PATIENT INFORMATION

Last Name _____ First Name _____ MI_____ SEX ____
DOB_____/_____/_____ Age_____
Address _____ City/State/Zip _____
Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____
E-mail Address:_____

How would you like appointment reminders? ☐ Phone Call ☐ Text ☐ E-Mail

Occupation_____ Employer_____
Employer Address_____ City/State/Zip _____
Did this injury occur on the job: _____ YES _____ NO
Human Resources contact:_____

SPOUSE or EMERGENCY CONTACT INFORMATION

Last Name _____ First Name _____ Phone # ( )_____
Address (City/St/Zip)_____ Relationship _____
Spouse DOB _____/_____/_____

PRIMARY INSURANCE INFORMATION:

Insurance Co. Name _____ Name of Insured _____
DOB _____/_____/_____ SS# _____-_____-_____ Relationship _____
Insured's Employer _____
POLICY # _____ GROUP # _____

HIPAA CONSENT: Health Insurance Portability and Accountability Act

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations. You have a right to revoke this consent in writing, singed by you. However, such a revocation shall not affect any disclosure we have already made in relation to you on your prior consent. The practice provides this form to comply with the health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or heal care operations.
2. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3. The practice reserves the right to change the notice of privacy practices.
4. The patient has the right to request restricted use of their information.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters relating to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

I understand that I have the right to obtain a copy of Advanced Physical Therapy Notice of Privacy Practices.

_____ _____
Patient Signature Date