ADVANCED PHYSICAL THERAPY

Patient Registration

Full Name_____ **Gender** _____**M** _____**F** **Social Security #** _____

Date of Birth _____ **Age**_____ **Current Height** _____ **Current Weight** _____

Home Address _____ **City** _____ **Zip** _____

Home Phone _____**Cell Phone** _____

Email Address _____ **Status:** _____**Single** _____**Married**

Emergency Contact Person _____ **Ph** _____

Primary Insurance, Policy Holder's Name _____ **DOB:** _____

Secondary Insurance:_____ **Policy Holder name & DOB:**_____

Referring MD: _____ **How did you hear about us?** _____

1. What is your occupation? _____ **~Are you working now?** _____ **YES** _____**NO**

2. Is this a Motor Vehicle Accident Claim? _____ **Is this a Worker's Comp. Claim?** _____

3. Approximate date of injury? _____ **Is it getting worse, better, or staying the same?** _____

4. Where is your pain/problem? _____

5. What caused your pain? _____ **Have you ever had this pain before?** _____**YES** _____**NO**

6. Is your pain constant? (never goes away) _____**YES** _____**NO**

7. Are any of your usual daily activities affected? ____**YES** ____**NO**

~If yes, describe how? _____

8. On the scale, <u>circle</u> your worst pain level in the past couple of days: Mild Moderate Severe
1....2…3…4…..5….6….7....8....9….10 _____

9. Are you taking any medication for this pain/problem? ____**YES** ____**NO**

~If yes, what are you taking, and does it help? _____

10. List all medications you are currently taking:_____
_____

11. List all past surgeries with dates: _____

12. List all medical conditions you have (or were told you have)? _____
_____

<u>Consent to Treatment:</u> I consent to rehabilitation and related services at Advanced Physical Therapy. I understand, acknowledge and affirm that such rehabilitation and related service may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____ **initial**

<u>Liability:</u> I know and agree that Advanced Physical Therapy is not responsible for loss or damage to personal valuables. _____ **initial**

Patient/Guardian Signature _____ **Date** _____

Advanced Physical Therapy

Statement of Privacy Notice

Effective June 1, 2003

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner, and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at 480-840-6777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at 480-840-6777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building.
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Advanced Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date

Office Policies

Because we commonly have a waiting list, **we have a $25 charge for missed appointment or for cancellation with less than 24 hours' notice.** Additionally, if you are going to be more than 15 minutes late, please provide us with a courtesy call as this will hold your appointment and you will not incur a charge for missed appointment. Please help us serve you better by keeping your scheduled appointments so we can better serve you in a timely, professional manner.

Signature_____

Financial Agreement

Regarding Insurance:

As a service to you, our billing office will gladly bill your insurance company directly on a bi-weekly basis. Our billing office will also bill supplemental insurance and secondary insurance companies. For us to perform this service for you, please provide us with the necessary information specified below:

- If you are using health insurance, we will need to obtain a copy of your insurance card, as well as the assignment of benefits form filled out (located in new patient paperwork). **Each patient is responsible for meeting their deductible and paying co-insurance/co-payments according to their insurance plan at the time of service.**

- If you have no insurance coverage, or if we are unable to verify medical benefits, we offer a discounted cash option at the discretion of the provider. Payment is due in full at the time of service.

Signature_____

**By signing, you agree that you have read the Financial Agreement and understand your financial responsibly for treatment.

Credit Card on File:

To better serve you, we recommend a credit card to be on file with our office, however this is optional. This card can be used for co-pays and/or co-insurance amounts or can be used as a backup should you forget to bring your method of payment on your treatment date.

Card # _____

Exp Date _____ **CVV**_____

Advanced Physical Therapy

Assignments of Benefits

Effective January 1, 2022

Patient Name:_____ Insurance:_____

☐ **IF YOU DO NOT HAVE INSURANCE AND CHOOSE TO BE SELF-PAY, PLEASE CHECK BOX**

- I understand that services rendered to me by Advanced Physical Therapy are my financial responsibility and that the provider will bill my insurance company (listed above) as a courtesy.

- I authorize my insurance company to pay my benefits directly to Advanced Physical Therapy and I understand that I will be fully responsible for any outstanding balance on my account.

- I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service

- I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company (listed above).

- I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

- I also understand that should my insurance company send payment to me; I will notify and forward the payment to Advanced Physical Therapy within 48 hours.

- I agree that if I fail to send the payment to Advanced Physical Therapy and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

- I understand any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

****I agree that any and all questions pertaining to my benefits and financial responsibility have been addressed by Advanced Physical Therapy.** **_____ Initial**

By signing below, you acknowledge that you have read the Assignment of Benefits and understand responsibility for treatment.

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date