PATIENT INFORMATION

DATE________________________

FIRST NAME_______________________ LAST NAME____________________________

ADDRESS____

CITY______________________________ STATE_______________ ZIP_________________

PHONE NUMBER (   )___________________ DATE OF BIRTH______________________

SOCIAL SECURITY NUMBER ____________________

YOUR EMPLOYER____

ADDRESS____

CITY____ ZIP ___________________________

PHONE NUMBER (   )____________________

OCCUPATION____

NAME OF YOUR INSURANCE COMPANY____

INSURED NAME____

PATIENT RELATION TO INSURED____

WAS THIS AN ACCIDENT_________________ DATE OF INJURY ____________________

HOW DID THIS ACCIDENT OCCUR____

NAME OF ATTORNEY ____

IN CASE OF AN EMERGENCY WHOM TO CALL ___________________________________

PHONE NUMBER (   ) ______________________ RELATIONSHIP ___________________

BILLING INFORMATION

WE WILL BILL ONE INSURANCE AS A COURTESY TO OUR PATIENTS, AFTER YOUR INSURANCE HAS PAID ALL BENEFITS, I THEN BILL YOU FOR THE BALANCE ON YOUR ACCOUNT. YOUR PAYMENT IS EXPECTED IN FULL WITHIN 30 DAYS.

IT IS THE RESPONSIBILITY OF THE PATIENT TO KNOW WHAT THEIR INSURANCE COMPANY DOES OR DOES NOT COVER.

THOSE ACCOUNTS NOT PAID IN FULL AFTER 30 DAYS ARE PLACED WITH A COLLECTION AGENCY.

I HAVE READ AND UNDERSTOOD THE ABOVE POLICY.

PATIENT ____ DATE ____________________

WITNESS ____ DATE ____________________

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I HEREBY ASSIGN PAYMENT DIRECTLY TO E.T. PHYSICAL THERAPY FOR SERVICES RENDERED TO ME (OR MY DEPENDENT). I AUTHORIZE E.T. PHYSICAL THERAPY TO DISCLOSE ALL OR ANY PART OF MY (OR MY DEPENDENT'S) RECORD TO ANY PERSON OR CORPORATION WHICH MAY BE LIABLE FOR ALL OR PART OF THE CHARGES OF E.T. PHYSICAL THERAPY, INCLUDING BUT NOT LIMITED TO INSURANCE COMPANIES, WORKERS, COMPENSATION CARRIERS, OR EMPLOYERS.

PATIENT ____ DATE____________________

E.T. Physical Therapy

Medical History

Patient Name ____Age_________

Type of Injury/Condition____

Onset/ Injury Date___________________________

Type of Surgery & Date______________________
Next Doctor's Appointment ____________

Have you had any imaging performed:

X-Ray CT Scan
MRI Doppler Ultrasound

Have you recently noted :

Weight Loss/Gain Nausea/Vomiting Fatigue
Weakness Fever/Chills/Sweats Numbness/Tingling
Pregnant/IUD Headaches Change in Vision or Hearing
Pain at Night Cramps in Legs When Walking Insomnia

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

Surgeries Loss of Consciousness Fractures Sprain/Strains
Diabetes Blood Pressure Problems
Heart Problems Cancer Osteoporosis
Circulation Problems Asthma/Breathing Problems Lung Disease
Easy Bruising/Bleeding Leg/Ankle Swelling Urinary Problems
Indigestion/Heartburn Fainting Allergies/Skin Sensitivity Any previous injury that may affect current care_________________________________
Explain & give approximate dates for any items indicated above____________________
Are you currently taking medications Yes/No ____________________________________
Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other__________
Rate your pain (1= minimal 10=severe)
At it's worst 1 2 3 4 5 6 7 8 9 10 / At it's best 1 2 3 4 5 6 7 8 9 10
Is there anything you would like to include or ask your physical therapist

.____

Signature: ____

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.

E.T. physical therapy LEGAL DUTY

E.T. physical therapy 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

E.T. physical therapy 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, E.T. physical therapy 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.

E.T. physical therapy 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, E.T. physical therapy 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 for any reason, you may later revoke that authorization to stop future disclosures at any time.

E.T. physical therapy 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 patient exam areas 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. E.T. physical therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that E.T. physical therapy 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 practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on E.T. physical therapy health information practices or if you have a complaint, please contact E.T. physical therapy.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand E.T. physical therapy notice of Information Practices. I understand that E.T. 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 if I notify the practice. I also understand that ABC PT/OT 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 _***Insert*** E.T. physical therapy 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

____
Signature

____
Date

I also authorize E.T. physical therapy 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