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Notice of Patient Information Practices

This notice describes how medical and personal information about you may be used or disclosed and how you can obtain access to this information. Please review this form carefully.

OUR LEGAL DUTY
Mullaney & Associates, LLC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION
Mullaney & Associates, LLC uses personal health information primarily for treatment, obtaining payment for treatment, conducting administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing, tracking, and research studies. In any other situation, Mullaney & Associates, LLC will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease further disclosures at any time. If and when any changes are made in our privacy and confidentiality polices, a new Notice of Information Practices will be provided to you. You may request a copy of our Notice of Information Practices at any time. Our HIPPA Compliance Officer is Christine Mullaney. She can be reached at 732-970-4974.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes. You may request in writing that we not disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Mullaney & Associates, LLC will consider requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS
If you are concerned that Mullaney & Associates, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPPA Compliance Officer, Christine Mullaney, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Mullaney & Associates Physical Therapy, LLC
Christine Mullaney, DPT & Michael Mullaney, DPT
127 Main St Suite E
Matawan, NJ 07747
732-970-4974

If this is a sporting related injury, can we speak to your coach regarding this injury and plan of care? **Y / N**

Acknowledgement of Receipt of Practice's Notice of HIPAA Privacy:
I have received the Notice of Patient Information Practices for Mullaney & Associates Physical Therapy, LLC.

_____	_____	_____	_____
Patient Name	Date	Patient/Guardian Signature	Date

Christine M. Mullaney, DPT Michael J. Mullaney, DPT
127 Main St. Suite E Phone: 732-970-4974
Matawan, NJ 07747 Fax: 732-970-4088
E-mail: mullaneyassociates@gmail.com

Print Name: _____ **Date:** _____

Height: _____ **ft** _____ **in** **Weight:** _____ **lbs**

Are you presently working? ☐ Yes ☐ No **Date of next physician's visit:** _____/____/_____ **Date of injury/ onset:** ____/____/____ **Have you ever had these symptoms before?** ☐ Yes ☐ No

Check which apply to your symptoms?

☐ **Work related injury** ☐ **Recurrence of previous injury**
☐ **Motor vehicle accident** ☐ **Injury related to lifting** ☐ **Injury related to falling**
☐ **Cause unknown** ☐ **Athletic / recreational injury** ☐ **Other:**_____

Have you had a related surgery? ☐ Yes ☐ No **Date of surgery?** _____

Do you have, or have you had any of the following?

	YES	NO		YES	NO
Diabetes	☐	☐	**Allergies to Aspirin**	☐	☐
Chest Pain / Angina	☐	☐	**Allergies to heat**	☐	☐
High Blood Pressure	☐	☐	**Allergies / Poor tolerance to Cold** ☐		☐
Heart Disease	☐	☐	**Other Allergies**	☐	☐
Heart Attack	☐	☐	**Hernia**	☐	☐
Heart Palpitations	☐	☐	**Seizures**	☐	☐
Pacemaker	☐	☐	**Metal Implants**	☐	☐
Headaches	☐	☐	**Dizziness / Fainting**	☐	☐
Kidney Problems	☐	☐	**Recent Fractures**	☐	☐
Are you Pregnant?	☐	☐	**Surgeries**	☐	☐
Cancer	☐	☐	**Skin Abnormalities**	☐	☐
Osteoporosis	☐	☐	**Sexual Dysfunction**	☐	☐
Bowel / Bladder Abnormalities	☐	☐	**Nausea / Vomiting**	☐	☐
Urine Leakage	☐	☐	**Ringing in your ears**	☐	☐
Asthma / Breathing Difficulties	☐	☐	**Rheumatoid Arthritis**	☐	☐
Liver / Gallbladder Problems	☐	☐	**Special Diet Guidelines**	☐	☐
Smoking	☐	☐	**Hypoglycemia**	☐	☐
Stroke / CVA	☐	☐	**Other:** _____		
Vision:					
Do you wear glasses/contacts? ☐		☐	Other Visual Disturbances?	☐	☐
Glaucoma?	☐	☐	Explain: _____		
Macular Degeneration?	☐	☐			

If yes on any of the above please briefly explain and give approximated date:_____
_____

Is there any other information regarding your past medical history that we should know about?_____
_____

Are you presently taking Medications? If yes please list what medication and for what condition?
_____
_____

Payment Policy Form

I. _____ **Primary Insurance/Secondary Insurance:** We will bill your primary insurance as a courtesy to you. We assume payment of insurance benefits **is not forthcoming on charges older than 60 days. Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved.** Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your benefits. While we take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. **Please become familiar with your benefit plan before beginning treatment.**

II. _____ **Medicare:** We will bill Medicare for you. In most cases, Medicare will pay 80% of the allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

III. _____**Self Pay**: Please pay the balance in full at the time of service or upon the receipt of monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Mullaney & Associates, LLC is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection.

IV. _____**Workers' Comp:** We will bill your workers' comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

V. _____ **Other:**_____
_____

VI. _____**Cancellation Policy:** To maintain appointment times available for all of our patients, there is a charge of $65.00, billed to the patient, for each instance a patient does not show for a scheduled appointment or does not give a 24-hour cancellation notice

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to Mullaney &Associates, LLC. In the event they file insurance on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and there is a default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. Interest may be charged at a rate of %1.5 per month (%12 annually) for unpaid balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payments of said benefits. A copy of this assignment will be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized staff at Mullaney &Associates, LLC as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

_____ _____

Authorized Signature **Date**

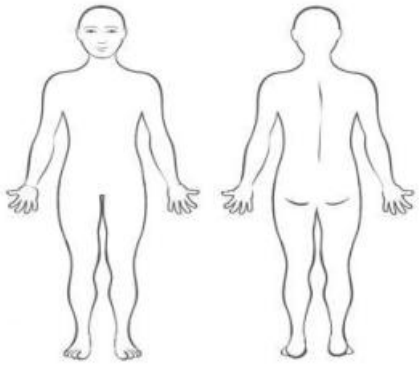
Christine M. Mullaney, DPT **Michael J. Mullaney, DPT**
127 Main St. Suite E Phone: 732-970-4974
Matawan, NJ 07747 Fax: 732-970-4088
E-mail: mullaneyassociates@gmail.com

Please fill out the form below so we can better understand your symptoms.

When did your symptoms begin?_____

What are your symptoms? Please circle any that apply. Pain Numbness Tingling Other_____

Where do you feel your symptoms?



If you have pain, what type is it? Please circle any that apply. Dull Ache Sharp Throbbing Shooting

Burning?

On a scale of 0---10, what is worst your pain gets?_____
How is your pain at its best?_____
How is your pain today?_____

What activities, positions etc make your pain better?_____

What activities, positions etc make your pain worse?_____

If applicable, How long can you sit before your pain increases?_____

If applicable, How long can you stand before your pain increases?_____

If applicable, How long can you walk/run before your pain increases?_____

Have you undergone any diagnostic tests related to your symptoms (x---ray, mri, emg)?_____

Are you currently working?_____,if so what do your job duties include(sitting, standing,

lifting?)_____

Do you have difficulty with any of the following (circle all that apply) :

Sleeping Stairs transferring sit---stand lifting, carrying, pushing

Sports Activity Other_____

Authorization For Communication

Name _____

Check off list of all allowable methods of contact:

___Home phone _(____)_____-_____

___Cell phone __(____)_____-_____

___Work phone _(____)_____-_____

___Mail to home address

Can personal health information be left on your voice mail ? ____yes ____ no

comments_____

Can personal health information be left with a family member or significant other ?

____yes ____no

If yes please fill in information below:

Name _____

Telephone _(____)_____

Patient's signature date