other documents which you have generated pertaining to any treatment and/or service rendered to the undersigned. The information requested includes but is not limited to chart notes, reports, written reports, x-rays, tests, MRI's, EMG's, CT scans, drug administration records, hospital records, pharmacy records, and any other data pertaining to undersigned's physical, medical, and any other health related information concerning the above stated patient.

I understand that you will provide this information within a reasonable period of time.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Rehabilities

We are committed to providing you the best experience and care to create an environment for healing.

Please review the following to help us maximize our ability to help you.

1. Please dress comfortably or bring a change of clothes.
2. Please ask questions if you are unclear about your treatment or bill.
3. Please sign in during each visit.
4. Please update us with any change of address or insurance information.
5. Most importantly, please talk with one of our team members if ever you are not happy with any part of your experience.

Cancellation and No-Show Policy

We require 24 hours advanced notice for cancellations. Your consideration gives us the chance to assign another person to your time slot. If you cancel with less than 24 hour notice, you may be assessed a cancellation fee of $25.00

If you miss an appointment without calling us before its scheduled time, you may be assessed a $25.00 no-show fee payable before your next visit. I have read and agree to the Cancellation and No-Show Policy.

_____ _____

Patient Signature Date

Rehabilities
Medical History

Name: _____ Date of Birth: _____/_____/_____ Age: _____
(Last) (First)

Male_____ Female_____ Dominant Hand: Right_____ Left_____ Height: _____ft._____in. Weight: _____

Employment Status

☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled ☐ Retired

Are you on modified duty or on temporary leave because of an injury? ☐ Yes ☐ No

Present Occupation: _____ If Retired, former occupation: _____

(MUST COMPLETE) Date of Injury/Accident: _____ If Chronic, approximate start date: _____

With whom do you live? ☐ Spouse ☐ Children (#____) ☐ Parent(s) ☐ Sibling ☐ Caregiver ☐ Friend ☐ Other

Health Habits

Do you like to exercise? ☐ Yes ☐ No How often do you exercise? _____ days/week

Is your current weight satisfactory? ☐ Yes ☐ No _____

Do you smoke? ☐ Yes (# of packs/day _____) ☐ No ☐ PriorUse / Date Quit: _____

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications *(please list all that you take)*

Prescription and Non-Prescription Drugs *(antacids, antihistamines, aspirin, herbals, vitamins, etc.)* including dose and frequency:

_____
_____
_____

Any known allergies to medications? ☐ Yes ☐ No If so, what? _____

Medical History- Please check if you **have** or **ever had**:

☐ Asthma/Allergies	☐ High Blood Pressure	☐ Headaches/Migraines	☐ Hypoglycemia
☐ Cancer	☐ Head Injury	☐ Muscular Dystrophy	☐ Osteoporosis
☐ Diabetes	☐ Multiple Sclerosis	☐ Seizures/Epilepsy	☐ Skin Disease
☐ Lung Problems	☐ Repeated Infections	☐ Stomach Ulcers	☐ Circulation/Vascular Problems
☐ Parkinson's Disease	☐ Thyroid Problems	☐ Broken Bones	☐ Infectious Diseases (TB, Hepatitis, HIV)
☐ Stroke	☐ Blood Disorders	☐ Kidney Problems	☐ Developmental/growth Problems
☐ Arthritis	☐ Depression	☐ Heart Problems	☐ Other

Have you ever had surgery? ☐ Yes ☐ No If yes, please list and give dates.

/ /		/ /	
_/ /		__ / /	

Have you had any of the following medical tests *for your current condition? (check all that apply)*

☐ Angiogram	☐ Arthroscopy	☐ Biopsy	☐ Blood Scan
☐ CT Scan	☐ Discogram	☐ Doppler Ultrasound	☐ Echocardiogram
☐ EEG	☐ ECG	☐ EMG	☐ Mammogram
☐ MRI	☐ Myelogram	☐ NCV	☐ Pulmonary Function Test
☐ Spinal Tap	☐ Stress Test	☐ X-rays	☐ Other

Do you have a pacemaker or any other implanted device? ☐ Yes ☐ No If yes, explain_____

By signing below I acknowledge that the above information is true to the best of my knowledge.

Signature: _____ Date: _____