

# Hairston & Daley Physical Therapy

## REGISTRATION FORM

**(Please Print)**

|  |                                  |                          |                      |   |   |   |  |
|--|----------------------------------|--------------------------|----------------------|---|---|---|--|
| Today's date:  |                                  |                          |                      |   |   |   |  |
| <b>PATIENT INFORMATION</b>   |                                  |                          |                      |   |   |   |  |
| Patient's last name:   |                                  | First:                   | Middle:              | <input type="checkbox"/> Mr.<br><input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss<br><input type="checkbox"/> Ms. | Marital status (circle one)<br>Single / Mar / Div / Sep / Wid |  |
| Is this your legal name?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | (Spouses name):          |                      | Birth date:<br>/ /  | Age:  | Sex:<br><input type="checkbox"/> M <input type="checkbox"/> F |  |
| Street address:  |                                  |                          | Social Security no.: |   | Home phone: ( )   |   |  |
|  |                                  |                          |                      |   | Cell phone: ( )   |   |  |
| P.O. box:  |                                  | City:                    |                      | State:  |   | ZIP Code:   |  |
| Occupation:  |                                  | Employer Name & Address: |                      |   | Employer phone no.:<br>( )                                    |   |  |
| Email Address:   |                                  |                          |                      |   |   |   |  |
| Referred to Hairston and Daley by:   |                                  |                          |                      |   |   |   |  |

|   |           |                        |                         |            |                            |                   |
|---|-----------|------------------------|-------------------------|------------|----------------------------|-------------------|
| <b>INSURANCE INFORMATION</b>  |           |                        |                         |            |                            |                   |
| <b>(Please give your insurance card to the receptionist.)</b>   |           |                        |                         |            |                            |                   |
| Person responsible for bill:  |           | Birth date:<br>/ /     | Address (if different): |            | Home phone no.:<br>( )     |                   |
| Occupation:   | Employer: | Employer address:      |                         |            | Employer phone no.:<br>( ) |                   |
| Please indicate primary insurance:  |           |                        |                         |            |                            |                   |
| Subscriber's name:  |           | Subscriber's S.S. no.: | Birth date:<br>/ /      | Group no.: | Policy no.:                | Co-payment:<br>\$ |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |           |                        |                         |            |                            |                   |
| Name of secondary insurance (if applicable):  |           | Subscriber's name:     |                         | Group no.: | Policy no.:                |                   |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |           |                        |                         |            |                            |                   |

|   |  |                          |                        |                        |
|---|--|--------------------------|------------------------|------------------------|
| <b>IN CASE OF EMERGENCY</b>   |  |                          |                        |                        |
| Name of local friend or relative :  |  | Relationship to patient: | Home phone no.:<br>( ) | Cell phone no.:<br>( ) |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Hairston and Daley. I understand that I am financially responsible for any balance. I also authorize Hairston and Daley or insurance company to release any information required to process my claims. |  |                          |                        |                        |
| Patient/Guardian signature  |  |                          | Date                   |                        |

# Hairston & Daley Physical Therapy

## HEALTH HISTORY

**(Please Print)**

|   |             |
|---|-------------|
| <b>NAME</b> <i>(Last, First, M.I.):</i> | <b>DOB:</b> |
|---|-------------|

### HISTORY OF CURRENT INJURY

|                                 |                      |                                     |   |
|---------------------------------|----------------------|-------------------------------------|---|
| <b>CHIEF COMPLAINT:</b>         |                      |                                     |   |
| Pain scale: <i>(circle one)</i> | 1 2 3 4 5 6 7 8 9 10 | Date of injury & onset of symptoms: |   |
| Frequency & Duration of pain:   |                      | Type of pain: <i>(circle)</i>       | Burning Aching Sharp Dull Shooting Other: _____ |
| Location of pain:               |                      | What makes the pain worse/better?   |   |

### PAST MEDICAL HISTORY

|  |   |   |                    |   |   |                     |   |   |                 |   |   |
|--|---|---|--------------------|---|---|---------------------|---|---|-----------------|---|---|
| Have you ever had the following? Circle Y or N |   |   |                    |   |   |                     |   |   |                 |   |   |
| Small Pox                                      | Y | N | Migraine Headaches | Y | N | Bleeding Tendency   | Y | N | Thyroid Disease | Y | N |
| Pneumonia                                      | Y | N | Tuberculosis       | Y | N | Back Trouble        | Y | N | Hepatitis       | Y | N |
| Rheumatic Fever                                | Y | N | Diabetes           | Y | N | High blood pressure | Y | N | Kidney Disease  | Y | N |
| Heart Problems                                 | Y | N | Cancer             | Y | N | Low blood pressure  | Y | N | Parkinson       | Y | N |
| Arthritis                                      | Y | N | Polio              | Y | N | Asthma              | Y | N | Smoking         | Y | N |
| Infectious Mono                                | Y | N | Bronchitis         | Y | N | Stroke              | Y | N | Other:          |   |   |
| Epilepsy                                       | Y | N | Hernia             | Y | N | Aids/HIV            | Y | N |                 |   |   |

### RECENT SURGERIES/HOSPITALIZATIONS/SERIOUS ILLNESS

| Year | Reason | Hospital |
|------|--------|----------|
|      |        |          |
|      |        |          |
|      |        |          |

### CURRENT MEDICATIONS (INCLUDE NON-PRESCRIPTION)

|  |
|--|
|  |
|  |

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|                                   |             |
|-----------------------------------|-------------|
| <i>Patient/Guardian signature</i> | <i>Date</i> |
|-----------------------------------|-------------|

### THERAPIST REVIEW NOTES

|  |
|--|
|  |
|  |

|                            |             |
|----------------------------|-------------|
| <i>Therapist Signature</i> | <i>Date</i> |
|----------------------------|-------------|

# Hairston & Daley Physical Therapy

## HMO CO-PAY POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to your Physical Therapy evaluation/treatment.

All HMO plans have different policies regarding member liability for Physical Therapy Treatments. According to your HMO authorization, they have informed our office that your co-payment is \_\_\_\_\_ **per physical therapy visit** and your maximum duration treatment is \_\_\_\_\_ **per condition**.

Please contact your insurance carrier directly if you have any questions regarding your policy and benefits.

The co-pay **must be paid** at the time services are rendered, or if you prefer, you may pay your co-pay on a weekly basis.

Certain medical supplies are available for purchase, please understand that these items are **not refundable** and payment is expected at the time of purchase. Some of the HMO plans will pay for durable medical equipment, but this does require prior authorization and the item cannot be ordered until we receive that authorization from the HMO medical group.

Thank you for understanding our HMO Policy. Please let us know if you have any questions or concerns.

**I have read and understand the HMO Policy. I agree to pay for my services according to this policy.**

\_\_\_\_\_ (Patient Signature or Personal Representative)

\_\_\_\_\_ (Date)

\_\_\_\_\_ (Print Name)

\_\_\_\_\_ (Relationship to patient)

**I have received a copy of the above information.**

# Hairston & Daley Physical Therapy

## HIPPA

**(Please Print)**

### HIPPA CONTACT LIST

Please provide a list of people who may inquire about your physical therapy. This list may be updated at your request.  
(Examples: Law offices, Schools, Coaches, Personal Trainers, Spouses, Children, etc.)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

**(Please Print)**

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (Hippa). Under Hippa, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I, \_\_\_\_\_ (print patient name or personal representative), acknowledge that **Hairston and Daley Physical Therapy** has provided a written copy of its Notice of Privacy Practices for Protected Health Information to (check one)  myself or  personal representative: \_\_\_\_\_.  
(If signing as a personal representative, documentation of your legal right to do so must be provided).

\_\_\_\_\_  
(Patient Signature or Personal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to patient)

### TO BE COMPLETED BY HAIRSTON AND DALEY PHYSICAL THERAPY

We made a good faith attempt to provide the above patient with a copy of our Notice Privacy Practice for Protected Health Information, but we were not successful for the following reason:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Title)

# Hairston & Daley Physical Therapy

## SUMMARY OF NOTICE OF PRIVACY PRACTICES

A new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") goes into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received our full Notice.

**Your Rights as a Patient.** You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

**Use of Protected Health Information.** We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

**Disclosures of Protected Health Information Requiring Your Authorization.** For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

**Disclosures of Protected Health Information Not Requiring Your Authorization.** We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

**Communication to You of Confidential Information by Alternative Means.** If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

**Restrictions to Use and Disclosure.** You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

**Access to Protected Health Information.** You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

**Amendments to Medical Records.** You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

**Accounting of Disclosures of Protected Health Information.** You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

**Other Uses of Your Health Information.** Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

**How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights.** You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.