CONFIDENTIAL MEDICAL HISTORY/EVALUATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Is this Injury? Work Related: Y N Auto Accident: Y N Other: _____ Date of injury/accident _____

Have you received any Physical Therapy or Speech Therapy services this year? (please circle) Yes No

If yes, and these visits were provided by outpatient services, how many visits have you had? _____

Chief Complaint: _____

Current Symptoms (Please Circle): Pain Numbness Stiffness Weakness Is this Condition: New Acute Chronic

List Current Medications/Dosages: _____

_____

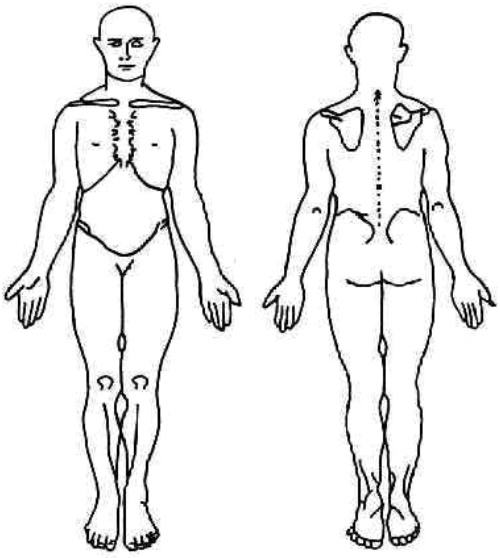
Are you allergic to any medications? Y N If yes please list: _____

List any surgeries: _____

Which of these Diagnostic or Rehab Services have you had for this injury? MRI X-Rays Other: _____

Do you have any of the following?	Yes	No
Diabetes		
Shortness of Breath/Chest		
Coronary Heart Disease		
Do you have a Pacemaker		
High Blood Pressure		
Heart Attack/Surgery		
Stroke/TIA		
Blood Clot/Emboli		
Epilepsy/Seizures		
Thyroid trouble/Goiter		
Anemia		
Infectious Disease		
Asthma, Bronchitis, Emphysema		
Cancer or Chemo/Radiation		
Arthritis/Swollen Joints		
Osteoporosis		
Varicose Veins		
Gout		
Sleeping Difficulties		
Emotional/Psychological Problems		
Bowel/Bladder Problems		
Severe/Frequent Headaches		
Vision/Hearing Difficulties		
Dizziness or Faintness		
Are you Pregnant		

Mark or **Shade** the areas where you are experiencing symptoms



Mark a Line across the scale indicating your **Level of Pain**

Pain as Bad as It Could Be

No Pain at All

Smoking Yes No	Daily ____ Weekly ____	
Alcohol Consumption Yes No	Daily ____ Weekly ____	
Are you aware of your diagnosis?	Yes No	
Are you aware of your prognosis?	Yes No	

Have you had 2 or more falls in the past year? Yes No

Have you had a fall with injury in the past year? Yes No

HEIGHT _____ WEIGHT _____ BMI _____

Patient/Parent/Guardian Signature: _____ **Date:** _____

Physical Therapy Center

PATIENT REGISTRATION FORM

Patient's Name: _____
Last First MI

Birth Date: _____ Social Security #: _____

Address: _____
Street # City State Zip

Home Phone #: _____ Cell #: _____ Alternate#:_____

Would you like reminder: *Texts* *Emails* *Neither* Email Address (required)_____
Cell phone provider: Verizon, AT&T, Sprint, other: _____ (some providers may not be available).

Employer/School: _____ Work #: _____
Sex: M F Marital Status: S M D W Other
Spouse/Parent (if minor): _____ Phone: _____

Chief complaint/Reason for Therapy: _____ Referring Doctor: _____
Date of Injury or Onset: _____ If Surgery- date(s): _____
Is condition related to: Employment Y N Auto Accident Y N

Primary Insurance Company: _____
Policy Holder: _____Date of Birth:_____
Policy Holder's Social Security #: _____Relationship to Patient: _____
Policy Number: _____Group #: _____

Secondary Insurance Company:_____
Policy Holder: _____Date of Birth: _____
Policy Holder's Social Security #: _____Relationship to Patient: _____
Policy Number: _____Group #: _____

Have you received any Home Health care within the past 30 days? Y N Discharge Date: _____

Emergency Contact Person: _____Relationship: _____Phone #: _____

Family Doctor: _____City, State: _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. I understand that I am responsible to inform this office of any changes that occur. I authorize release of payment directly to Physical Therapy Center regardless of participation in or out-of-network. Should I default on my financial responsibility, and collection action is necessary, I will be responsible for collection costs of 35% (thirty-five percent) of unpaid balances sent to collection, and I agree to pay all reasonable attorney fees and court costs. I understand that I may obtain a copy and/or ask questions about the "Notice of Privacy Practices" at any time. Furthermore, I will not hold PTC liable for any personal items that may be lost, damaged or stolen while on their property, during treatment, and/or while working independently in the gym.

In order for you to succeed in your rehab, it is imperative that you arrive on time for your appointments. If you are 10 minutes late for your appointment, you may not be seen and therefore rescheduled for another day/time. If you accumulate 3 no-show and/or cancellations without a 24 hour notice, *OR* 2 consecutive no-shows, your physical therapy care may be discontinued. You may also be charged a fee of $25 per no-show.

Patient or Authorized Person's Signature: _____ Date: _____

PHYSICAL THERAPY CENTER
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.

This notice of Privacy Practices describes how Physical Therapy Center (We) may use and disclose your "protected health information" (PHI) to carry out treatment, payment and/or healthcare operations and for other purposes that are permitted or required by law. It describes your right to access, and controls your protected health information. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

We are required to maintain the privacy of your health information and to provide you with a notice as to our legal duties and privacy practices with respect to information collected and maintained about you. We are required to abide by the terms of the Notice of Privacy Practices. We may change the terms of our notice at any time. Any new notice will be given to you upon your request and will be effective for all PHI we maintain at that time.

HOW WE MAY USE OF DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe ways we may use of disclose your protected health information. There are explanations of what we mean for each category of uses and disclosures.

*Treatment, Payment and Healthcare Operations
Federal law permits Physical Therapy Center to use and disclose your PHI without your authorization or consent for the purposes of treatment, payment and healthcare operations.
*Treatment
We may disclose PHI to other healthcare providers who are responsible for your medical treatment. For example, we may provide other physicians, upon request, copies of various information to assist him/her in treating you.
*Payment
We may use of disclose information about you to determine coverage eligibility for insurance plan benefits, obtain copayment/coinsurance amounts and to facilitate payment for the treatment/services you receive from our healthcare providers.
*Healthcare Operations
Healthcare operations refer to business functions undertaken by Physical Therapy Center. Operations may include referral/specialist, recommending treatment alternatives and/or providing information regarding services that may be of interest to the individual. Information may be disclosed for purposes of medical review, legal services, audit services, and fraud and abuse detection programs. We will share protected health information for purposes of claim administration on behalf of your medical insurance plan.

Other uses and disclosures permitted without authorization
Federal law allows Physical Therapy Center to disclose PHI without your authorization or consent in the following ways:

- To you or a personal representative designated by you or designated by law to act for you.
- To the Secretary of Health and Human Services or any employee of HHS as part of an investigation to determine our compliance with Federal Privacy laws
- To the State Physical Therapy Board to respond to inquiries/investigations of our practice or requests for audit.
- In response to court order, subpoena, discovery requests or other lawful judicial or administrative proceeding.
- As required for law enforcement purposes. For example, to notify authorities of a criminal act.
- As required by law.
- As required to comply with Worker's Compensation and/or other similar programs established by law.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures
You have the right to request Physical Therapy Center to limit its uses and disclosures of PHI in relation to treatment, payment or healthcare operations. You also have the right to restrict the disclosure of PHI to family members or personal representatives. Any such request must be in writing and must state the specific restriction and to whom it applies.

Right to Access Your Protected Health Information
You have the right to copies of your PHI following the procedures of Physical Therapy Center. Federal law prohibits you from having access to psychotherapy notes: information for use in a civil, criminal or administrative action or proceeding. If your request for access is denied you may file a written complaint to: US Department of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201.

Federal law indicates you read and sign this Notice as notification of your right to an accounting and disclosure rights pertaining to Private Health Information after April 14, 2003.

_____ _____

PATIENT (PARENT/GUARDIAN) SIGNATURE **DATE**