Health & Sports Rehab, Inc.
438A Blue Hill Avenue
Dorchester, MA 02121
(617)541-8825 Fax (617)541-8815

* YOU ONLY NEED TO FILL OUT THE ASTRICK

1. *Patients Name_____*Cell Phone_____

2. *Social Security#_____/_____/_____*Work# (_____)_____*Ext#____

3.*Address_____

4. *City, State, Zip_____

5. *Your E-Mail Address_____

6. *Date of Birth_____*Date Injured_____

7. *Referring Physician_____

8. *Family Physician_____

*Referring Attorney Name_____

Address_____

City, State, Zip_____

*Phone # (_____)_____Ext. #_____

If this is an auto injury: No fault (motor or vehicle) accident claims

*Automobile Insurance Co._____

Address_____

City, State, Zip_____

Phone # (_____)_____

Person handling your claim_____ Ext. #_____

*Insured Name(The owner of the car you was in)_____

Claim / File #_____

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BI CLAIM

* YOU ONLY NEED TO FILL OUT THE ASTRICK

All information of the car that hit you

*Automobile Insurance Co._____

Address_____

City, State, Zip_____

Phone # (_____)_____

Person handling your claim_____ Ext. #_____

*Insured Name(The owner of the car that hit you)_____

Claim / File #_____

CONFIDENTIAL PATIENT INFORMATION

NAME _____ D.O.B. _____ SSN _____

ADDRESS _____

INJURY STATEMENT:

This is to certify that I/we _____ were involved in:

L.S. _____ A Worker's Compensation Accident
L.S. _____ A Slip and Fall Accident
L.S. _____ An Automobile Accident
L.S. _____ Others

Which occurred on _____, 19____at or near _____ and that I was injured as a result of this above described incident, that I have been and am now in pain because of it, and I have requested care for my injuries from Columbus Medical Associates. All of the information on this page is correct and true to the best of my knowledge.

Witness _____ Date _____

Height _____ Age _____ Approx. Weight _____ Male _____ Female _____
If Auto accident, you were _____Driver _____Passenger _____Pedestrian.
You were hit from _____Front _____Back _____Right Side _____Left Side
Describe how you were thrown: _____

Please circle symptoms since accident.

Headache	Irratability	Pain or Numbness in Left Arm
Sore Neck	Tension	Pain or Numbness in Right Hand
Stiff Neck	Dizziness	Pain or Numbness in Left Hand
Upper Back Pain	Chest Pain	Pain or Numbness in Right Leg
Upper Back Stiffness	Loss of Balance	Pain or Numbness in Left Leg
Mid Back Pain	Difficulty in Standing	Pain or Numbness in Right Foot
Mid Back Stiffness	Difficulty in Walking	Pain or Numbness in Left Foot
Low Back Pain	Difficulty in Sitting	Pain in Hips
Low Back Stiffness	Difficulty in Reading	Other _____
Nervousness	Pain or Numbness in Right Arm	_____

Hospitalized After Accident
____Yes ____No
If Yes-Where _____
X-Rays Taken____Yes ____No

Circle the following conditions you have had / had:

Arthritis	Bursitis	Hernia	Low Back Pain	Neck Pain/Stiffness
Painful Tailbone	Poor Posture	Sciatica	Spinal Curvature	Swollen Joints
Convulsions	Epilepsy	Diabetes	High Blood Pressure	Low Blood Pressure
Poor Circulation	Lumbago	Headaches	Numbness	Neuralgia

Have you had any major surgery in the past? Yes_____ No_____ If yes, please describe._____

Are you suffering from any major illness? Yes_____ No_____ If yes, please describe. _____
_____Was it aggravated by the accident?_____

I, _____ state all of the above to be true and accurate.
signature

Initial Doctor Exam

Notice Muscular Symmetry WNL____ Other_____
Gait WNL____ Other _____
Antalgic_____
Guarded_____
Alert_____ Confused_____ Cooperative_____
Palpate skull Tramatic Injury ____yes ____no If yes, describe._____

Palpate spine Note Scoliosis _____
WNL___ Military Neck _____
WNL___ Hypo-Hyper Kyphosis _____
WNL___ Hypo-Hyper Lordosis _____

ASSIGNMENT OF PAYMENT

TO: **Health & Sports Rehab, Inc.**
438A Blue Hill Avenue
Dorchester, MA 02121

You are hereby authorized to release any information concerning my heath condition to any Insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at the HEALTH & SPORTS REHAB, INC., or its subsidiaries.

I authorize and assign the direct payment to you of any sum I now or hereafter owe to you, by my attorney out of any proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services to refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sum due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amount owed directly from me. I understand that whatever amounts you do not collect from the insurance proceeds (whether it be all or part of what is due) I personally owe you. I understand that any amount or claim not paid after 90 days of insurance company receipt is automatically due to me.

DATE_____ _____
PATIENT SIGNATURE

_____ _____
WITNESS PRINT PATIENT NAME

Health & Sports Rehab, Inc.

438-A Blue Hill Ave. • Dorchester, MA 02121
(Corner of Warren Street)
Phone (617) 541-8825 • Fax (617) 541-8815

AFFIDAVIT

I, _____ of full age, being duly sworn, according to law,upon
(Name)
depose and say that:

1. On or about _____, I lived at _____
(Date of Occurrence) (Street Address)

_____
(City) (State) (Zip Code)

2. I was injured in an accident involving: [] Motor Vehicle [] Slip & Fall []Occupational

3. I was the: [] Driver [] Passenger [] Pedestrian [] Employee

4. I am executing this affidavit in order to present a documented showing by tender of evidentiary proof in admissible format in order to substantiate the burden of proof necessary to meet statutory requirements of mandates of law relating to the assessments and evaluations of pain; injury; loss function; impairment; and effects on the activities of my daily living, as is present as a result of the above mentioned accident that occurred on: _____

5. My date of birth is: _____

   Social Security #: _____

   Home Phone #: _____

Signature_____

Sworn and subscribed to me before this

_____day of _____, 200

Notary Public – State of Massachusetts

My commission expires June 22, 2012

Health & Sports Rehab, Inc.
438A Blue Hill Avenue
Dorchester, MA 02124
(617)541-8825 FAX (617)541-8815

[redacted]

In accordance with Chapter 273 of the Acts of 1988, we are now required to obtain information regarding other health benefits (HMO, Medicare, health insurance, etc.) available to you before we can process your claim for Personal Injury Protection Benefits (PIP).

If you do not have any other benefits available through your own policy or those of a household member, please sign SECTION (1). If you have other benefits available to you, please complete SECTION (2). In addition, if you have benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete SECTION (3) as well.

[redacted]

If you do not have any medical insurance, (such as BC/BS, Harvard Health Plan, Medicare, Tufts), then sign here and date.

I certify that I DO NOT HAVE any accident and/or health benefits available to me through my own policy or that of a household member.

_____ _____

DATE PATIENT NAME

If you have medical insurance please complete Section (2)

SECTION TWO: BENEFITS INFORMATION

Your name_____

Health Insurance Company_____

Policy Number_____

Policyholder (if not your policy)_____

Date_____ Signature_____

SECTION THREE: ADDITIONAL BENEFTTS INFORMATION

Health Insurance Company_____ Policy Number_____

Name of Policyholder_____ Relationship_____

Date_____ Signature_____

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct any physician, surgeon or health organization who has examined or treated me at any facility or hospital to give to Health & Sports Rehab, Inc. and its associated medical and physical therapy staff any and all information including psychiatric, drug, HIV information, lab results, radiological results or information acquired in the course of such treatment or examination.

NOTE: A photocopy of this information is as valid as an original.

Patient's signature:_____ Date: __/__/___

Printed name of requesting person or patient: _____

Parent's or guardian's signature (if minor): _____

Health & Sports Rehab, Inc.

438A Blue Hill Avenue
Dorchester, MA 02121
(Corner of Warren Street)
Phone: (617) 541-8825
Fax: (617) 541-8815

Acknowledgement of Receipts of Notice of Privacy Practice

919 Washington Street
Dorchester, MA 02124
(Corner of Gallavan Blvd.)
Phone: (617) 265-5000
Fax: (617) 282-9686

With my signature below, I acknowledge receipt of Health & Sports Rehab, Inc. Notices of Privacy Practices.

_____
Name

_____
Signature

_____
If personal representative, please provide patient's name and

_____
Relationship to patient (e.g. guardian, parent of child under 18)

_____
Date

NOTICE OF PRIVACY PRACTICE

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 and Accountability Act of 1996 ("HIPPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically , on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPAA") provides penalties for covered entities that misuse personal health information.

As required by "HIPPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:
treatment, payment, and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example would include a physical examination or pertinent ancillary test results.
- **Payment** means such activities 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 visits to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvements activities, auditing functions, cost-management analysis, and customer service. An example would be a quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about other benefits or services that may be of interest to you. We may leave messages at your home with a family member, personal representative, or on your answering machine regarding appointment dates or instruction for care.

We may discuss medications, pre and post operative treatment, and instructions for care, with at family member or personal representative.

We may share your protected health information with a representative of an implant manufacturer or distributor.

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 that we have already taken actions relying on our authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree with a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to request amendments to your protected health information.
- The right to receive an accounting of disclosures of protected health information upon request.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the righ to change the terms of our notice of privacy practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our privacy officer, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office We will not retaliate against you for filing a complaint.

For information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 Toll Free (877)696-6775