Mount Vernon Rehabilitation Medicine Associates

EMG Patient Registration Form

Demographic Information

Last Name:_____ **First Name:**_____ **MI:**_____

Date of Birth:_____ **Soc Sec No:**_____ **Gender:** □**Male** □**Female**

Height:_____ **Weight:**_____ **Dominant Hand:** □ **Left** □**Right**

Home Address:_____ **City:**_____ **State:**_____ **ZIP:**_____

Home Phone:_____ **Mobile Phone:**_____

Email Address:_____

Emergency Contact Person:_____ **Emergency Contact Phone #:**_____

Information about Physicians

Name of Doctor who Referred you for the test:_____

Name of your Primary Care Doctor:_____

List any other doctors who should receive results of the test:_____

_____

Medications and Allergies

List all Medications you are allergic to:_____

_____

List all Medications you are taking (please include dose and for how long you have been taking each)
(Please be sure to include vitamins and supplements
[As an alternative, you may attach a list of your medications.]

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mount Vernon Rehabilitation Medicine Associates

Please describe your symptoms and/or the reason you are having this test:

_____
_____
_____
_____
_____
_____
_____
_____

For how long have you had this problem? _____

If this problem began after an injury, please describe the injury:

_____
_____
_____
_____

If have had prior EMG(s), please list the approximate date(s) and the name(s) of the doctor(s) who performed the test(s):

_____
_____
_____

List your current and prior medical conditions:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List your prior surgeries and approximate dates:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Smoking Status:
□ Never Smoked
□ Former Smoker
□ Current Every Day Smoker
□ Current Heavy Smoker
□ Unknown if Ever Smoked
□ Smoker, Current Status Unknown
□ Current Some Day Smoker
□ Current Light Smoker

Alcohol Use:
□ Never
□ Rare
□ Weekly
□ Daily
□ Heavy Use
□ Current Light Smoker

Problematic Drug Use:
□ Never
□ Prior
□ Current

Employment Status:
□ Employed □ Student □ Retired □ Homemaker □ Unemployed □ Disabled

Occupation:_____

Ethnicity/Race:
□ American Indian or Alaska Native
□ Hispanic or Latino
□ Asian
□ Black or African American
□ Native Hawaiian or Pacific Islander
□ White
□ Decline to Answer
□ Other:
_____

Preferred Language:
□ English
□ Spanish
□ Other:
_____

Is there anything else you would like us to know?

_____
_____
_____
_____

Consent regarding payment/insurance:

I herby authorize Mount Vernon Rehabilitation Medicine Associates to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of all information necessary to secure payment of benefits to my insurance company or health care program.

I understand that I am financially responsible for any and all charges on my account whether or not paid by my insurance plan.

Patient Signature:_____ **Date:**_____

MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES

Receipt of Notice of Privacy Practices and HIPAA Written Acknowledgement Form

I, _____have received a copy of Mount Vernon Rehabilitation Medicine Associate notice of privacy practices and HIPAA.

_____ _____

Signature of Patient/Representative Date

NOTICE OF PRIVACY PRACTICES AND HIPAA

MOUNT VERNON REHABILITATION MEDICINE ASSOCIATES

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

The Health Insurance Portability & Accountability Act of 1966 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used an disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. We are committed to the privacy of your personal identifiable health information (PHI) and will use strict privacy standards to protect it from unauthorized use or disclosure.

Understanding Your Health Record: Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made,. Typically, this record contains your symptoms, examination and test results, diagnosis and treatment plan. This information is referred to as a health or medical record. Understanding what is in your record and how your health information is used helps you to ensure its accuracy and make more informed decisions when authorizing disclosure to others.

Uses and Disclosures That are permitted without your consent or authorization: We may share your PHI, as allowed by federal law, for health oversight activities. When consistent with Virginia Law, if we believe in good faith that the use of the PHI is necessary, we will release your PHI to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

Your PHI can be shared for judicial or administrative proceedings, with public authorities for law enforcement reasons, for activities deemed necessary by appropriate military command authorities, and to coroners, funeral directors or medical examiners (about decedents). We can also release your PHI in compliance with worker's compensation or similar programs established by law.

We may release your PHI to secure payment for health care services provided by our practice such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Your PHI may also be used or disclosed for health care operations which include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. This information will then be used to continually improve the quality and effectiveness of the health care and services we provide.

We may use and disclose your PHI for treatment to provide, coordinate or manage your health care and related services with other health care providers.

We may use your PHI to contact you wit appointment reminders or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. (please inform us if you do not wish to be contacted for appointment reminders).

Required Uses and Disclosure: We are required to disclose your PHI, upon request, to the Secretary of the United States Department of Health and Human Services in connection with the investigation of our compliance with federal privacy regulations.

Right to Inspect and Copy Medical Information: Your health record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to inspect and copy your PHI subject to certain limitation. We may exclude information compiled in anticipation of legal proceedings. Virginia law prohibits you from inspecting and obtaining copies of your medical records if your attending physician or clinical psychologist has filed a written statement that your review of these records would be injurious to your health. Our practice charges a fee to cover the cost of copying your PHI.

Right to Request Restrictions on Use and Disclosure: any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent of the actions we may already have taken relying on your authorization. You may request us to limit our communication with you to a certain way or location, for example, to call you only at work or by mail.

If you are present and give us verbal permission, we may share your PHI with a family member, friend or another person of your choosing. If you are not present or are incapacitated and it is an emergency, we may share your PHI with a family member or a friend if sharing your PHI is in your best interest.

Right to Amend PHI: You have the right to request us, in writing, to amend your PHI if you believe the information is inaccurate or incomplete, but you cannot have any information deleted from you PHI. We may deny your request for amendment if it is determined that the information at issue is accurate and complete or if it was not created by our practice.

Maintenance and Destruction of Records: We will maintain your records for a minimum of six(6) years following your last date of service. Records eligible for destruction will be disposed of in a manner that fully protects patient confidentiality. There will be no further notice given prior to the destruction of records.

Information Protection: We keep you oral, written and electronic PHI safe using physical, electronic and procedural means,. These safeguards follow federal and state laws. We require our employees to protect PHI through written policies and procedures. PHI is limited to only those employees who need the data to do their job.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We are required to follow the privacy notice that is currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions. Effective for all PHI that we maintain. We will post any revisions to our notice and you may request a copy of the revised Notice of Privacy Practices from this office.

If you feel your privacy protections have been violated, you have the right to file a written complaint with our office or with the Department of Health and Human Services. We will not penalize or discriminate against you in any manner if you choose to file a complaint.

For more information or to file a complaint, please contact:

Privacy Officer
2501 Parkers Lane
Alexandria, VA 22306

-or-

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201