PATIENT REGISTRATION

Today's Date _________________

Area of Injury To Be Treated______________________

Date of Injury _________________ Surgery? ___Y___N If so, date? ___________________

Name ____
First MI Last

Address ____
Street P.O. Box Apt #

____
City State Zip

Home Phone _____-_____-_______ Work Phone______-______-________ Cell Phone______-______-_______

Male ___ Female ___ Marital Status ___M___ S___ D ___W Date of Birth____/____/_____ SSN_____-____-__________

Occupation: ________________________ E-Mail : ____

Physician Information

Primary Care Physician Name ____

Referring Physician Name ____

Have you had physical therapy before? ___ No ___ Yes If yes, when? ____

Is your condition related to an auto accident? ____ Y ____ N

If Auto accident, do you have Med Pay coverage? ____ Y ____ N

Auto Med Pay Information

Claim #_______________________

Insurance Company________________________________ Med Pay Amount________________________

CONSENT TO TREATMENT

I hereby authorize the professional staff at to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

_______________________________________ _______________________________________
Patient/Guardian Signature Date

_______________________________________ _______________________________________
Patient/Guardian Printed Name Staff Witness Signature

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name _______________________________________

Date of Birth _____________________

Are you or could you currently be pregnant? ____ Y ____ N
Were you hurt on the job? _____ Y ____ N

Have you EVER been diagnosed with any of the following conditions?

Condition	*Yes*	*No*	*Condition*	*Yes*	*No*
Cancer			Epilepsy		
Heart Problems			Chemical Dependency		
Pacemaker			Diabetes		
Circulation Disorder			Multiple Sclerosis		
Deep Vein Thrombosis			Head Injury/Concussion		
Stroke			Thyroid Problems		
Rheumatoid Arthritis			Headaches		
Anemia			Depression		
High Blood Pressure			Anxiety		
High Cholesterol			Other:		

Please list all surgeries and the date:

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Please list all current medications:

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

CANCELLATION POLICY

We strive to provide our patients with excellent service and quality care. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment. While we expect you to keep all of your appointments, we recognize there may be a time when you need to cancel. We would appreciate 24-hour notice if you need to cancel so we can fill your appointment time. If you do not give 24 hour notice or no show for an appointment, a $25 fee may be billed to you. If you miss 3 consecutive appointments, we may have to notify your physician and will require a new referral in order to continue your treatment.

____ _________________________________
Patient/Guardian Signature Date

Our staff will provide you with as much information regarding your insurance coverage as possible.
We will contact your insurance company to verify your physical therapy benefits and let you know what your responsibility will be and due at the time of service. We encourage you to also call your insurance provider to discuss your coverage and what your financial obligations may be.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) ____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to Atlanta Sport and Spine Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that Atlanta Sport and Spine Physical Therapy complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

NOTICE OF INFORMATION PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information.

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice

- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

We will use your health information for regular health operations. For example, members of our staff may use the information in your health record to phone you regarding confirmation of appointments or to notify patients of missed appointments. Logistics may dictate that portions of treatments are conducted in an open gym atmosphere where disclosures may be overheard. Every reasonable precaution is taken to limit these events.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication. After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Public Health. As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

EFFECTIVE DATE: February 15, 2013

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Patient Name (please print)

____

Patient Signature

____

Date