ABLE **PHYSICAL THERAPY**

Please, don’t hesitate to ask for assistance in filling out this important information

PATIENT REGISTRATION FORM

Last Name:	First Name:	MI:	Title: Mr. Mrs. Ms.
Street Address:	Social Security #:	Home Phone: ( ) -	
Address (apartment #):	Date of Birth: (MO / DAY / YEAR) _____/_____/_____	Cell Phone: ( ) -	
City:	How did you learn about us? ___Doctor ___Employer ___Family ___Friend ___Other	Work Phone: ( ) -	
State: / Zip Code:		Referring Doctor:	

Marital Status:	Employment Status:	Student:	Is this your first experience with physical therapy?	Family Doctor:
___Single ___Married ___Widowed ___Other:______	___Full Time ___Part Time ___Retired ___Unemployed	___Full Time ___Part Time ___NA	Y / N	Doctor’s Phone Number:

E-Mail Address **(if you would like to receive an “e-newsletter”):**

EMERGENCY CONTACT:

NAME________________________________PHONE____________________RELATIONSHIP____________________

WORK / AUTO INJURY INFORMATION

Is this is a work related injury: YES / NO	Is this an auto related injury: YES / NO
Your Employer: Phone#:	Auto Insurance Company:
Claim #: Contact:	Claim Number:
Date of Injury: / /	Date of accident: / /

INSURANCE INFORMATION

<u>Primary</u> Insurance Company Name	Mailing Address	
Insurance Company Phone	Policy Number	Group Number
<u>Secondary</u> Insurance Company Name	Mailing Address	
Insurance Company Phone	Policy Number	Group Number

COMPLETE IF INSURANCE IS NOT IN YOUR NAME (SPOUSE / PARENT / GUARDIAN)

Insured’s Name:	Insured’s Social Security #:	Your relationship to the Insured: ___Spouse ___Guardian ___Mother ___Other___________ ___Father ____________________
Insured’s Address:	Insured’s Date of Birth:	

Please provide a copy of your insurance card (both sides) for our records or bring the card with you for us to copy.

Thank you

Past Medical History

Patient Name: ________________________________ Date of Birth: ________________________________

Have you ever received therapy for your current problem: Yes No

Could you be or are you pregnant? Yes No

- **Please circle if you have ever had any of the following:**

Arthritis	**Tuberculosis**	**Blood Clot**	**High Blood Preasure**
Osteoporosis	**Cancer or Tumor**	**Weight Gain or Loss**	**Current Infections**
Heart Disease	**Chronic Cough**	**Smoke**	**Heart Attack**
Pacemaker	**Fainting Spells**	**Thyroid Problems**	**Stroke**
Asthma	**Head Injury**	**Shortness of Breath**	**Seizures/Epilepsy**
Substance Abuse	**Hernia**	**Kidney/Bladder Problems**	**Hepatitis**
Previous Fractures	**Diabetes**	**Anemia**	**Previous Surgeries**
Hypersensitivity to Heat or Cold	**Hearing Loss**	**Swelling in Ankles**	**Depression/Anxiety**

If you have answered Yes to any of the above questions, please explain and give approximate dates:

____

____

____

____

Do you have any allergies? Yes No If yes, list them:

____

____

____

Are you presently on any medication? Yes No If yes, list them:

____

____

____

This information is correct to the best of my knowledge.

Signature : ______________________________ Date: _____/______/______

Notice of Privacy Practice

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 you 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 service, the service 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. 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 public health department.

Other uses and disclosures require your authorization

Disclosure of your health information or its use for any purpose other then 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 or disclose of information that occurred before you notified us of you 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 to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Notice of Privacy Practices

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 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 policy and practices that are outlined on this notice.

OUR RIGHT TO REVISE PRIVACY PRACTICES
As permitted by law, we reserve the right to amend or modify our privacy policy and practice. The changes in our policies and practices may be required by changes in state and federal 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 the Company's Privacy Officer.

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 President by sending a letter or phoning in your complaint to the address and phone number listed below.

Able Therapy Services
Jonathan Sakowski, DPT, OCS
2605 Reach Road
Suite A
Williamsport, Pa 17701
570-322-2251
(You may also file a written complaint with the Office of Civil Rights)

I authorize Able Physical Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Able Physical Therapy. I authorize Able Physical Therapy to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

Consent for treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment at Able Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

Assignment of Benefits

I authorize payment directly to Able Physical Therapy, Inc. This is a direct assignment of my rights and benefits under this policy.

Notice of Privacy Policy

I hereby acknowledge that I have been offered a copy of the privacy practice notice for Able Physical Therapy. PLEASE NOTE THAT PRIVACY POLICY IS MADE AVAILABLE TO OUR PATIENTS IN THE WAITING AREA.

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

I have read the above terms and agree, 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 treatment unless agreed to in writing by myself and a representative of Able Physical Therapy.

Signature____**Date:**________________