

Patient Registration Form For Office Use Only: Account #: _____ Provider: _____

Patient Name: _____
Billing Address: _____ City, State, Zip: _____
Permanent Address: _____ Apt#: _____ City, State, Zip: _____

Home Phone: _____ Business Phone: _____
Cell Phone: _____ Email Address: _____

Sex: Male Female Date of Birth: _____ Age: _____ Patient SS#: _____

Insured's Name: _____ Insured's Date of Birth _____
Relationship to Patient (circle one): Self Spouse Child Other _____

Is Patient (circle one): Single Married Other _____ Employed F/T Student P/T Student Other _____

Referring Physician: _____
Primary Care Physician Name: _____

Is Injury related to an accident (circle one): Yes No If yes (circle one): Job related Auto Accident Other _____
Date of Injury _____ Claim # _____ Contact Person Name/Phone Number: _____

Employer Name: _____ Phone Number: _____
Address: _____ City, State, Zip _____
Emergency Contact Name: _____ Phone Number: _____
Address _____ City, State Zip _____ Relationship _____

Insurance/Workman's Compensation Information

Primary Insurance	Secondary
Company Name: _____	Company Name _____
Policy Holder Name: _____	Policy Holder Name: _____

Notice: The above information is for the purpose of maintaining a complete and accurate medical record. It is also for the purpose of extending credit and is warranted to be true.

AUTHORIZATION TO PAY: I hereby authorize payment directly to Physicians Physical Therapy Service for any medical benefits otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

Your Benefits: Co-pay: \$ _____ Deductible: \$ _____ Met YTD: \$ _____ Co-Insurance %: _____
Visit limitations: _____ Verified by: _____ Date: _____

This is an estimation of benefits and not a guarantee of payment as noted by your insurance company. Benefits listed were obtained from a customer service representative with your insurance company or were obtained in detail from their website.

Physicians Physical Therapy Service verifies your insurance benefits as a courtesy to you. We do not accept responsibility for the **accuracy** of the information provided by your insurance company. If you have further questions or concerns regarding your benefits, please contact your insurance company directly.

I, _____, have read and understand the above information.

Patient/Responsible Party Signature Date



PHYSICIANS
PHYSICAL
THERAPY
SERVICE

Health History Form

Please read all bold headings, circle or fill in all words that apply to your past or present symptoms.

Please inform your therapist if there are any additions to your history form during your care.

Name _____ Date _____ Sex: M F
 Age _____ Height _____ Weight _____ Right Handed Left Handed
 Physician _____ Date of last visit with Physician _____
 Chief Complaint (including location & symptoms) _____

Rate your pain: No Pain ----- Worst it could be
 0 1 2 3 4 5 6 7 8 9 10

When did pain begin? _____
 How did pain begin? (auto accident, work related injury, gradual onset, traumatic injury, surgery, lifting, pulling, slip/fall) _____

Increased pain with: sitting, coughing, walking, exercise, rest, other: _____

Decreased pain with: sitting, walking, exercise, rest, other: _____

Medications (including prescription and non-prescription drugs): _____

Allergies (to medication and other irritants): _____

Surgery (dates and procedures) : _____

Imaging (X-rays, MRI, CT scan, other test, area of the body, dates and results if known): _____

Exercise when injury-free (list recent activities, frequency, as well as future goals): _____

Aerobic exercise (frequency and duration): _____

Have you been to physical therapy before? _____ When and where? _____

Past Medical History (Check all that apply to you, use the back side of this sheet for additional information)

<p>Infection/Disease: <input type="checkbox"/> bone infection <input type="checkbox"/> abscess <input type="checkbox"/> Hepatitis (B, C) <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Lymes <input type="checkbox"/> recent fever, chills, night sweats <input type="checkbox"/> other _____ Cancer: (affected tissue and dates): _____ Hormone: <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Osteoporosis other: _____ _____</p>	<p>Lung: <input type="checkbox"/> Asthma <input type="checkbox"/> TB <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Pulmonary <input type="checkbox"/> Hypertension <input type="checkbox"/> Pulm. Embolus <input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> other _____ Blood Vessels: <input type="checkbox"/> deep vein Thrombosis <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Bypass surgery <input type="checkbox"/> Anemia <input type="checkbox"/> Hypertension other: _____ _____</p>	<p>Heart: <input type="checkbox"/> Heart Attack <input type="checkbox"/> Pacemaker <input type="checkbox"/> valve disorder <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Cardiac Hypertrophy <input type="checkbox"/> Heart Transplant <input type="checkbox"/> other _____ Gastrointestinal: <input type="checkbox"/> Ulcer <input type="checkbox"/> Appendectomy <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Colitis <input type="checkbox"/> Crohns other _____ _____</p>	<p>Kidney: <input type="checkbox"/> Kidney Stones <input type="checkbox"/> loss of control <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> other _____ Reproductive: Men: <input type="checkbox"/> Prostate surgery <input type="checkbox"/> Hernia Women: <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian Cysts Pregnant? _____ Due date _____ <input type="checkbox"/> other _____ Diabetes: Diabetic? _____ Insulin dep.? _____</p>	<p>Neurologic: <input type="checkbox"/> Seizures <input type="checkbox"/> MS <input type="checkbox"/> ALS <input type="checkbox"/> Guillain-Barre <input type="checkbox"/> other _____ Skin: <input type="checkbox"/> Cellulitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Scleroderma <input type="checkbox"/> other _____ Orthopedic: <input type="checkbox"/> fractures <input type="checkbox"/> dislocations <input type="checkbox"/> surgery _____ _____ _____</p>
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Therapist's Signature _____ Patient's Signature _____

Physicians Physical Therapy Service

Consent for Care & Treatment

I, the undersigned or designated representative for the patient, do hereby agree and give my consent for Physicians Physical Therapy Service to furnish any and all medical care and treatment to _____ considered necessary and proper in diagnosing and/or treating his/her physical condition. I understand that no guarantees or promises are made concerning the outcome of treatment.

Patient/Guardian/Responsible Party

Date

Patient Information Consent Form

I have read and fully understand Physicians Physical Therapy Service's Notice of Information Practices. I understand that Physicians Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that Physicians Physical Therapy Service will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physicians Physical Therapy Service's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Patient/Guardian/Responsible Party

Date



Physicians Physical Therapy Service

While on the premises of Physicians Physical Therapy Service each patient is responsible for his or her own belongings. Physicians Physical Therapy Service waives all liability for personal items left unattended.

Payment Policy

As a courtesy to all our patients, we bill your insurance company after coverage has been verified. It is the patient's responsibility to know and understand what their insurance company does and does not cover. Physicians Physical Therapy Service verifies insurance coverage on all its patients including deductibles, co-insurance, and office copay amounts. Physicians Physical Therapy Service notifies each patient in writing of their benefit coverage. However, Physicians Physical Therapy Service does not accept the responsibility for the accuracy of the information provided to us by your insurance company. In any event, the entire bill is the patient's responsibility. Any overpayment will be promptly refunded.

HMO or PPO Members: Copays are due at the time of each visit

Our contract with your insurance company dictates that we collect the specified copayment at the time of service.

We accept cash, personal checks, VISA, MasterCard, American Express, and Discover

there is a returned check processing fee of \$25.00 per occurrence

Private Insurance: Deductible and co-insurance amounts are billed monthly once your insurance company has processed your claim. Payment in full is due within 20 days of the statement date. Those accounts not paid in full after the due date may be placed with a collection agency. The patient/responsible party may be responsible for 100% of the collection costs, reasonable attorney fees, and other costs that may be incurred to enforce collection of any amounts outstanding. Up to 50% of the patient's principal balance due may be added to the collection fees once the account is forwarded to the collection agency.

I have read and understand the payment policy.

Patient/Guardian

Date

Witness

Date

Cancellation Policy

We are aware that sometimes it is impossible to keep your scheduled appointment. However, we request that you inform us 24 hours in advance so we may schedule another patient in your place. We have an answering machine available for messages after hours and on weekends. If you do not inform us and do not show for your appointment, there will be a \$25.00 charge billed directly to you, not your insurance company. This policy helps us serve all our patients effectively. Thank you for your cooperation.

I have read and understand the cancellation policy.

Patient/Guardian

Date

NOTICE OF PATIENT INFORMATION PRACTICES

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

Effective: 4-14-03

Physicians Physical Therapy Service's LEGAL DUTY

Physicians Physical Therapy Service is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Physicians Physical Therapy Service uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Physicians Physical Therapy Service may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Physician Physical Therapy Service may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Physicians Physical Therapy Service's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information, you may later revoke that authorization to stop future disclosures at any time.

Physician Physical Therapy Service may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Physicians Physical Therapy Service will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

For More Information or to Report a Complaint

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Letha Miller or Tamara Galloway, PT (practice owner) at (602) 230-4478. If you are concerned that Physicians Physical Therapy Service may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

Physicians Physical Therapy Service
Letha Miller, Privacy Officer
PO Box 32490
Phoenix, AZ 85064
Tel. 602 230-4478
Fax 602 230-9962

Office for Civil Rights
Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

**PHYSICIANS PHYSICAL THERAPY SERVICE
PATIENT INFORMATION CONSENT FORM**

I have read and fully understand PHYSICIANS PHYSICAL THERAPY SERVICE (PPTS) Notice of Information Privacy Practices. I understand that PPTS may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that PPTS will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in PPTS's Notice of Information privacy practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

I also authorize PPTS to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Date