CANYON PHYSICAL THERAPY

907 23rd Street, Canyon, Texas 79015
Phone #806-655-6824 or Fax # 806-655-6823

Patient Information and Registration Form

This Information is Confidential

Today's Date_____

What are we seeing you for today? _____

Patient Name:

_____

(First) (Middle) (Last)

DOB: _____ Age: _____

Address:

_____

City: _____ State: _____ Zip: _____

SSN: _____ Gender: M F Marital Status: S M D W

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Name and Phone Number: _____

Date of Onset/Injury/Accident: _____

Have you had Home Health Care since January? Y / N

If So with Whom: _____

Have you been discharged? Y / N Discharge Date: _____

Have you had outpatient Physical Therapy since January? Y / N / If so with whom:

_____

Have you been in a rehab facility since January? If so with whom:
Y/N_____

Was This A Job Related Injury? Y N If YES, do you have legal representation? Y N

Name of Attorney: _____ Phone Number: _____

Was This A Motor Vehicle Accident? Y N Contact Information: _____

Whom may we thank for your referral to our office?

_____

EMPLOYER INFORMATION

Employer: _____ Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ Contact Person: _____

Phone: (_____) _____-_____ Ext: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____
Contact Phone Number: _____ Policy #_____ Group#_____
Relationship to Patient: Self Spouse Parent Other
Policy Holder's Name: _____ Address:_____
City: _____ State: _____ Zip:_____
Birthdate: _____ Sex: M F_____ Contact Number:_____
SS#_____

Secondary Insurance Carrier: _____

Contact Information: _____ Policy #_____ Group #_____

Patient Signature: _____ **Date**: _____

If patient is under the age of 18, Parent or Legal Guardian must sign below giving consent for the above named patient to receive Physical Therapy treatments.

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

Medical History:

Name: _____ Height_____Weight_____
Referring Physician: _____
Primary Care Physician: _____
Have you had surgery for this injury: Yes No
Type of Surgery: _____
Other Previous Surgeries:

_____

_____

List of Medications you are currently taking:

_____

_____

_____

_____

Have you had any of the following services for this Injury/Episode?
(Please circle if applicable)

Chiropractor CT Scan EMG/NCV General Practitioner Massage Therapist MRI X-Rays

Myelogram Neurologist Orthopedist Podiatrist Physical Therapy Occupational Therapy

Do you have now or have you ever had any of the following?
(Please circle if applicable)
Asthma, bronchitis, or emphysema Stroke/TIA Tuberculosis Diabetes Anemia Arthritis

Severe or frequent headaches Osteoporosis Shortness of Breath/Chest Pain Epilepsy/Seizures

High Blood Pressure Joint Replacement Coronary Heart Disease or Angina Gout Hernia

Sleeping Problems Weight Loss/Energy Loss Allergies Weakness Ringing in the Ears

Pacemaker Blood Clot/Emboli Pins/Metal Implants Thyroid Trouble/Goiter Cancer Radiation

Chemotherapy Infectious Diseases Dizziness/Fainting

Do you smoke? Y or N Pregnant? Y or N

Are there any other conditions or problems that we should be aware of?

Patient/Guardian Signature: _____Date:_____

Benefit Assignment/Release of Information

I hereby assign all medical to include major medical benefits to which I am entitled, including Medicare and 3rd Party payers to Canyon Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment.

Patient/Responsible Party Signature: _____Date:_____

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for that amount of money refunded to your insurance company. In the event your company establishes internal usual and customary fee schedule, you will responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit payment to Canyon Physical Therapy.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim worker's compensation benefits and you are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy

Canyon Physical Therapy will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health Care operations generally include those activities we perform to improve our quality of care.

A summary of our Notice of Privacy Practices is furnished to you at the time of admit, however a complete version of our Privacy Practices is available upon request. I understand what financial obligations I have, as benefits verified are done as a courtesy and is not guaranteed until claims are received from your insurance. **I also understand that any charge(s) that is not covered by my insurance is my responsibility.**

_____ _____

Patient/Guardian/Responsible Party Signature **Date**

CANYON PHYSICAL THERAPY

907 23rd Street, Canyon, Texas 79015

HIPAA Notice of Privacy Practices

This Information is Confidential

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW Y0U CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control 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 or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of Canyon Physical Therapy. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physical therapist or Canyon Physical Therapy has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information,

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physical therapist or Canyon Physical Therapy is not required to agree to a restriction that you may request. If physical therapist or Canyon Physical Therapy believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ **Signature**: _____ **Date**: _____

Responsibilities of Patient

We are **Canyon Physical Therapy** and value YOU as our patient. You are very important to us and we will provide the best possible care available. In turn, we expect you to be on time for your appointments and to not miss your appointments. There will be a $25.00 fee charged for no shows and cancellations within 24 hours of scheduled appointments. We strive to reach the best possible outcomes as expected from you and your physician. Prompt and consistent visits are important to reach your goals.

However, if you are late to your appointment it affects your treatment as well as other patients on the schedule. Many insurance companies require us to treat patients on a one on one basis. If you are more than 20 minutes late, please call us as we may only be able to do a partial treatment or we may have to reschedule you for another time.

Insurance companies require progress reports during your therapy to warrant continuing care and paying for each treatment. If you no call/no show for 3 visits, your lack of progress may require us to discharge you from therapy.

If you are a worker's compensation patient and you miss an appointment that is not made up in the same week, we are required to communicate the missed appointment to your insurance adjustor, case manager, physician/or employer.
Patient initials_____

We schedule patient appointments Monday thru Friday.

Please know that when you go back to the doctor it is necessary for us to update the physician on your progress in physical therapy. Let us know when you have a doctor's appointment as well as any changes made to your appointments.

My next doctor appointment is:_____

Patient/ Responsible Party Signature **Date**

Consent for Care and Treatment

I, _____do hereby agree and give my consent for Canyon Physical Therapy to furnish medical care and treatment to me that is considered necessary and proper in diagnosing or the treatment of my physical and mental condition.

Patient/Responsible Party Signature:_____Date:_____