GAYLE S. SCHWARTZ, MD & ASSOCIATES
PHYSICAL MEDICINE & REHABILITATION
ELECTRODIAGNOSTIC TESTING

Fall-Risk Assessment

Name:______________________________ Birth date: ______________

Please answer to the best of your ability:

How many falls have you had in the past year? ______________________________

Of those falls how many resulted in an injury? ______________________________

When was the last time you had your vision examined? (date) ____________________

When was your last visit to your primary care provider? (date) ____________________

Cardiologist? __________________ Neurologist? __________________

Other?______________________

In regards to bladder control, are you (circle one):

Continent Incontinent Nighttime Incontinent

Do you live alone (yes or no)? _____________________

Do you live in a house (yes or no)? __________________

If so, is it ☐ 1 story ☐ 2 story ☐ split level ☐ Other__________

Do you live in an apartment or condominium (yes or no)? ______________________

If so, is it elevator accessible (yes or no)? ____________________________

What floor/level do you live on? ________________________________

Please tell us the number of steps you must go up to enter your home from the outside.____

Are there handrails on ALL of the stairs, indoors and outside (yes or no)? ______________

If so, are there rails on both sides of the stairs (yes or no)? _________________

Do you wear an emergency alert device (yes or no)? __________________________

Signature: ______________________________ Date:__________________

1920 GREENSPRING DR·SUITE 125·TIMONIUM, MD 21093·T: 410-308-4900·F: 410-308-4960
700 CORPORATE CENTER CT·SUITE D·WESTMINSTER, MD 21157·T: 410-871-4455·F: 410-308-4960

NAME ______________________________ DATE __________

ADDRESS ______________________ CITY __________ STATE ____ ZIP ______

TELEPHONE: HOME ______________ CELL ______________ WORK ______________

DATE OF BIRTH __________ AGE ____ GENDER: M or F HANDEDNESS: R, L, or AMBIDEXTRIOUS

MARITAL STATUS (circle one): DIVORCED/ MARRIED/PARTNERED/SEPARATED/ SINGLE/ WIDOWED

EMAIL: ____________________ WOULD YOU LIKE ACCESS TO PATIENT HEALTH PORTAL? Y or N

OCCUPATION __________ RACE __________ ETHNICITY __________ LANGUAGE __________

PRIMARY CARE DOCTOR ____________________ T: ______________ F: ______________

DO YOU HAVE AN ADVANCE CARE PLAN OR SOMEONE LEGALLY AUTHORIZED TO MAKE HEALTH CARE DECISIONS FOR YOU? Y or N (Please provide documentation if possible)

EMERGENCY CONTACT: ____________________ TELEPHONE: ______________

IS YOUR VISIT RELATED TO AN *AUTO ACCIDENT*? Y or N; IF YES WHAT IS THE DATE OF INJURY? ________

WORK INJURY? Y or N; IF YES, WHAT IS THE DATE OF INJURY? ____________

IF NO, WHO SHOULD WE BILL FOR TODAY'S VISIT? (PLEASE LIST ALL INSURANCE COMPANIES IN ORDER OF WHETHER THEY ARE PRIMARY OR SECONDARY, ETC) ____________________

REASON FOR VISIT ______________________________

IF COMPLAINT IS PAIN:

PAIN RATING: INDICATE YOUR CURRENT LEVEL OF PAIN BY MARKING AN "X" ON THE SCALE BELOW

0 1 2 3 4 5 6 7 8 9 10

NO PAIN SEVERE PAIN

WHAT IS THE LOCATION OF YOUR PAIN? ______________________________

WAS THERE AN EVENT THAT CAUSED THIS? GIVE DATE AND DESCRIBE ____________________

DESCRIBE THE CHARACTER OF YOUR PAIN (WHAT DOES IT FEEL LIKE?) ____________________

DOES THE PAIN MOVE OR RADIATE ANYWHERE? ______________________________

WHAT MAKES YOUR PAIN WORSE? ______________________________

WHAT MAKES YOUR PAIN BETTER? ______________________________

DO YOU HAVE ANY NUMBNESS, TINGLING, OR WEAKNESS? ____________________

HAVE YOU HAD ANY CHANGES IN YOUR BOWEL, BLADDER, OR SEXUAL FUNCTION? ______________

HAVE YOU HAD ANY RECENT CHANGE IN: •WEIGHT ☐ •FEVER ☐ •CHILLS ☐ •UNUSUAL RASH ☐

HOW LONG CAN YOU: SIT __________ STAND __________ WALK __________

IMAGING/TESTING:

X-RAYS:	DATE:	FACILITY:
CT SCAN:	DATE:	FACILITY:
MRI:	DATE:	FACILITY:
EMG/NCS:	DATE:	FACILITY:

HAVE YOU EVER SMOKED? Y or N   WHAT WAS YOUR QUIT DATE? _____ HOW MUCH DO YOU CURRENTLY SMOKE? _____

DO YOU CONSUME ALCOHOLIC BEVERAGES? Y or N   HOW OFTEN & IN WHAT QUANTITY? ________________________

MEDICAL PROBLEMS:

STOMACH ULCERS	Y or N	LUNG DISEASE	Y or N
GERD	Y or N	THYROID DISEASE	Y or N
KIDNEY DISEASE	Y or N	CANCER	Y or N
LIVER DISEASE	Y or N	NEUROLOGIC DISORDER	Y or N
DIABETES	Y or N	OSTEOPENIA/OSTEOPOROSIS	Y or N
CARDIAC DISEASE	Y or N	HEPATITIS	Y or N
HIGH BLOOD PRESSURE	Y or N	HIV POSITIVE	Y or N

<u>DATE OF LAST:</u> FLU SHOT ____________________   PNEUMONIA VACCINE __________________

<u>PRIOR SURGERIES:</u>

PROCEDURE: ____ DATE: ________________

PROCEDURE: ____ DATE: ________________

PROCEDURE: ____ DATE: ________________

<u>ALLERGIES</u> (INCLUDING DRUGS AND LATEX): ____

<u>CURRENT MEDICATIONS and DOSAGE</u> (PRESCRIPTION, SUPPLEMENTS, OVER-THE-COUNTER, AND HERBAL REMEDIES):____

____

____

____

____

FAMILY HISTORY:

FATHER	ALIVE	AGE AT DEATH	MEDICAL PROBLEMS:
MOTHER	ALIVE	AGE AT DEATH	MEDICAL PROBLEMS:
BROTHER(S)	# TOTAL:	# DECEASED	MEDICAL PROBLEMS:
SISTER(S)	# TOTAL:	# DECEASED	MEDICAL PROBLEMS:
SON(S)	# TOTAL:	#DECEASED	MEDICAL PROBLEMS:
DAUGHTER(S)	# TOTAL:	#DECEASED	MEDICAL PROBLEMS:
OTHER	# TOTAL:	#DECEASED	MEDICAL PROBLEMS:

PERMISSION GIVEN FOR YOUR DOCTOR TO CONNECT WITH YOUR PHARMACY ELECTRONICALLY? Y or N

PHARMACY NAME________________________________PH.____________________ FAX _________________

PHARM. ADDRESS____

DO YOU WISH TO HAVE A CHAPERONE IN THE ROOM DURING THE EXAMINATION? Y or N

PLEASE LIST ANY DOCTORS YOU WOULD LIKE US TO SEND YOUR NOTES TO (PLEASE INCLUDE SPECIALTY)

____

<u>CONSENT TO EVALUATE/TREAT</u>

I, ________________________________, GIVE MY CONSENT TO ALLOW GAYLE S. SCHWARTZ, M.D. TO EVALUATE AND, IF APPROPRIATE, TREAT ME.

I AUTHORIZE GAYLE S. SCHWARTZ, M.D. AND/OR HER STAFF TO RELEASE ANY RECORDS PERTAINING TO MY MEDICAL CONDITION TO MY INSURANCE COMPANY AND/OR MY ATTORNEY.

____ ____________________________

PATIENT'S SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At this office, we have always kept your health information secure and confidential. This office now uses Electronic Health Records (EHR) and a new law requires us to inform you about how we continue maintaining your privacy with Electronic Protected Health Information (E-PHI), and that we give you this notice and to follow the terms of this notice.

The initial HIPAA law permits us to use or disclose your health information to those involved in your treatment for example, a review of your file by a specialist doctor whom we may involve in your care.

- We may use or disclose your health information for payment of your services. For example we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer.
- We may use your information to contact you either by phone or by email to remind you of an upcoming appointment. If you are not home, we may leave a message on an answering machine or with a person who may answer the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some of all of your health care information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- We may share information that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges (HIEs) in which we participate. For example, information about your past medical care and current medical conditions and medications can be available to us or to your primary care physician or hospital, if they participate in the HIE as well. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. The Chesapeake Regional Information System for Our Patients, Inc. (CRISP), is a regional internet-based HIE in which we participate. We may share information about you through CRISP for treatment, payment, health care operations, or research purposes. You may opt out of CRISP and disable access to your health information available through CRISP by contacting CRISP at 1-877-952-7477 or completing and submitting an Opt-Out form (available in our office) to CRISP by mail, fax, or through their website at crisphealth.org. Even if you opt-out of CRISP, public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers through CRISP as permitted by law. Your hospital or health care provider may also participate in other HIEs, including HIEs that allow your provider to share your information directly through our electronic medical record system. You may choose to opt-out of these other HIEs by calling 1-855-389-6928.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we will not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or phone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you. We may charge you a reasonable fee for this service.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but we will add new information.

The new Omnibus Final Rule requires us to make additional statements in this Notice of Privacy Practices due to the fact that we now use EHR technology in this office.

- If for any reason there is a breach of E-PHI, the individuals involved will be notified in writing by this office. If the breach involves up to 500 patients then we will publicly post the names of those responsible on the Health and Human Services website. If the breach involves more than 500 patients we will again post the names of those responsible on the Health and Human Services website but also notify local media as well.
- We will not sell your E-PHI.
- Patients at our practice should not be contacted with fundraising materials. If you are contacted by anyone claiming to be from this office for fundraising purposes please notify our office immediately. Phone calls regarding your personal account billing statements do not constitute fundraising calls.
- Patients now have a right to restrict certain disclosures of E-PHI to a health plan. This only applies where the individual pays out of pocket in full for health care services. You must sign a disclosure if you wish to restrict your records to your health plan.
- You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of this change in writing.

You may file a complaint to the Department of Health and Human Service, Independence Ave, S.W., Room 509f, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information, please contact our Privacy Officer, at (410) 308-4900.

This notice goes into effect as of September 1, 2013.

ACKNOWLEDGEMENT

I have received a copy of Gayle S. Schwartz, M.D. & Associates' Notice of Privacy Practices.

DATE: ____________ **Signature:** ______________________________ **Print Name:** ________________________

If signing as a parent or guardian, please note the name of the patient______________________________

GAYLE S. SCHWARTZ, M.D. & ASSOCIATES

PHYSICAL MEDICINE & REHABILITATION
ELECTRODIAGNOSTIC TESTING

OFFICE POLICIES

At Gayle S. Schwartz, M.D. & Associates, we value you and your time. In order to provide prompt, efficient service to all of our patients, we must enforce the following policies:

OFFICE HOURS

Our normal business hours are Monday through Friday 8:00am – 4:30pm. Our hours for scheduling appointments are Monday through Friday 8am – 4pm.

APPOINTMENTS

We see patients by appointment only. We make every effort to get you into our office on a timely basis. If you must cancel an appointment, please call twenty-four (24) hours in advance, during normal business hours, in order to make this time available to other patients. A $25.00 fee will be charged for missed appointments and appointments not cancelled within the twenty-four (24) hour time frame. We make every effort to see our patients at their scheduled time. Please arrive at your scheduled time. In order to avoid inconveniencing other patients, if you are more than fifteen (15) minutes late for your appointment, it may have to be rescheduled and a $25.00 missed appointment fee will be charged. We call to confirm our patient's appointments 2 business days prior to their scheduled appointment to confirm. We do REQUIRE that if we have to leave you a message that you return our call and let us know that you are still planning on coming. If we do not hear from you, we will cancel your appointment and will tell you so in our message. It is imperative that you call us back!

PAYMENT

Payment (including co-payments, deductibles, and self-pay patients) is due at the time of service. A $30.00 fee will be charged for all returned checks. If your co-payment (if one is due) is not received at the time of service, a $10.00 processing fee will be applied to your bill. If your account remains past due over sixty (60) days then a 1.5% interest will be applied on a monthly basis, which will be 18% interest annually. If your account is turned over to collections, an additional fee of $50.00 will be added to your account.

TELEPHONE CALLS

Due to the number of telephone calls that the doctors receive on a daily basis we will be charging a fee to you for the calls you request from Dr. Schwartz to personally answer. Calls to the office staff are at no charge. Your insurance is not responsible for these fees, you will be billed directly, and the payment is due within thirty (30) days. The cost of each telephone call can vary. The fees will range from $10.00 to $50.00 depending on the complexity of the call. **If you are experiencing a medical emergency, please do not hesitate to call us. Dr. Schwartz is always available for medical emergencies.**

OTHER FEES

There will be a fee for filling out forms or writing a letter on behalf of the patient that will be billed to you directly. Payment is due before release of forms or letter. The fee will be from $10.00 to $50.00 depending on the complexity of the form and/or letter.

The cost of medical records copies is $0.76 cents per page plus the cost of postage if mailed. This includes the doctors' office note for your visit and/or reports you are requesting. This will also include copying any prescriptions that were given to you at your time of service, if you have lost or misplaced them. This includes all prescriptions for medication, radiology and/or physical therapy prescriptions.

Thank you in advance for helping us to keep this office running efficiently. Any questions please contact the office staff.

Signature: ______________________________ **Date:** ______________

If signing as a parent or guardian, please note the name of the patient______________________________

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