PATIENT REGISTRATION

PATIENT'S DEMOGRAPHIC INFORMATION

First Name	Last Name	MI	Date of Birth _____/____/_____	Age	Marital Status	Today's Date _____/_____/_____
Address	City	State	Zip		Gender	
Email Address (will be kept private)			Cell Phone (_____) -_____- _____		Home Phone (_____) _____- _____	
Referring physician	Referring Physician Phone #		Date of Injury (work or auto)		Social Security Number	
Employer 's Name: Address:			Occupation		Work Phone (_____) _____- _____	
Emergency Contact (Last, First, MI)	Relationship to Patient				Phone (_____) _____- _____	

PRIMARY INSURANCE INFORMATION

Person Responsible for Payment	Phone (_____) _____-_____	Address (Street – City – State –Zip)	
Primary Insurance Company/Plan	Primary policy holder' name	Primary Insurance ID#	Primary Policy Group #
Primary Policy Holder's DOB	Primary Policy Holder's Relation to Insured:	Insured's SS #	Primary Insurance Phone #

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company/Plan	Secondary policy holder' name	Secondary Insurance ID#	Secondary Policy Group #
Secondary Policy Holder's DOB	Secondary Policy Holder's Relation to Insured	Secondary Insurance Phone #	

WORKER'S COMP/ AUTO ACCIDENT

WC/ Auto Accident date	WC/ Auto Insurance Name	WC/ Auto Claim or Case #	Adjuster or Case Manager's Name
Adjuster or Case Manager's Phone #	Employer's Name	Employer's Address	Employer's Phone #

Patient Name:_____
Date of Birth_____

PATIENT RESPONSIBILITY AND AGREEMENT

PATIENT RESPONSIBILITY

- I request that payment of benefits be made on my behalf to Austin Physical Therapy Specialists for any services rendered.
- I understand and acknowledge that submission of claims is not a guarantee of payment. If for any reason my carrier does not cover any and/or all of my physical therapy treatments, I agree that I am responsible for the payment of the entire amount.
- I understand that it is my responsibility to make sure that my bills are paid in a reasonable time (no longer than 4 months from the date of treatment). If for any reason any portion of my bill is not paid, I understand that I am financially responsible for charges for services rendered.
- I understand and agree that if my carrier makes any payments directly to me for services rendered, I will remit the same payment to Austin Physical Therapy Specialists.
- I understand that it is my responsibility to notify Austin Physical Therapy Specialists of any changes to my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization.
- I understand and agree that if I claim Worker's Compensation or Auto No-Fault benefits and am subsequently denied, I will be financially responsible for the services rendered.

I hereby authorize Austin Physical Therapy Specialists. LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Name:
_____
Responsible Party Signature:
_____
Relationship to Patient:
_____ **Date:** _____

PATIENT AGREEMENT

- **LATE CANCELLATION POLICY** - I acknowledge that there is a 24-hour Cancellation Policy and understand that if I do not cancel 24 hours before my scheduled appointment, I accept the responsibility of being charged $75.00.
- I understand a late cancellation may be re-scheduled to avoid the cancellation fee if the appointment is re-scheduled within the same Monday-Friday period.
- I understand that I am responsible for my deductible, co-payments, and all late cancellation or no-show fees.
- I understand that all deductibles, co-payments, and co-insurance are due at the time of service.
- I understand that if I miss two (2) consecutive appointments without calling to cancel, then my future scheduled appointments will be removed and, to make future appointments, I will call to schedule each appointment on the same day I'm requesting it.
- Please inform the front desk of all scheduling changes. Your therapist is not responsible for your physical therapy schedule.
- If any changes are made with regard to patient insurance or payment coverage, the patient is to alert our office as soon as possible.
- If I am claiming Worker's Compensation or Auto No-Fault, it is my responsibility to inform the front desk of the scheduled IME date and results.

Signature: _____
Date:_____

CREDIT CARD AUTHORIZATION

I hereby authorize Austin Physical Therapy Specialists. LLC to charge my credit card account for services rendered to apply as payment to my account balance.

Card Holder's Name (as it appears on card)

_____

Credit Card #: _____

Expiration Date: _____

Billing Zip Code _____

Signature:_____

CONSENT TO TREATMENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. Even though all efforts will be made in my treatment care, I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the services provided at Austin Physical Therapy Specialists.

It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from our services. Therefore, if evaluation techniques, manual therapy techniques or prescribed exercise techniques are not fully understood, it is my responsibility to obtain a clearer understanding of what the therapist's objective and outcomes are, and how he/she is trying to achieve them. I further understand that as a part of therapy instruction or required manual treatments, the clinical staff may place their hands on various parts of my body, such as the head, neck, breastbone, ribcage, pelvis or buttock.

Name: _____

Signature:_____

Relationship to Patient: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

PURPOSE: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOWYOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE GOES INTO EFFECT ON APRIL 14, 2003 AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

1.) OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need the record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways that we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2.) OUR LEGAL DUTY

a. Law Requires Us To:

i. Keep medical information private.
ii. Give you this notice describing our legal duties, privacy practices and your rights regarding medical information.
iii. Follow the terms of this notice that is now in effect.

b. We Have The Right To:

i. Change the privacy practices and terms of this notice at any time, provided that the law permits the changes.
ii. Make the changes in our policy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes were made.

3.) USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes the different ways that we use and disclose medical information. Not every use of disclosure will be listed. However we have listed all the ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purposes not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us and confirming receipt of written authorization.

a. For Treatment:

The HIPAA regulation permits nearly unlimited sharing of information among providers who are involved in a patient's treatment. Uses and disclosures of information commonly include collection of information from the patient by a physician or other medical practitioner for: performing diagnostic tests and reviewing results, consulting with other providers on diagnosis or treatment, referring a patient to another provider, and transmitting information to another provider such as phoning prescriptions into a pharmacy or placing an order for an ice machine, brace, or other durable medical equipment.

b. For Payment:

We are permitted to disclose to the patient's health plan, any information needed to process a claim. For example: to determine whether a patient is eligible for coverage under a health plan, to determine whether tests or services are covered under a health plan, to submit a claim or inquire about the status of a claim, to process payment or claims remittances, and to process credit card transactions.

c. For Health Care Operations:

Staff may use and disclose only the "minimum necessary" information for the task at hand. This includes: maintenance of medical records, maintenance of accounting records, quality assurance activities, staff performance evaluations, conducting financial and management audits, investigating complaints, supporting legal activities, resolving grievances, and general business management.

d. For Law Enforcement:

Your health information may be disclosed to law enforcement agencies to facilitate investigations, inspections, or mandated reporting.
Your health information may be disclosed to public health agencies as required by law.

4.) HIPAA NOTICE OF PRIVACY PRACTICES

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

5.) INDIVIDUAL RIGHTS

You have the right to request restrictions on the use and disclosure of your protected health information, the right to receive confidential communications regarding your treatment and condition, the right to inspect and copy your health information, the right to amend or submit corrections to your health information, and the right to receive a printed copy of this notice. As permitted by federal regulations, we require that a request to copy or review protected information be submitted in writing. If you would like to submit a comment about our privacy practices, you may do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern
to: ***HIPAA Privacy Official; Premier Physical Therapy; 1536 Third Ave., Fl. 5; New York, NY 10028.***

6.) ACKNOWLEDGEMENT OF FORM

I have received the Notice of Privacy Practices and I have been provided the opportunity to review the contents.

Name (please print clearly): _____

Signature: _____ Date ----------

PATIENT SUBJECTIVE QUESTIONNAIRE

Name _____ **D.O.B.** _____ **Date** _____

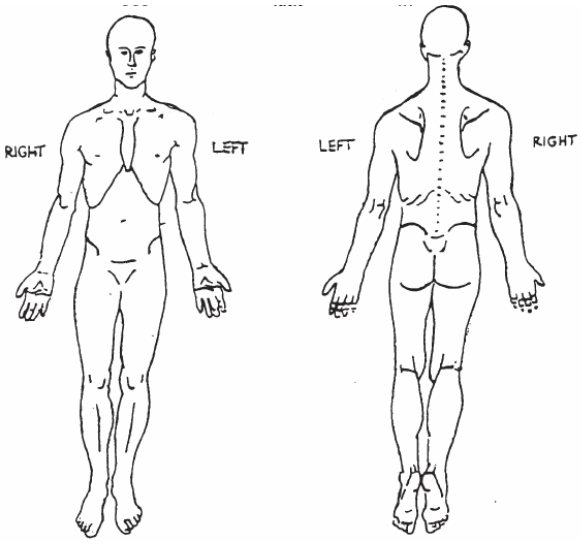
Reason for visit (low back pain, headaches, etc): _____ Date of injury: ----------
Please indicate how your pain started:

☐ Trauma ☐ Work Accident ☐ Surgery
☐ Motor Vehicle Accident ☐ Pregnancy Related ☐ Chronic Pain (unsure of cause)
☐ Progressive ☐ Sports Injury
☐ Other (briefly explain)_____

Have you had Physical Therapy or Chiropractic treatments previously? ☐ YES ☐ NO
Have you had any of the following diagnostic studies?

	NO	YES	Date (year)	Where
Diagnostic X-Rays	☐	☐	_____	_____
CT Scan (computed tomography)	☐	☐	_____	_____
MRI (magnetic resonance image)	☐	☐	_____	_____
Other: _____	☐	☐	_____	_____

On the body diagrams mark and label your primary areas of concern:



On the line below, please indicate (with an "X") the maximum and minimum amount of pain your feel on a daily basis:

No Pain----------Worst Possible Pain
0-----1-----2------3-----4-----5-----6-----7-----8-----9-----10

What activities make your pain worse? (Please check (x) all that apply to you)

☐ Lying on back ☐ Exercise (during)
☐ Bending forward ☐ Bending backwards
☐ Sitting ☐ Exercise (after)
☐ Coughing / Sneezing ☐ Standing
☐Twisting ☐ Early Morning
☐ End of Day ☐ Walking
☐ None ☐ Other _____

Initial---------

WORK STATUS

Are you: ☐ Currently working ☐ Unemployed If yes, ☐ Full Duty or
☐ Disabled ☐ Retired ☐ Light Duty
☐ Employed but not working

What is your occupation? _____

Type of work: ☐ Sedentary ☐ Light☐ Heavy Lifting <50 lbs ☐ Very Heavy Lifting > 50 lbs

Do you do a lot of standing, bending or twisting at work? ☐ NO ☐ YES

Are you having difficulties at work because of your pain? ☐ NO ☐ YES
Were you injured at work? ☐ NO ☐ YES

Explain _____

Past Medical History

Condition	Yes	No	*Condition*	Yes	No
Diabetes			**Asthma**		
High Blood Pressure			**Dizziness/Vertigo**		
Heart Disease			**Difficulty Breathing**		
Stroke			**Incontinence**		
Pacemaker			**Falls**		
Neurological Disorder			**Multiple Sclerosis**		
Cancer			**Psychiatric Treatment**		
Osteoarthritis			**Broken Bones**		
Osteoporosis/Osteopenia			**Other:**		
Rheumatoid Arthritis			**For women: Pregnant?**		

Social History

Do you smoke, chew ? _____ Y _____ N If yes, how much: _____
Do you drink alcohol ? _____ Y _____ N If yes, how much: _____

Initial---------

Current Medications

Briefly list any other pertinent information that may be beneficial for your therapist to know:

FOR OFFICE USE ONLY

BLOOD PRESSURE : ----------

PULSE:----------

TEMPRATURE: ----------

O2:----------

NOTE: ----------

Initial --------

Austin Physical Therapy Specialists. LLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Last Name of Patient: _____
First Name of Patient: _____
Date of Birth: _____

I hereby authorize medical providers and personnel of Austin Physical Therapy Specialists to discuss and/or release my protected health information with:

_____ _____
(Relationship) (Name)

_____ _____
(Relationship) (Name)

_____ _____
(Relationship) (Name)

This authorization shall be in force and in effect from_____ until_____
at which time this authorization to use or disclose this protected health information expires.
Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

Signature of Patient ----------

Date ----------

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