ALLIANCE Physical Therapy

Patient Information Form

Patient Information

Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security #
Street Address	City, State, Zip			Home Phone
Cell Phone	E-mail Address			Occupation
Work Phone	How would you like us to contact you? [ ] E-mail [ ] Mail [ ] Both			
Employer	Address			Phone
Referring Doctor	Address			Phone

Guarantor/Guardian Information (Responsible Party)

Guarantor/Guardian Name	Sex	Relation to Patient	Date of Birth	Social Security #
Street Address	City, State, Zip			Home Phone

Health Insurance Information

Primary Insurance Carrier	Mailing Address			
Phone	Policy #	Group #		
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security #
Secondary Insurance Carrier	Mailing Address			
Phone	Policy #	Group #		
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security #

Workers Compensation Information

Carrier Name	Mailing Address	Phone
State Accident Took Place	Date of Injury	Claim #	Adjuster/Case Manager

Auto Insurance/ Med Pay Information

Auto Ins./Med Pay Name	Mailing Address	Phone
State Accident Took Place	Date of Injury	Claim #	Adjuster

Attorney Information

Attorney	Mailing Address
Phone	Fax

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in Full (unless otherwise restricted by law or agreement we may have with your insurer). Also some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT. In the event the account is turned over for collections, the collection fees and /or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy. You are also responsible for durable medical equipment purchased at our clinics, which are not covered by your health insurance.

Patient/Parent or Legal Guardian Signature_____ Date _____

Consent for Treatment of a Minor

As a parent and/or legal guardian, I authorize Alliance Physical Therapy to treat the minor patient named in the attached forms while I am not present.

Patient's Name _____ Parent/Legal Guardian Signature _____ Date _____

Consent for Release of Medical Information

I hereby authorize Alliance Rehabilitation dba Alliance Physical Therapy and my therapists to release medical information contained in my/the patient's records to any necessary insurance carrier(s) and/or employer(s) and/or organizations(s), for the purpose of obtaining information and /or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of the records may also be sent to referring physician(s) at the request of the physicians treating me/the patient. Unless noted below, medical records released may include diagnostic and therapeutic information. Withhold from release:
Please specify, if any:_____

Initial_____ Date _____

Consent for Treatment in an Open Setting

Alliance Physical Therapy in compliance with Federal HIPAA Regulations is committed to protecting our patient's health information and privacy. Our therapists and staff will be making every effort to ensure that your protected health information ("PHI") is kept private. However, due to the nature of the open setting of our therapy area, your treatment will be performed in the presence of other individuals. In some instances, it is possible that other patients and staff will overhear information relating to your treatment, diagnosis and insurance benefits.

By signing this consent, you are consenting to the possible disclosure of your protected health information to any other individuals who may be present in the therapy area. By signing below, I acknowledge and agree to the above conditions.

Patient/Parent or Legal Guardian Signature _____ Date _____

No Show/Cancellations

We realize circumstances might cause you to miss a scheduled appointment; however, to provide the best care and service to each patient, we ask that you notify us 24 hours in advance to cancel your appointment. We will be more than willing to reschedule your appointment for a different time on the scheduled day OR within 24 hours. Please be aware that failure of proper notification could result in a No Show/Cancellation fee of $25. We value our patient/therapist relationships and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated but will help you (and others) achieve a positive outcome.

Initial _____ Date _____

Medicare

Alliance Physical Therapy is not a Medicare provider and cannot bill Medicare for you. Due to Medicare's guidelines, we are unable to treat Medicare patients for physical therapy. I confirm that I do not have and do not intend to bill Medicare. **Initial_____ Date _____**

HIPAA 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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physical therapist's practice.

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.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Alliance Rehab and Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision accreditation, certifications, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintain compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Law Enforcement: Your health information may be disclosed to law enforcement agencies 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 states' public health department. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the providers practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed

 The right to receive a printed copy of this notice

COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint in writing with the **Chief Compliance Officer Matthew Hammond, Alliance Physical Therapy, PO Box 1822 Merrifield, VA 22116**. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the **Chief Compliance Officer Matthew Hammond, Alliance Physical Therapy, PO Box 1822 Merrifield, VA 22116. Telephone (855) 806-4296**

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 Officer of your complaint. We will not retaliate against you for filing a complaint.

Alliance Physical Therapy 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 policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

I have read and understand the HIPAA Notice of Privacy Practices

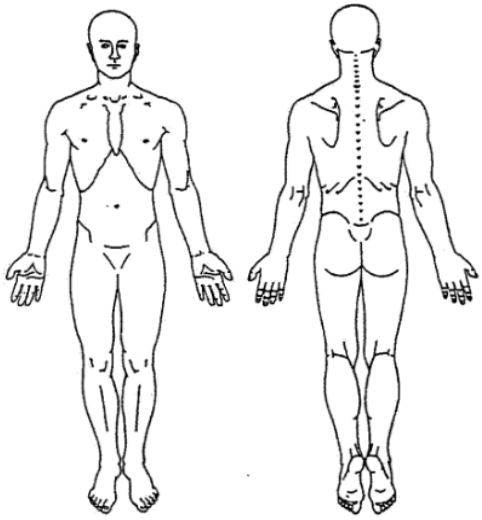
Patient/Parent or Legal Guardian Signature _____Date_____

Patient History

1) What areas of the body (ie. Neck, L-Hip, R-Knee, etc.) or conditions (ie. Fibromyalgia, osteoarthrits, etc.) are you currently seeking physical therapy treatment for?

2) If there are multiple areas of involvement, which region/problem is of greatest concern at this time?

3) Have you been treated for this same problem before? Yes/No If yes, when & who treated this problem?



Shade your areas of pain and discomfort on the figures to the left:
Please rate your pain on the scale below from 0 to 10:
(0=no pain 10= worst pain)
Pain at rest: 0 1 2 3 4 5 6 7 8 9 10
Pain with activity: 0 1 2 3 4 5 6 7 8 9 10
What is the frequency of your pain? Constant Intermittent
Is your pain worse in the: AM PM Mid-Day

4) Current Level of Physical Activity: High Medium Low None List Activities (if any)

5) Please list all prescription medications you are taking, reason for medication (ie: Prozac for depression), Frequency (ie:3 times a day), and Root of Administration (ie: oral). Attach list if needed.

Medical History (Please circle any that apply past or present):

Cardiovascular Disease	Asthma/Breathing Difficulty	Hepatitis/Liver Disease	Depression
High Blood Pressure	Congestive Heart Failure	Epilepsy/Seizures	Anemia
Diabetes (I or II)	Multiple Sclerosis	Thyroid Condition	Osteoporosis
Stroke or Heart Attack	Fibromyalgia	Neurological Condition	Chronic Infections
Arthritis (Osteo/Rheum)	Migraines/Headaches	Eating Disorder	Lupus
Kidney/Renal Disease	Dizzy/Vertigo	Drug/Alcohol Abuse	HIV/AIDS

Cancer (Type:_____Location(s):_____Year:_____Status:_____)
Other:_____

7) Do you have a pacemaker, internal defibrillator, insulin pump, metal fixator or any other implanted medical device(s)?

6) Are you currently pregnant or is there even a possibility you may be pregnant? Yes / No If Yes, how many weeks pregnant are you?

I certify, to the best of my knowledge that the above information is complete and true. If my medical/health status changes, I will inform you immediately.

Print Name: _____ Date of Birth:_____

Patient's Signature:_____ Date:_____