PHYSICIANS PHYSICAL THERAPY SERVICE
REGISTRATION FORM

PATIENT INFORMATION

Patient's Name First:	M.I.:	Last:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Preferred Method of Contact: [ ] Home Phone [ ] Cell Phone [ ] Text [ ] Email [ ] Check Here For No Appt Reminder			
Date of Birth:	SSN:	Gender:	
Marital Status: (Circle One) Single / Married / Other	Patient Status: (Circle One) Employed Full-Time / Full-Time Student / Part-Time Student		
Spouse's Name:	Date of Birth:	SSN:	
Date of Injury:	Place (State) of Injury:		
Emergency Contact:			
Relationship:	Phone: ( )		

PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD

Insurance Name:		ID #:
Name of Insured:	Date of Birth:	Group #:
Relationship to Insured: (Circle One) Self / Spouse / Minor / Other		
Employer:	Work Phone:	
Insurance Name:		ID #:
Name of Insured:	Date of Birth:	Group #:
Relationship to Insured: (Circle One) Self / Spouse / Minor / Other		
Employer:	Work Phone:	

RESPONSIBLE PARTY / GUARDIAN INFORMATION

Name Last:	First:	M.I.:	SSN:
Address:	City:	State:	Zip:
Relationship to Insured: (Circle One) Self / Spouse / Other		Date of Birth:	
Employer:	Work Phone:		

AUTO INSURANCE COMPANY

Auto Insurance Company Name:	
Claim Number:	
Other Party's Auto Insurance Company (if applicable):	
Claim Number:	
Attorney Name:	Phone: ( )

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Physicians Physical Therapy Service and hereby authorize and give my consent for PPTS to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize and give my consent for Physicians Physical

Therapy Service to treat _____ (minor's name) while I am not present.

Patient / Guardian / Responsible Party Signatur		**Date:**

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

AUTO / PERSONAL INJURY FINANCIAL POLICY: It is the policy of Physicians Physical Therapy Service to coordinate the registration, billing, and collection for services provided to patients referred for treatment due to injuries from a motor vehicle or personal injury accident. At the time of registration, the patient is asked to provide the following: auto insurance card, medical plan insurance card, claim number(s), attorney information.

PPTS will coordinate billing of services with the patient's auto insurance agent or insurance carrier, and/or where necessary, the patient's attorney. PPTS will use the medical plan coverage to bill for services in the event the patient's benefits through the auto insurance are exhausted. PPTS can only accept a patient for treatment with the required documentation. PPTS will not accept a patient based upon a promise to pay for services from possible settlement proceeds.

In the event your auto insurance benefits are exhausted and PPTS does not have health insurance information on file, your account will become self-pay. As a self-pay patient, you are required to pay $125 for your initial evaluation visit, $100 for return visits 45 minutes or longer, and $75 for return visits less than 45 minutes. Payment is required at each visit. Failure to make payment will result in future visits being cancelled until payment is received.

As a courtesy to you. Physicians Physical Therapy Service will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. Physicians Physical Therapy Service is not responsible for problems between the patient and insurance carrier, nor can PPTS intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment.

_____

Initials

PRIVACY NOTICE and RELEASE OF MEDICAL INFORMATION: A Notice of Privacy Practices (NPP) is available for your review or you may take it with you. The NPP describes Physicians Physical Therapy Service's comprehensive efforts to protect the privacy of your personal health and financial information. The NPP also describes how much information may be used, released or shared under the Health Insurance Portability and Accountability Act (HIPAA).

_____

Initials

ATTENDANCE, CANCELLATION, and NO SHOW: Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforseen circumstances, we do require at least 24 hours notice of cancellation. There is a $25 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally.

_____

Initials

EQUIPMENT / SUPPLY RESPONSIBILITY: Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, PPTS requires payment by the patient for any equipment/supply at the time the order is placed. PPTS will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. Physicians Physical Therapy Service accepts credit/debit cards or personal checks as payment options. In the event payment is returned for insufficient funds, $20 plus the amount charged by the depository institution will be applied to your account.

_____

Initials

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hearby authorize PPTS Physical Therapy to share any and all of my medical / billing information with the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

PATIENT AUTHORIZATION

- By my initials and signature I understand these policies and my financial obligations for services rendered.

- I hereby assign payment of benefits by my insurance company to Physicians Physical Therapy Services, and I accept responsibility to ensure my insurance carrier makes payment on my account within 60 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.

- I hereby agree to pay any office visit/co-payment charges with each visit.

- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature: _____ **Date:** _____

Parent / Guardian / Guarantor: _____ **Date:** _____

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__ 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)

Infection/Disease:
___bone infection
___abscess
___Hepatitis (B, C)
___HIV/AIDS
___Lymes
___recent fever, chills, night sweats
___other _____
_____

Cancer: (affected tissue and dates):
_____
_____

Hormone:
___Hyperthyroid
___Hypothyroid
___Osteoporosis
___other: _____
_____

Lung:
___Asthma
___TB
___Pneumothorax
___Pulmonary
___Hypertension
___Pulm. Embolus
___chronic cough
___shortness of breath
___other _____
_____

Blood Vessels:
___deep vein Thrombosis
___Arteriosclerosis
___Bypass surgery
___Anemia
___Hypertension
___other: _____
_____

Heart:
___Heart Attack
___Pacemaker
___valve disorder
___Arrhythmia
___Congestive Heart Failure
__Cardiac Hypertrophy
___Heart Transplant
___other _____
_____

Gastrointestinal:
___Ulcer
___Appendectomy
___Gall Bladder
___Colitis
___Crohns
___other _____
_____

Kidney:
___Kidney Stones
___loss of control
___Urinary Tract Infection
___other _____

Reproductive:
Men:
___Prostate surgery
___Hernia
Women:
___Endometriosis
___Ovarian Cysts
Pregnant? _____
Due date _____
___other _____
_____

Diabetes:
Diabetic? _____
Insulin dep.?_____

Neurologic:
___Seizures
___MS
___ALS
___Guillain-Barre
___other _____
_____

Skin:
___Cellulitis
___Psoriasis
___Scleroderma
___other _____

Orthopedic:
___fractures
___dislocations
___surgery_____
_____
_____

Therapist's Signature_____**Patient's 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. PLEASE REVIEW IT CAREFULLY.

I. Our Duty to Safeguard Your Protected Health Information

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. Copies of our privacy policies and procedures are maintained in the business office, and a copy of this Notice may be found on our website at www.freedomofmotion.com. We are required by state and federal regulations to abide by the privacy practices describe in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for the health care treatment or services you receive is considered protected health information (PHI). As such, we are required to provide you with this Privacy Notice that contains information regarding our privacy practices that explains how, when and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum necessary protected health information to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will post a copy of the new/revised Privacy Notice in the main lobby and on our website. You also may request and obtain a copy of any new/revised Privacy Notice from the business office.

Should you have any questions concerning our Privacy Notices, the names, addresses, telephone numbers, website addresses, etc., of whom you should contact are listed on the last page of this document.

II. How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/ or disclose your health information for purpose of treatment, payment, or for the operations of our facility. For other uses, as you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release your protected health information to an outside party, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have examples of the different types of uses or disclosures.

These include:

Use and Disclosures Related to Treatment: We may disclose your protected health Information to those who are involved in providing medical and nursing care services and treatments to you. For example we may release health information about you to our nurses, nursing assistants, medication aids/ technicians, medical and nursing students, therapists, pharmacists, medical records personnel, consultants, physicians, etc. We may also disclose your protected health information to outside entities performing other services relating to your treatment, such as physicians, diagnostic laboratories, pharmacies, or home health/hospice agencies,

Use and Disclosures Related to Payment: We may use or disclose your protected health information to bill and collect payment for services or treatments we provided to you. For example, we may contact your insurance facility, health plan, or another third party to obtain payment for services we provided to you.

Use and Disclosures Related to Health Care Operations: We may use or disclose your protected health information to perform certain functions within our facility should these uses or disclosures become necessary to operate our facility and to ensure that you and others we provide care and services to continue to receive quality care and services. For example, we may take your photograph for medication identification purposes or use your health information to evaluate the effectiveness of the care and services you are receiving. We may disclose your protected health information to our staff (nurses, nursing assistants, physicians, staff consultants, therapists, etc.) for auditing, care planning, treatment, and learning purposes. We may also combine your health information with information from other health care providers to study how our facility is performing in comparison to like facilities or what we can do to improve the care and services we provide to you. When information is combined, we remove all information that would identify you so that other may use the information in developing research on the delivery of health care services without learning your identity.

III. Uses and Disclosures Requiring Your Written Authorization

For uses and disclosures of your protected health information beyond treatment, payment and operations purposes, we are required to have your written authorization, except as permitted by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing. The name, address, telephone number of the person to contact is located on the last page of this document. You may use our *Authorization for Use or Disclosure of Protected Health Information* form and/ or our Revocation of an Authorization form to submit your request to us. Copies of these forms are available in the business office.

Examples of uses or disclosures that would require your written authorization include, but are not limited to, the following:

1. A request to provide your protected health information to an attorney for use in a civil litigation claim.
2. A request to provide certain information to an insurance or pharmaceutical facility for the purpose of providing you with information relative to insurance benefits or new medications that may be of interest to you.
3. A request to provide certain information to another individual or facility
4. Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
5. Uses and disclosures for marketing purposes or that constitute the sale of medical information about you.

IV. Uses or Disclosures of Information Based Upon Your Verbal Agreement

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (because you were not present or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose health information relevant to the person's involvement in your care. For example, if you are sent to the emergency room, we may only inform the person that you suffered an apparent heart attack, stroke, etc., and/or we may provide information on your prognosis or progress. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

Information Used or Disclosed in the Facility: We may use or disclose your name, treating room/area in our clinic. Information concerning your general condition or location may be provided to callers or visitors when they ask for you by name. You may object to the release of this information. You may use our *Request to Restrict the Use or Disclosure of Protected Health Information* form to notify us of your objection or your objection may be listed on the last page of this document. (See also Section VI, paragraph 1.)

Information Disclosed to Family Members, Friends or Others Involved in Your Care: We may disclose your protected health information to your family members and friends who are involved in you care or who help pay for your care. You may use our Request to Restrict the Use or Disclosure of Protected Health Information form to notify us of your objection or your objection may be listed on the last page of this document. (See also Section VI, paragraph 1.)

V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and federal laws and regulations either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

When Required by Law: We may disclose your protected health information when a federal, state or local law requires that we report information about suspected abuse, neglect, or domestic violence, reporting adverse reactions to medications or injury from a health care product, or in response to a court order or subpoena.

For Health Oversight Activities: We may disclose your protected health information to a health oversight agency such as a protection advocacy agency, the state agency responsible for inspecting our facility or to other agencies responsible for monitoring the health care system for such purpose as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations and civil rights issues.

To Avert a Serious Threat to Health or Safety: We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.

For Specific Government Functions: We may disclose your protected health information of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities (such as protection of the President), or to correctional institutions.

VI. Your Rights Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain on our premises:

To Request Restrictions on Uses and Disclosures of Your Protected Health Information: You have the right to request that we limit how we use or disclose your protected health information for treatment payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for you pare or services. For example, you could request that we not disclose to family members or friends information about a medical treatment you received.

Should you request a restriction places on the use and disclosure of your protected health information, you must submit such request in writing. (Note: You may submit such request using our Request to Restrict the Use and Disclosure of Protected Health Information form. Copies of this form are available in the business office). The name, address, and telephone number of the person to whom the request is to be submitted is listed on the last page of this document.

We are not required to agree to your restriction request. However, should we agree, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

Notwithstanding the foregoing, we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to a health care plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

The Right to Inspect and Copy Your Medical and Billing Records: You have the right to inspect and copy your health information, such as your medical- and billing records that we use to make decisions about your care and services. In order to inspect and/ or copy your health information, you must submit a written request to us. If you request a copy of your medical information, we may charge you a reasonable fee for the paper, labor, mailing, and/ or retrieval costs involved in filing your request. We will provide you with information concerning the cost of copying your health information prior to performing such service. The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your request on our Request for Inspection/ Copy of Protected Health Information form. Copies of these forms are available in the business office.

The Right to Amend or Correct Your Health Information: You have the right to request that your health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such request of us for as long as we maintain/retain your health information. Your request must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request. If we approve your request we will make such amendments/ corrections and notify those with a need to know of such amendments/ corrections.

We may deny your request if:

a. Your request is not submitted in writing;
b. Your written request does not contain a reason to support your request;
c. The information was not created by us, unless the person or entity that created the information is no longer available to make amendment;
d. It is not part of the health information kept by or for our facility;
e. It is not part of the information which you would be permitted to inspect and copy; and/ or
f. The information is already accurate and complete.

If your request is denied, we will provide you with a written notification of the record(s) of such denial and your right to have the request, the denial, and any written response you may have relative to the information and denial process appended to your health information.

Then name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document.

The Right to Request Confidential Communications: You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any health information about you to a family member's address. We will agree to your request as long as it is reasonably easy for us to do so. You are not required to reveal nor will we ask the reason for your request. To request confidential communications you must:

a. Notify us in writing;
b. Indicate what information you wish to limit;
c. Indicate whether or not you wish to limit or restrict our use or disclosure of such information; and
d. Identify to whom the restrictions apply (e.g., which family member(s), agency, etc.)

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your requests on our Request for Restriction of Confidential Communications form. Copies of these forms are available in the Business Office.

The Right to Request an Accounting of Disclosures of Protected Health Information: You have the right to request that we provide you with a listing of when, to whom, for what purpose, and what content of your protected health information

we have released over a specified period of time. This accounting will not include any information we have made for the purpose of treatment, payment, or health care operations information released to you, your family, or the facility directory, disclosures made for national security purposes, or any releases pursuant to your authorization.

Your request must be submitted to us in writing and must indicate the time period for which you wish the information (e.g., May 1, 2013 through August 31, 2013). Your request may not include releases for more than six (6) years prior to the date of your request. Your request must indicate in what form (e.g., printed copy, or email) you wish to receive this information. We will respond to your request with in sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be notified of such extension. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your request on our *Request for an Accounting of Disclosures of Protected Health Information* form. Copies of these forms are available in the business office.

The Right to Receive a Paper Copy of This Notice: You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at any time or you may obtain a copy of this information from our website (www.freedomofmotion.com, as applicable). The name, address, and telephone number to whom you may obtain a paper copy of this notice is listed on the last page of this document.

The Right to Notification if a Breach of Your Health Information Occurs: You have the right to be notified in the event we discover that a "breach" of your unsecured protected health information (as defined in the applicable Privacy laws) has occurred. In that circumstance, we will notify you promptly with the following information:

a. A brief description of what happened;
b. A description of the health information that was involved;
c. Recommended steps that you can take to protect yourself from harm;
d. What steps we are taking in response to the breach; and
e. Contact procedures so you can obtain further information.

VII. How to File a Complaint about Our Privacy Practices

If you have reason to believe that we have violated your privacy rights, violated our privacy procedures, or you disagree with a decision we made concerning access to your protected health information, etc., you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

The name, address, and telephone number of the person to whom you may file your complaint is listed below on this document. You may submit your complaint on our Privacy Practices Complaint form. Copies of these forms are available in the business office.

Effective Date: September 23, 2013

Concerns you may have about our privacy practices per office may be addressed to:

Office Location	Arrowhead/Glendale, Mesa Gateway, and Phoenix	Chandler, and Mesa	Avondale, Buckeye, Glendale, and Goodyear/Litchfield
Contact	Letha Miller	Marie Renner	Lynette Makemson
Address	1300 N. 12th St., Suite 506	1257 W. Warner Rd, Suite A2	3050 N. Litchfield Rd., Suite 100
Address 2	Phoenix, AZ 85006	Chandler, AZ 85224	Goodyear, AZ 85395
Phone/Fax	P (602) 253-6623	P (480) 821-2286	P (623) 935-5505

Or

HCUS Dept. of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202)619-0257 or 1-877-696-6775