Spalding University CORF New Patient Information Form

Patient Name:_____E-Mail Address:_____Age:_____Sex:_____

Social Security Number:_____-_____-_____ Date of Birth:____/____/_____Marital Status:_____Phone: _____

Address:_____City/State/Zip:_____

Employer:_____Occupation:_____

Employer Address:_____Work Phone Number:_____

Spouse (or parent, if minor):_____ Social Security Number:_____-_____-_____

Spouse or Parent Employer:_____Address:_____

Contact Person Outside Home:_____Phone No.:_____

Referring Physician:_____Primary Care Physician:_____

Onset Date (injury, accident, surgery date or recent date symptoms started): _____/____/_____
(For workers compensation or auto accident we must have the date of injury.)

How did you hear about us? Family/Friend ❒ TV ❒ Radio ❒ Physician ❒ Internet ❒ Other _____

Billing Information *(Please present insurance card)*

Workers Comp Auto Accident Medicare Anthem Humana Aetna Group Health Other:_____

If you want us to bill under workers comp or for an auto accident, we will do so but we ask that you present us with your personal health insurance information as back up.

Primary Insurance:_____Address:_____City/State/Zip_____

Phone No:_____Subscriber No. or Claim No:_____Subscriber's Date of Birth_____

Subscriber's relation to patient_____

Precertification or Referral No:_____Adjuster/Case Manager:_____

Secondary Insurance:_____ Address:_____Phone: _____

Subscriber No. or Claim No.:_____Adjuster/Case Manager:_____

CONSENT TO TREATMENT

1 **I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services and fully understand that I am financially responsible for any services not covered by this authorization.**

2 **I have presented myself to this facility for treatments and consent to diagnostic procedures and care provided by my attending therapist.**

3 **I realize I have the right to refuse any drugs, treatments, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.**

4 ****NOTE TO WORKERS COMP** I hereby authorize my rehab consultant to receive my records related to my work injury. This information may be faxed or mailed.**

5 **I understand if I do not attend therapy for two weeks or miss three consecutive appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for any further treatment and will be receiving a new evaluation. This is in compliance with State Law.**

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

_____**DATE:**_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____**DATE:**_____

SIGNATURE OF WITNESS

**Spalding University Corf does not discriminate on the basis of race, color, national origin, disability or age.*

SPALDING UNIVERSITY CORF Comprehensive Outpatient Rehabilitation Facility

Consent to Evaluate and Treat

I, _____, individual client

Or I, _____parent/guardian/foster parent of

_____, give permission to Spalding University CORF to perform:

___ Physical Therapy Assessment and Treatment

___ Occupational Therapy Assessment and Treatment

___ Speech Language Pathology Assessment and Treatment

___ Assistive Technology Assessment, Intervention and Training

I have received a copy of the Notice of Privacy Practices _____ (Initial)

_____ _____

Signature/Relationship Date

_____ _____

Witness Date

SPALDING UNIVERSITY CORF

HEALTH INFORMATION DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize SPALDING UNIVERSITY CORF to disclose my health information that is directly related to my current treatment at SPALDING UNIVERSITY CORF to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to the individuals below even though involved in my care.

NAME	RELATIONSHIP

Signature of Patient (or Patient's Representative) **Date:**

Signature of Witness **Date:**

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐ Power of Attorney ☐ Guardian ☐ Surrogate Decision-Maker
☐ Executor of Legal Rep. ☐ Parent ☐ Other (please specify) _____

Provide documentation or explanation of your authority to act for the patient

_____

CORF Case Management

Welcome to the CORF!

Thank you for allowing us to serve you and your family! We consider it both an honor and a privilege to spend this time with you. Our goal is to insure that you receive outstanding care and support while you are with us at CORF. Within the next few days, someone will be contacting you to schedule a brief visit to address any ongoing questions you might have regarding your family's needs and how we might help make you aware of the full spectrum of services available to you. The visit will be held here at Spalding and will be scheduled to coincide with your existing appointments: no special trips will be necessary!

Again, we're thrilled to be working with you and I look forward to seeing you soon. If you have questions or concerns prior to our meeting please feel free to contact me at the number provided below. I am eager to help in any way possible!

Dr. Shannon E. Cambron, EdD., MSW
CORF Case Coordinator
901 South Third Street
Louisville KY 40203
502-873-4475

SPALDING UNIVERSITY CORF'S NOTICE OF PRIVACY PRACTICES

Effective September 14, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply Spalding University CORF and each of its subsidiaries, affiliates, and entities managed or controlled by Spalding University CORF, including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. Use or disclosure pursuant to this Notice may include electronic transmittal or disclosure of your personal health information.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Spalding University CORF. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to Spalding University CORF, Attn: Administrative Manager 845 S. Third Street, Louisville KY 40203.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: With your written agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Spalding University CORF, Attn: Administrative Manager 845 S. Third Street, Louisville KY 40203.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures:
We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information
You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. If you request a copy of your personal health information, you may be charged a nominal fee for copying and postage.

Amendments to Your Personal Health Information
You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information
You have the right to receive an accounting of certain disclosures made by us of your personal health information after September 14, 2014. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Workers' Compensation: For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use or disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, 845 S. Third Street, Louisville KY 40203. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, 845 S. Third Street, Louisville KY 40203.

_____ _____

Patient Signature or Legal Guardian **Date**

WHAT YOU SHOULD KNOW ABOUT HIV & AIDS

WHAT IS AIDS?

AIDS is the Acquired Immune Deficiency Syndrome – a serious illness that makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infections, this person becomes ill. These infections can eventually kill a person with AIDS.

WHAT CAUSES AIDS?

The human immunodeficiency virus (HIV) causes AIDS. Early diagnosis of HIV infection is important! If you have been told that you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment for you. Free or reduced cost anonymous and confidential testing with counseling is available at most local health departments in Kentucky. After being infected with HIV, it takes between two weeks to six months before the test can detect antibodies to the virus.

HOW IS THE HIV VIRUS SPREAD?

- ☐ Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen or cervical/vaginal secretions are exchanged.
- ☐ Sharing syringes, needles, cotton, cookers and other drug injecting equipment with someone who is infected.
- ☐ Receiving contaminated blood or blood products (very unlikely now because blood used in transfusions has been tested for HIV antibodies since March 1985).
- ☐ An infected mother passing HIV to her unborn child before or during childbirth, and through breast feeding.
- ☐ Receipt of transplant, tissue/organs, or artificial insemination from an infected donor.
- ☐ Needle stick or other sharps injury in a health care setting involving an infected person. Infections can sometimes be prevented by taking post-exposure prophylaxis anti-retroviral drugs. Strict adherence to universal precautions is the best way to prevent exposures.

YOU CANNOT GET HIV THROUGH CASUAL CONTACT SUCH AS:

- ☐ Sharing food, utensils, or plates
- ☐ Touching someone who is infected with HIV
- ☐ Hugging or shaking hands
- ☐ Donating blood or plasma (this has NEVER been a risk for contracting HIV)
- ☐ Using public rest rooms
- ☐ Being bitten by mosquitoes or other insects
- ☐ Using tanning beds (always clean before and after use)

HOW CAN I PREVENT HIV/AIDS?

- ☐ Do not share needles or other drug paraphernalia.
- ☐ Do not have sexual intercourse except with a monogamous partner whom you know is not infected and who is not sharing needles. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams, and water based lubricants every time you have sex.
- ☐ Educate yourself and others about HIV infection and AIDS.

WOMEN AND HIV/AIDS

For females with HIV/AIDS in Kentucky, heterosexual exposure and injection drug use are the most common modes of transmission of HIV. HIV can be spread through body fluids (i.e., blood, semen, vaginal secretions, and breast milk).

- **All pregnant women should have blood tests to check for HIV infection.**
- Mothers can pass HIV infection to their babies during pregnancy, labor and delivery, and by the child ingesting infected breast milk.
- Without treatment, about 25% (1 out of 4) of the babies born to HIV infected women will get HIV.
- Medical treatment for the HIV infected woman during pregnancy, labor, and delivery can reduce the chance of the baby getting HIV from its mother to less than 2% (less than 2 out of 100).
- An HIV infected mother should not breastfeed her newborn baby.

IS TREATMENT AVAILABLE IF I ALREADY HAVE HIV/AIDS?

After being infected with HIV, it takes between two weeks to six months before the test can detect the HIV virus. **Early diagnosis of HIV infection is important!** Free anonymous and confidential testing and counseling is available at every Health Department in Kentucky. Testing requires drawing a small tube of blood from a vein in your arm. If you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment.

GETTING TESTED FOR HIV:

If you have never been tested for HIV, you should be tested at least once. Centers for Disease Control and Prevention (CDC) recommends being **tested at least once a year if you do things that can transmit HIV.** These include:

- Injecting drugs or steroids with used injection equipment
- Having sex with someone who has HIV or any sexually transmitted disease (STD)
- Having more than one sex partner since your last HIV test
- Having a sex partner who has had other sex partners since your last HIV test
- Having sex for money or drugs (prostitution- male or female)
- Having unprotected sex or sex with someone who has had unprotected sex
- Having sex with injecting drug user(s)
- Having had a blood transfusion between 1978 and 1985
- Pregnant women or women desiring to become pregnant

Remember: You can't tell whether or not someone has HIV just by looking at them!

IF YOU NEED MORE INFORMATION:

http://www.cdc.gov/hiv/
Kentucky HIV/AIDS Program 502-564-6539
The National AIDS Hotline 1-800-342-AIDS
Your local health department's HIV/AIDS Coordinator

Spalding University CORF Medical Screening Form

Name:_____ Date:_____

Please circle YES or NO

Do You Have A History Of:	SELF	FAMILY
Diabetes?	Yes...No	Yes...No
High Blood Pressure?	Yes...No	Yes...No
Heart Attack?	Yes...No	Yes...No
Heart Disease?	Yes...No	Yes...No
High Blood Cholesterol?	Yes...No	Yes...No
Smoking?	Yes...No	Yes...No
Chest Pain?	Yes...No	Yes...No
Dizziness/Fainting?	Yes...No	
Shortness of Breath?	Yes...No	
Ankle Swelling?	Yes...No	
Night Coughing?	Yes...No	
Stroke?	Yes...No	Yes...No
Cancer?	Yes...No	Yes...No
Osteoporosis?	Yes...No	Yes...No
Osteoarthritis?	Yes...No	Yes...No
Rheumatoid Arthritis?	Yes...No	Yes...No
Rheumatic Disease?	Yes...No	Yes...No
Alcohol Use?	Yes...No	
↳ Current number drinks/week?	_____	
Allergies?	Yes...No	
↳ Type?	_____	
Asthma?	Yes...No	
↳ Always have inhaler with you?	Yes...No	
Childhood Diseases?	Yes...No	
Falling?	Yes...No	
↳ Number of times in last year?	_____	
Headaches?	Yes...No	
Kidney Disease?	Yes...No	
Lung Disease?	Yes...No	
STDs?	Yes...No	
Seizures?	Yes...No	
Pacemaker/Defibrillator?	Yes...No	
Assistive Device (e.g. cane)?	Yes...No	

In the Past 3 Months, Have You Experienced:	
Unexplained change in your health?	Yes...No
↳ If yes, please describe:	
_____	
Explained illness or injury?	Yes...No
↳ If yes, please describe:	
_____	
Unexplained weight change?	Yes...No
Night sweats?	Yes...No
Fever?	Yes...No
Numbness or tingling?	Yes...No
Changes or difficulty with bowel?	Yes...No
Changes or difficulty with bladder?	Yes...No

In the past month, have you frequently been bothered by feeling down, depressed or hopeless? ..... Yes ... No

In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things? ..... Yes ... No

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Speech
☐ Vision ☐ Communication

Do you regularly exercise? ..... Yes ... No
Number of days per week? _____
Number of minutes per session?_____

What is your body weight?_____ height? _____

Please list any medicine allergies you may have:

_____
_____

Are you allergic to Latex? Yes...No Adhesives? Yes...No

Please list or provide a copy of the medications you are currently taking: (Dosages not necessary)

_____
_____
_____

Please list any major surgeries in your past:

_____
_____
_____
_____

Other:

_____
_____
_____
_____
_____

Women:

Are you or could you be pregnant? ..... Yes ... No

Patient/Representative Signature:_____ Therapist Signature: _____

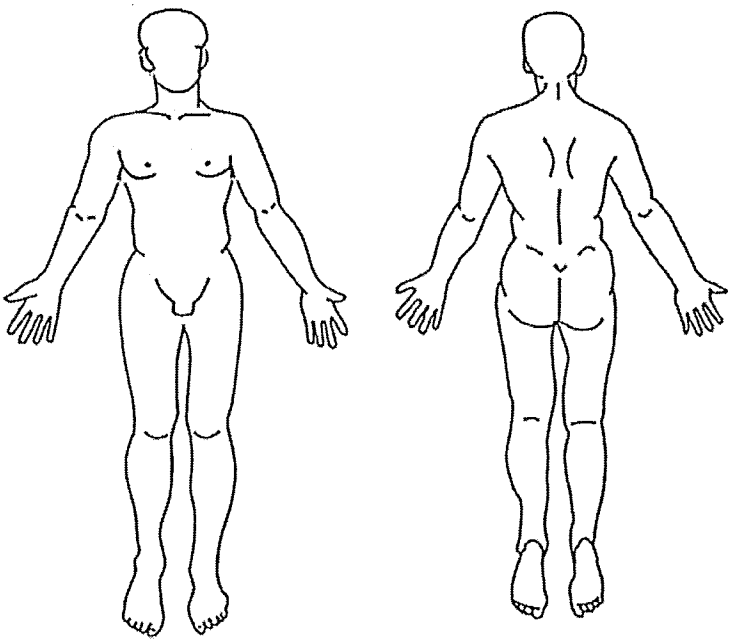
Spalding University CORF Medical Screening Form – Page 2

Name:_____ Date:_____

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

_____

0 1 2 3 4 5 6 7 8 9 10

(**0** = none →**10** = worst imaginable. Indicate level for each with B, C, and W)

What makes your pain or symptom worse?

_____

What makes your pain or symptom better?

_____

Are your symptoms: (check one)
□ Getting worse □ The same □ Improving

How are you able to sleep at night? (check one)
□ Fine □ Moderate Difficulty □ Only with Medication

Do you have pain at night? Yes ... No

When (date) did your problem begin? _____

Have you been treated for this before? Yes ... No
When? How?_____

PATIENT SPECIFIC FUNCTIONAL SCALE

Please list three (3) activities that you are having difficulty performing. Please rate your ability next to each activity

(**0** = unable to perform → **10** = can perform normally)

1. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
2. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
3. _____ _____
   0 1 2 3 4 5 6 7 8 9 10

Other Relevant Information? _____

_____

_____

_____

Patient or Representative Signature: _____ Date: _____

Reviewer Signature/Initials: _____ Date: _____

Spalding University CORF Inclement Weather Procedures

The Spalding University Comprehensive Outpatient Rehabilitation facility will follow the same inclement weather procedures set for Spalding University.

If you are scheduled for therapy and the Spalding University CORF is closed due to the weather, you will receive a phone call notifying you that the Spalding CORF will be closed. You can also check the local news to see if Spalding University is closed or delayed.

If Spalding University is on a delayed schedule and your appointment is scheduled during the closed time, you will be contacted by phone to reschedule your appointment.

If Spalding University closes before your appointment time, you will be notified by phone to reschedule your appointment.

*Please make sure that we have your current phone number in our system. A message will be left if an answering machine picks up.

The most accurate Spalding University closing and delay information is available from the following sources:

- Spalding University website: www.spalding.edu
- Spalding University Inclement Weather Line at 502-585-7102
- E2 Campus Alert System* (*You can register online here.*)
- News media. (*Stations have the information, but typically they cannot report details. If you hear about scheduling changes on the news, it is best to check one of the official sources listed above.*)