



Patient Registration

Name: (Last) (First) (MI)			Social Security #: - -		
Address:			Date of Birth:		Gender: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/>		
Home Phone: ()			Work Phone: ()		
Cell Phone: ()			E Mail:		
Emergency Contact:			Phone: ()		Relationship:
I authorize PCPT to leave messages regarding my appointments/therapy at this number: HM <input type="checkbox"/> WK <input type="checkbox"/> CELL <input type="checkbox"/> E Mail <input type="checkbox"/> Initial: _____					

Insurance Information

Case in Litigation: Yes <input type="checkbox"/> No <input type="checkbox"/>		Name of Legal Counsel:		Phone #: ()	
Primary Insurance Name:			Policy ID#:		
Phone #: ()			Name of Policy Holder:		
Secondary Insurance Name:			Policy ID#		
Phone #: ()			Name of Policy Holder:		

Employment Information

Employer:	Job Title:
Address:	Phone: ()

Physician Information

Referring Physician:	Phone #: ()
Primary Physician:	Phone #: ()

Physical Therapy Information

Have you had Physical Therapy treatment in the past year? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, where?	How long?	
How did you choose <i>Personal Care Physical Therapy</i> for your current therapy? Physician Referred: <input type="checkbox"/> Advertisement/ Phone Book: <input type="checkbox"/> Family/Friend: <input type="checkbox"/>		

Authorizations

<ul style="list-style-type: none"> I understand I am financially responsible to <i>Personal Care Physical Therapy</i> for charges not covered by my insurance carrier. I authorize direct payment of benefits otherwise payable to me to this facility. I understand that I am responsible for forwarding any checks to this facility. I also understand that I will be responsible for 100% of the total amount due if I neglect to forward the checks in a timely manner. In the event there is a potential blood or body fluid exposure to a patient or employee I consent to the administration of an HIV and HBV Antibody test. I agree to pay all interest, court costs, collection and attorney's fees in the event this account is turned over for collections. 	
_____ Signature Patient /Parent or Legal Guardian	_____ Date



MEDICAL HISTORY

Do you have, or have you ever had any of the following:

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered yes to any of the above, please explain: _____

Are there any other medical considerations we should be aware of? _____

Are you taking any medications? If so please list: _____

Date of injury/onset of symptoms:

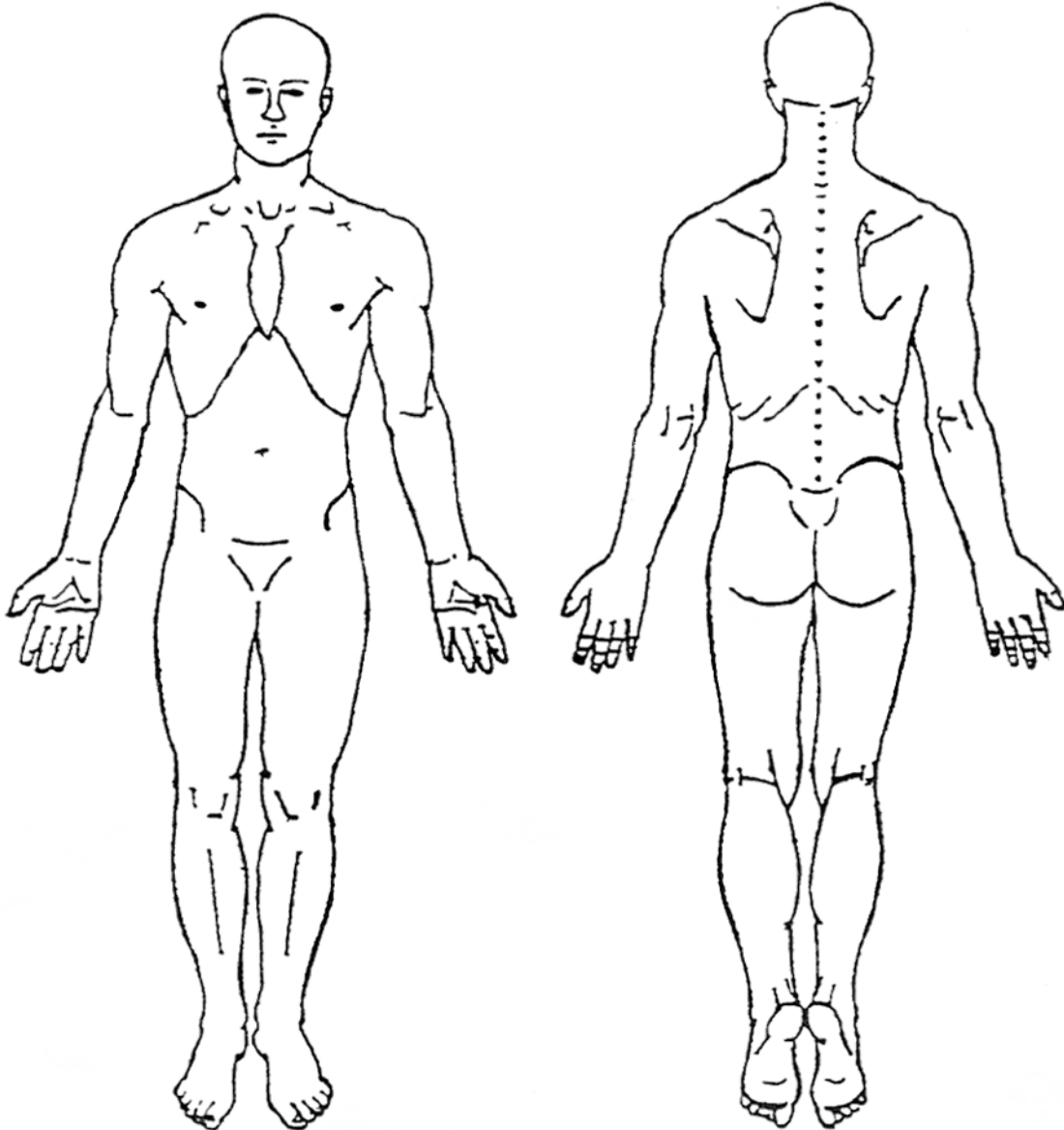
Have you ever had your current symptoms before? Yes No

Please check any of the following that apply to your injury:

- Recreational injury
- Motor vehicle accident
- Recurrence of a previous injury
- Work injury
- Injury from lifting
- Injury from falling
- Other: _____

Please indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain that are not related to your present injury or condition.

KEY	
///	Stabbing
XXX	Burning
OOO	Pins & Needles
===	Numbness



Patient Signature

Date

Relationship to Patient (if a minor)

HEALTH INFORMATION PRIVACY NOTICE

PLEASE READ THIS NOTICE CAREFULLY. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

In this notice, “We” means *Personal Care Physical Therapy* and “You” means each of our patients. Health information which may specifically identify You is called “Protected Health Information”.

We are required by law to protect the privacy of Your health information. The law also recognizes that it is sometimes We necessarily share Your information for purposes of providing Your care, obtaining payment, and conducting health care operations.

Some of the ways We use or disclose Your Protected Health Information:

1. **To Provide Treatment:** We may use your health information to coordinate care within our clinic, with your doctor, and with other health care professionals who may be involved in your care. For example, we may also share your health information with your rehabilitation case manager, physician’s assistant, or nurse practitioner.
2. **To Obtain Payment:** Some insurers require prior authorization and we may need to explain to your insurer why and what services you need. After we treat you, we will ask your insurer to pay us. Your insurer may want to review some of your health information to be sure that your care was medically necessary.
3. **To Conduct Health Care Options:** We may use and disclose health information in our health care operations as necessary to assure quality care for all of our patients. For example, our physical therapists meet periodically to review medical records to monitor the quality of care we provide at our clinic, or we may use it to make decisions in planning for additional space or new equipment. Some health information is used in training students at our facility
4. **Special Uses:**
 - a. To remind you when you have an appointment with us
 - b. To tell you about treatment alternatives that may be of interest to you
 - c. In an emergency when you are unable to speak for yourself
 - d. When required by law. For example:
 - i. When we are required by local, state, or federal law
 - ii. When there are risks to public health
 - iii. To report abuse or domestic violence (when specifically required or when the patient agrees to the disclosure)
 - iv. Oversight activities such as Medicare/insurance audits, inspections, licensure board investigations, etc.
 - v. For Workers’ Compensation or similar programs

Your Authorization May Be Required

All of us here at *Personal Care Physical Therapy* have great respect for you Protected Health Information. We will not disclose your health information, other than with your written authorization, except as required or permitted by law. Also, if you or your representative authorizes us to use your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect To Your Health Information

Your Right to Request Restrictions: You have the right to request a limit on the disclosure of your health information to someone who is involved in your care or the payment of your care. However, we are not required to agree to your request. If you wish to make a request for restrictions, please contact our Privacy Officer, Linda Brabant, P.T. at 928-214-7430.

Your Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. Please place your request with our Privacy Officer, Linda Brabant, P.T. at 928-214-7430. We may charge a reasonable fee for copying and assembling costs associated with your request.

Your Right to Amend Health Care Information. You have the right to request to amend your records if you believe that your information is incorrect or incomplete. The request must be made in writing to our Privacy Officer at our office at 1515 E. Cedar Ave. Suite E-2, Flagstaff, AZ 86004. We may refuse to make the requested amendments. Then you may submit a written statement as to why you disagree. We may then prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

Your Right to Know Who Else Sees Your Health Information: You have the right to request an accounting of certain disclosures that we have made of your health information over the past six years. We do not have to account for all disclosures, including those involving Treatment, Payment, and Health Care Operations as described above. There is no charge for an annual accounting but there may be for additional accountings.

Your Right to Complain: If you believe your privacy rights have been violated, you have the right to make a complaint to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint. You should submit your complaint in writing to our Privacy Officer, Linda Brabant, P.T. at 1515 E. Cedar Ave., Suite E-2, Flagstaff, AZ 86004. Please provide specific detail to enable us to investigate a potential problem.

Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information. Those rules also require us to give you a written copy of this HEALTH INFORMATION PRIVACY NOTICE. We willingly comply with the terms of this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice or privacy practices, we will provide a revised copy to you when you next seek treatment from us or at your request.

Effective Date

This notice takes effect on April 14, 2003



Receipt of Notice of PCPT Privacy Policy

Patient: _____

Chart #: _____

Date of Initial Visit: _____

Initial: _____ I have received a copy of *Personal Care Physical Therapy's* Notice of Privacy Policies. I understand that this information is provided to me to explain how my health information may be used or disclosed by Personal Care Physical Therapy and my rights with respect to my health information.

Release of Information

Initial: _____ *Personal Care Physical Therapy* may use or obtain my health information as noted in the Notice of Privacy Policies. This Facility may use or disclose my health information as required for purpose of providing my treatment, reimbursement, conducting healthcare operations, or as required by local and federal law.

Signature Patient/Parent or Legal Guardian

Date