IREDELL OCCUPATIONAL MEDICINE

TODAY'S DATE: _____

NAME: _____

DATE OF BIRTH: _____

SS # _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

HOME PHONE: _____

CELL PHONE: _____

EMPLOYER: _____

EMPLOYER CONTACT:_____

YOUR OCCUPATION: _____

JOB DURATION: _____

DEPARTMENT: _____

EMERGENCY CONTACT:

NAME: _____

RELATIONSHIP: _____

PHONE: _____

REASON FOR VISIT:

- o POST OFFER (PRE EMPLOYMENT) EXAM
- o INJURY / LACERATION
- o DOT EXAM
- o LHI (MILITARY) EVALUATION
- o RECHECK VISIT
- o FIT FOR DUTY EXAMINATION
- o RESPIRATORY QUESTIONNAIRE
- o PULMONARY FUNCTIONS / SPIROMETRY
- o DRUG SCREEN
- o BREATH ALCOHOL TESTING
- o HEARING TESTING / AUDIOMETRY
- o IMMUNIZATIONS
- o OTHER: _____

DRUG SCREEN:	**O NO**	**O YES**	**O DONE**
BAT:	**O NO**	**O YES**	**O DONE**

WORKERS COMPENSATION INJURY INFORMATION

DATE OF INJURY:_____

TIME OF INJURY: _____ AM / PM

PLACE OF INJURY: _____

INJURY REPORTED TO EMPLOYER? YES / NO

REPORTED TO WHOM? _____

HOW DID THE INJURY HAPPEN? (MECHANISM)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SEEN ELSEWHERE FOR THIS INJURY? YES / NO

IF SEEN, WHERE? _____

HAVE YOU HAD IMAGING FOR THIS INJURY, SUCH AS X-RAYS OR CT SCAN? YES / NO

PRIOR WORKER COMPENSATION INJURIES:

1. _____
2. _____
3. _____

PATIENT SIGNATURE: _____ DATE: _____

IREDELL OCCUPATIONAL MEDICINE

NAME:_____ DOB:_____

INJURY HISTORY:

o NEW INJURY

o FOLLOW UP VISIT

CURRENT INJURY / PAIN SITES:

1. _____

2. _____

3. _____

QUALITY OF PAIN:

o SHARP
o SHOOTING
o DULL
o ACHING
o THROBBING
o TINGLING
o BURNING
o CRAMPING
o NUMBNESS
o OTHER_____

SCALE: 1 2 3 4 5 6 7 8 9 10/10

PROGRESSION:

o WORSENING SINCE INJURY
o UNCHANGED
o IMPROVING
o RESOLVED

PAIN PROVOKED BY: _____

_____

PAIN IS EASED BY:_____

_____

PAIN IS: CONSTANT INTERMITTENT

PAIN RADIATING? YES NO

ASSOCIATED SYMPTOMS: YES NO

EXPLAIN: _____

_____

TODAY'S DATE: _____

PRIOR MEDICAL HISTORY

ALLERGIES: (MEDS, FOODS, INSECTS, TAPE….)

1. _____
2. _____
3. _____

LAST TETANUS IMMUNIZATION:_____

RELATED / IMPROTANT FAMILY HISTORY: YES NO

1. _____
2. _____

SOCIAL HISTORY:

o SMOKING:_____
o ILLICIT DRUG USE:_____
o ALCOHOL USE:_____

MEDICATIONS LIST: (DOSING AND FREQUENCY)

1. _____
2. _____
3. _____
4. _____

PAST SURGERIES / DATES

1. _____
2. _____
3. _____

OTHER PAST MEDICAL HISTORY:

1. _____
2. _____
3. _____

FDLMP (WOMEN) _____ NORMAL? YES NO

PATIENT SIGNATURE:_____DATE:_____

********** VITALS **********

WEIGHT: _____ # TEMP: _____ F

HEIGHT: _____INCHES RESP: _____ / MIN

BP: _____ _____ PULSE OX: _____% (R/A)

PULSE: _____ / MIN

IREDELL OCCUPATIONAL MEDICINE

NAME: _____

DATE OF BIRTH: _____

DATE OF INJURY:_____

OCCUPATION:_____

DATES OF REVIEW:

- _____
- _____
- _____
- _____
- _____

REVIEW OF SYSTEMS:

FOR THE FOLLOWING REVIEW, PLACE A MARK ON ANY HEALTH ISSUES THAT ARE RECENT CONCERNS IN THE PAST MONTH, EXCEPT FOR TODAY'S CONCERNS.

GENERAL:

- APPETITE LOSS
- CHILLS
- FEVERS
- NIGHT SWEATS
- SHAKINESS
- SIGNIFICANT WEIGHT CHANGE/LOSS

SKIN:

- BRUISING
- COLD SKIN
- DRY SKIN
- HAIR LOSS
- LUMPS
- PSORIASIS
- RASH
- ULCERS

HEENT:

- BLURRED VISION
- DOUBLE VISION
- EYE PAIN
- VISUAL LOSS
- EAR PAIN
- HEARING LOSS
- HEADACHE
- HORSENESS
- NOSE BLEED
- RINGING IN EARS
- SINUS PAIN
- SLEEP APNEA

CARDIOVASCULAR:

- CHEST PAIN
- HYPERTENSION
- IRREGULAR HEART BEAT
- RAPID HEART BEAT
- PALPITATIONS
- SHORTNESS OF BREATH

PROVIDER NOTES:

_____
_____
_____
_____
_____
_____
_____
_____

RESPIRATORY:

- CHRONIC COUGH
- COUGH WITH PRODUCTIVE SPUTUM
- BLOODY COUGH
- DIFFICULTY BREATHING
- SNORING

GASTROINTESTINAL:

- ABDOMINAL PAIN
- BLOODY STOOLS
- DIFFICULTY SWALLOWING
- HEARTBURN/REFLUX
- NAUSEA
- VOMITTING

NEURAL:

- DIZZINESS
- NUMBNESS
- HEADACHES
- SEIZURES
- TREMOR

PSYCHE:

- ANXIETY
- DEPRESSION
- HOMICIDAL THOUGHTS OR PLAN
- INSOMNIA
- NERVOUSNESS
- SLEEP DISORDER
- SUICIDAL THOUGHTS OR PLAN

ENDOCRINE:

- HEAT INTOLERANCE
- COLD INTOLERANCE
- THYROID PROBLEMS

HEMATOLOGY:

- ANEMIA
- BLOOD CLOTS
- EASY BLEEDING
- EASY BRUISING
- ENLARGED LYMPH NODES
- PAINFUL LYMPHNODES

PATIENT SIGNATURE:_____DATE:_____

Iredell Occupational Medicine
128 E. Plaza Dr.
Unit 3
Mooresville, NC 28115
980-444-2630

Welcome to Iredell Occupational Medicine

If your treating physician recommends that you attend therapy at our facility to assist you with your rehabilitation process, we would like to better help you understand the physical therapy process and things you may encounter. We are a multidisciplinary team and are here to assist you as much as we can in your effort to return to the best physical condition you can be.

While here you may work with a number of staff members to include, physical therapists, massage therapists, rehabilitation therapists, athletic trainers, vocational counselors and/or physicians. The person you work with closely depends on who the physician feels is most appropriate for your treatment.

Also while here, we will be working side by side with you to assist you in a number of ways. You may receive modalities (ice/heat/muscle stimulation/ultrasound) as well as therapeutic massage therapy, stretching and aerobic conditioning exercises. Strengthening and conditioning on our treadmill, bike and gym equipment will also be considered.

We will also be working with you to help you identify those work tasks that may concern you or that you think you may have difficulty with. Please be assured that we are familiar with your tasks through either communication with your employer or an actual employment site visit. Once those activities are identified we will ask you to assist us in simulating those activities. This will be simulated with light weights and gradually adding more weight and more frequency. The object of this work simulation is to help you progress back to performing your work tasks and activities as pain free and as safely as possible before you return to your physician and then work.

Each time you return to your physician for a follow-up visit, we will be forwarding your progress notes for review. At that time you will discuss your progress with your physician and further treatment recommendations.

Please, at any time you have questions or concerns, make them known to a staff member and we will do our best to help you resolve them.

Iredell Occupational Medicine

Patient Signature: _____ Date:_____

Occupational Medicine
128 E. Plaza Drive Unit 3
Mooresville, NC 28115-8000
Phone: (980) 444-2630
Fax: (980) 444-2631

1. CONSENT FOR TREATMENT

I voluntarily consent to outpatient care, encompassing diagnostic procedures and medical treatment at the Iredell Physician Network. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of the examination or treatment at the provider's office.

2. RELEASE OF MEDICAL INFORMATION:

I understand that Iredell Physician Network may release my health information to health care providers, health plans, and others for treatment, payment, health care operations and other purposes permitted by law. I also understand that Iredell Physician Network participates in the North Carolina Health Information Exchange ("HIE") called NC HealthConnex. By providing my email address below, I understand that I will receive an email on how to access my health information through Iredell Physician Network's electronic patient portal and that Iredell Physician Network may use my email address for other permissible communications.

3. ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Iredell Physician Network of outpatient benefits otherwise payable to the policyholder including major medical insurance and payment of surgical or medical benefits directly to physicians. I authorize the refund over overpaid insurance benefits, including where policy coverages are subject to coordination of benefits. If an overpayment results from multiple payments on this visit, I authorize Iredell Physician Network to deduct the amount of any other outstanding accounts I am responsible for from this overpayment.

4. FINANCIAL AGREEMENT

The undersigned severally agree, whether signing as a patient or otherwise, that in consideration of the service rendered to the patient, payment of the accounts to Iredell Physician Network and providers is guaranteed by the patient, spouse, parent, legal guardian, etc. with the regular terms of the physician office and physicians. While any insurance or other protection related to outpatient services maybe herby assigned to the payable directly to the Iredell Physician Network, the undersigned clearly understands that the payment obligation for the visit bill and physician is primarily on the patient, spouse, parent, legal guardian, etc. While insurance payments received by the Iredell Physician Network will be applied properly to the patient's account not so paid by insurance is nevertheless owing and payable. The undersigned also understands and agrees that the visit charges incurred where rendered in reliance on this agreement.

5. MEDICARE-MEDICAID CERTIFICATION:

I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct.

Patient Signature: _____ Date:_____

Iredell Physician Network

766 Hartness Road Suite B
Statesville, NC 28677
704-495-3162

NOTICE OF PRIVACY PRACTICES

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

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 01/01/2006, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practice, or for additional copies of the Notice, please contact us using the information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use of disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and discloses your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information the treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use of disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so**.**

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event or your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescription, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution of law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances**.**

Appointment Reminders: We may use of disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of the Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make you request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concern, please contact us.

If you are concerned that we may be violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with a U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.