

Patient Registration

Personal Information		<i>Please complete all areas</i>	
Social Security Number:		Date of Birth: / /	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Last Name:	Suffix:	First Name:	MI:
Address:			
City:		State:	Zip:
Home Phone:		Work Phone:	
Cell Phone:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	

How did you hear about us? Dr. _____ Dr.'s Nurse _____ Friend _____ Newspaper _____ Other: _____			
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Insured Party/Responsible Party (Leave blank if same as patient)			
Social Security Number:		Date of Birth:	
Relationship to Patient:			
Last Name:	Suffix:	First Name:	MI:
Address:			
City:		State:	Zip:
Home Phone:		Work Phone:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	

Patient's Employer Information			Insured's Employer Information (Leave blank if same as patient)		
Employer Name:			Employer Name:		
Employer Address:			Employer Address:		
City:	State:	Zip:	City:	State:	Zip:

Emergency Contact Information			
Last name:		First Name:	MI:
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Other:			
Home Phone:		Work Phone:	

Other Information	
Date of Injury (onset):	Accident: <input type="checkbox"/> No Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other
Description of injury:	If auto accident, list state accident occurred:

Patient Certification and Signature:	
I certify that all of the information provided herein is true and correct.	
Patient/Guardian Signature:	Date:

Patient Name:

Release of Information

All information provided herein is true and correct.

I hereby consent to treatment.

I give permission to First Choice Physical Therapy and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize First Choice Physical Therapy and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Information without patient identifiers may be used for quality assurance purposes.

I have read and understand the above release.

Patient or Guardian Signature:

Date:

Assignment of Benefits

I authorize payment directly to First Choice Physical Therapy, its subsidiaries and/or affiliates for services.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

Patient or Guardian Signature:

Date:

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for First Choice Physical Therapy.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Patient or Guardian Signature:

Date:

Payment Guarantee

I agree to pay First Choice Physical Therapy, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of First Choice Physical Therapy and/or its affiliates or subsidiaries.

Patient or Guardian Signature:

Date:

Benefit Verification

Primary Insurance Coverage? Yes No
 Secondary Insurance Coverage? Yes No (If yes, complete a separate form)

Information					<i>Please complete all areas</i>				
Patient Last Name:	Suffix:	First Name:	MI:	SS#:					
Insured Last Name:	Suffix:	First Name:	MI:	SS#:					

Insurance Information									
Insurance Company Name:							Phone Number:		
Insurance Billing Address:				City:			State:		Zip:
Adjuster or Claims Representative:					Phone Number:			Fax Number:	
Policy #:		Employer Group:			Employer Group Name:			Claim Number:	
Patient Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:									
DEDUCTIBLE		Deductible Start Amount:					Remaining Amount:		
COPAY	Patient Co-Pay %:		Patient Co-Pay \$:			Out of Pocket Limit:		Clinic in Network?	
LIMIT	<input type="checkbox"/> Per Condition <input type="checkbox"/> Per Calendar Year <input type="checkbox"/> Per Benefit Year					Visits:			
Attachment Requirements: <input type="checkbox"/> Evaluation <input type="checkbox"/> Plan of Care <input type="checkbox"/> Copy of RX <input type="checkbox"/> Daily Notes <input type="checkbox"/> Progress Note <input type="checkbox"/> Other									
Notes:									

PATIENT AUTHORIZATION, RELEASE, AND SIGNATURE

I have read the above estimation of benefits from my insurance company and agree to verify this information by reading my insurance benefits book or contacting my insurance company. I do not hold First Choice Physical Therapy and/or its affiliates responsible for any incorrect or omitted information or for any changes in my future coverage. I also agree that I am responsible for the contract between myself and my insurance company.

Patient/Guardian Signature:	Date:
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BRIEF MEDICAL HISTORY

Patient Name		Social Security Number	
Reason for therapy		Date of Injury or Onset of Symptoms	

Have you ever received therapy for the condition mentioned above? No Yes
 If so, when? _____ Successful Unsuccessful

Treatment received:

Do you now or have you ever had any of the following?

YES	NO	CONDITION	YES	NO	CONDITION
		Diabetes			Open Wounds
		Arthritis			Current Infection(s)
		High Blood Pressure			Hypersensitivity to Heat/Cold
		Heart Disease			Allergies
		Heart Attack			Hernia
		Pacemaker or Surgical Implant			Presently Pregnant
		Vascular Disease			Seizures
		Headaches			Metal in body
		Cancer/Tumor			Other:

MEDICATION	DOSE	FREQUENCY

X _____ **DATE:** _____
Patient/Parent/Guardian Signature

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of Your Health Information

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of First Choice Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your health information
- The right to amend and/or submit corrections to your health information
- The right to receive an accounting of how and to whom your health information has been disclosed
- The right to receive a printed copy of this notice

OUR HEALTH INFORMATION DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

OUR RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting First Choice Physical Therapy.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the company by sending a letter outlining your concerns:

First Choice Physical Therapy
#5 West, 8th & State Plaza
Quincy, IL 62301

You may also file a written complaint with the Office of Civil Rights.

Effective Date: March 1, 2005