Date:_____ Name:_____ Age:_____

Past Medical History (Include present & past conditions ie diabetes, high blood pressure, etc):_____

_____

_____

_____

Medications:_____

_____

_____

REVIEW OF SYMPTOMS

Constitutional Symptoms:

Good General Health.....No Yes
Recent weight change.....No Yes
Fever.....No Yes
Fatigue.....No Yes

Allergic/Immunologic:

Any allergies to medications.....No Yes
Specify_____
Any food allergies.....No Yes
Specify_____

Musculoskeletal:

Joint pain.....No Yes
Joint stiffness.....No Yes
Joint swelling.....No Yes
Back pain.....No Yes
Muscle pain.....No Yes

Neurologic:

Frequent headaches.....No Yes
Lightheaded or dizzy.....No Yes
Numbness or tingling sensations..No Yes

Psychiatric:

Confusion.....No Yes
Nervousness.....No Yes
Depression.....No Yes
Insomnia.....No Yes
Memory.....No Yes

Genitourinary:

Incontinence.....No Yes
Frequent Urination.....No Yes
Urgent urination.....No Yes

Gastrointestinal:

Loss of appetite.....No Yes
Constipation.....No Yes
Frequent diarrhea.....No Yes
Ulcer Disease.....No Yes

Endocrine:

Diabetes.....No Yes
Thyroid Disease.....No Yes

Cardiovascular:

Heart disease.....No Yes
High blood pressure....No Yes

Respiratory:

Shortness of breath....No Yes
Frequent cough.....No Yes

Vascular:

Peripheral vascular disease..No Yes
Vericose veins.....No Yes

Social/Vocational:

Marital Status: Single_____Married_____Separated_____Divorced_____Widowed_____
Alcohol Use: Never_____Rarely_____Moderately_____Daily_____
Tobacco Use: Never_____Rarely_____Moderately_____Daily_____Current packs/day_____
Occupation:_____

Family History	Age	Diseases	If deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____

REHABILITATION CONSULTANTS

698 West Avenue
Norwalk, CT 06850
TEL (203) 523-0100
FAX (203) 523-0480

PATIENT NAME_____BIRTHDATE_____

I ACKNOWLEDGE THAT IF, FOR SOME REASON, MY INSURANCE COMPANY DOES NOT PAY FOR MY VISITS/TREATMENTS, OR IF MY VISITS/TREATMENTS ARE NOT COVERED BY MY INSURANCE, THEN I AM RESPONSIBLE FOR FULL PAYMENT OF THE CHARGES. IF I DO NOT PAY THE CHARGES IN A TIMELY FASHION AND IF I AM SENT TO COLLECTIONS THEN I ACKNOWLEDGE THAT A 12% FEE WILL BE ADDED TO COVER THE COLLECTION COMPANY'S FEE. THIS IS TRUE EVEN IF I DO NOT HAVE INSURANCE BUT HAVE RECEIVED SERVICES BY THE PRACTITIONERS AT REHABILITATION CONSULTANTS (RCPC).

SIGNATURE_____DATE_____

I ACKNOWLEDGE THAT IF I HAVE A BALANCE I MAY BE ASKED TO PAY IT IN FULL BEFORE I AM ABLE TO MAKE AN APPOINTMENT FOR VISIT/SERVICES AT RCPC.

SIGNATURE_____DATE_____

I ACKNOWLEDGE THAT MY CO-PAY IS EXPECTED AT THE TIME OF MY APPOINTMENT AND THAT IF I FAIL TO DO SO I MAY BE CHARGED AN ADDITIONAL $15.00 BILLING FEE.

SIGNATURE _____DATE_____

I UNDERSTAND THAT I NEED TO INFORM RCPC AT LEAST 24 HOURS BEFORE I CANCEL MY APPOINTMENT AND THAT IF I DO NOT DO SO I MAY BE CHARGED A $50.00 FEE GIVEN THE "MISSED" VISIT FOR AN ESTABLISHED PATIENT AND A $100.00 FEE FOR A NEW PATIENT.

SIGNATURE_____DATE_____

I UNDERSTAND THAT IF I DO NOT SHOW FOR MY APPOINTMENT AT RCPC WITHOUT A CALL TO CANCEL APPOINTMENT I MAY BE CHARGED A $75.00 FEE GIVEN THE "NO SHOW" VISIT FOR ESTABLISHED PATIENTS AND A $150.00 FEE FOR A NEW PATIENT.

SIGNATURE_____DATE_____

I UNDERSTAND THAT IF I AM LATE FOR MY APPOINTMENT AT RCPC AND THERE IS NOT ENOUGH TIME FOR MY DOCTOR TO SEE ME I MAY BE CHARGED A LATE FEE OF $25.00 FOR AN ESTABLISHED PATIENT AND A $50.00 FEE FOR A NEW PATIENT.

SIGNATURE_____DATE_____

I GIVE MY PERMISSION TO RCPC TO RELEASE MEDICAL INFORMATION TO MY OTHER DOCTORS AND FACILITIES WHEN DEEMED NECESSARY AND TO MY INSURANCES IF REQUESTED IN ORDER FOR MEDICAL CLAIMS TO BE PROCESSED.

SIGNATURE_____DATE_____

I ACKNOWLEDGE THAT ALL RX REFILLS REQUIRE A 24 HOUR NOTICE DURING BUSINESS HOURS. PRESCRIPTIONS WILL ONLY BE FILLED *FROM MONDAY THROUGH THURSDAY* DURING BUSINESS HOURS. PLEASE DO NOT WALK-IN REQUESTING PRESCRIPTIONS.

SIGNATURE_____DATE_____

698 West Avenue
Norwalk, CT 06850
(203) 523-0100

Rehabilitation Consultants, PC

Claudio R. Petrillo, MD Silvia Knoploch, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby certify that I have received, read, and understand the Notice of Privacy Practices for Rehabilitation Consultants, PC. I also acknowledge that Rehabilitation Consultants, PC reserves the right to revise the notice and that any future changes or revisions will apply to all protected health information contained in my medical records and billing records for Rehabilitation Consultants, PC.

Appointment reminders

May we contact you via phone or mail to provide appointment reminders? Yes ☐ No ☐

. ay we leave messages regarding appointments either on voice mail, an answering machine or with the individual who answers the phone?

Yes ☐ No ☐

Patient Name: _____
Print Name

Patient / Representative: _____
Signature

Relationship Patient: _____

Date: _____

Office Use Only
I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:
Date:
Reason:
Signature:

698 West Avenue
Norwalk, CT 06850
(203) 523-0100

Notice of Privacy Practices
Rehabilitation Consultants, PC

Claudio R. Petrillo, MD Silvia Knoploch, MD

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our Responsibilities

Rehabilitation Consultants, PC are committed to:

- Maintaining the privacy of your health information
- Providing you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abiding by the terms of this notice
- Notifying you if we are unable to agree to a requested restriction
- Accommodating reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We will not use or disclose your health information without your authorization, except as described in this notice.

We reserve the right to change the content of our Notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice via US mail, electronic mail, fax or you may pick up a copy at Rehabilitation Consultants, PC.

Examples of Disclosures for Treatment, Payment and Health Operations

Rehabilitation Consultants, PC will use your health information for treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we will disclose protected health information to other physicians who may be treating you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Rehabilitation Consultants, PC will use your health information for payment. Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Rehabilitation Consultants, PC will use your health information for regular health care operations. We may use or disclose, as-needed, your protected health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. In addition, we may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Uses & Disclosures of Health Information Requiring Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke an authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use of disclosure indicated in the authorization.

Uses & Disclosures for Which Authorization is Not Required

We may use or disclose your protected health information in the following situations without your consent or authorization:

- Public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- A health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- A public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.
- To a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
- In the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- As authorized to comply with workers' compensation laws and other similar legally-established programs.
- All other uses or disclosures as permitted or required by law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Inspect and copy your protected health information.
- Request a restriction of your protected health information.
- Request to receive confidential communications from us by alternative means or at an alternative location.
- Have your protected health information corrected or amended.
- Receive an accounting of certain disclosures we have made, if any, of your protected health information.
- Obtain a paper copy of this notice from us

Questions Regarding Privacy Practices & Reporting Privacy Violations

If you have any questions about this notice and its content, or if you believe your privacy rights have been violated, you can file a complaint with our office or with the Secretary of Health & Human Services. There will be no retaliation for filing a complaint.

Rehabilitation Consultants, PC
Silvia Knoploch, MD
698 West Avenue
Norwalk, CT 06850
Phone: (203) 523-0100

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Revised Effective: February 1, 2005

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