



Registration Form (Please Print)

PATIENT INFORMATION						Date:	
How would you like to be addressed?							
Social Security Number		Last Name	First Name		MI	e-mail address	
Address			Zip Code	City		State	Telephone Number
Date of Birth		Sex (Circle one) Male or Female		If minor name of parent or guardian			
Marital Status (Circle One) Married Divorced Single Widowed Separated		Employment Status (Circle One) Retired Full Part None		Student (Circle One) Full Part None		Relationship to Insured (Circle One) Child Self Spouse Other	
Employer			Position				
Address			Zip Code	City		State	Employer's Phone Number
RESPONSIBLE PARTY (If Patient is responsible party, skip this section)							
Employed (Circle) Yes No		Last Name		First Name		MI	
Address			Zip Code	City		State	
Relationship to Insured (Circle One) Child Self Spouse Other			Social Security Number		Date of Birth		
Employer			Position			Business Phone Number/CellPhone #	
INSURANCE INFORMATION							
Primary Insurance Company			Policy # :		Name of Insured		
			Group #:		Social Security #:		
Address:			ID #		Date of Birth:		
Secondary Insurance Company			Policy #:		Name of Insured		
			Group #:		Social Security #:		
Address:			ID # :		Date of Birth:		
Employer:			Relationship to Insured (Circle One) Child Self Spouse Other				
If work comp, please provide claim number:							
Name of Rehab nurse:			Contact #:				
EMERGENCY INFORMATION							
Person to contact in case of Emergency			Relationship		Phone Number to Contact		
Address			City		State	Zip	

MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name: _____ Date: ___/___/___ Birth date: ___/___/___ Age: _____

Referring Physician: _____ Phone #: _____

Family Physician (if different): _____ Phone #: _____

Diagnosis: _____

Medical History: (Check all conditions that apply to you)

Heart/Circulation	Check	Pain	Check	Medical Conditions	Check
Heart Disease		No Pain Anywhere		HIV/AIDS	
Stroke		Feet		Fainting Spells	
Pacemaker		Knees		Shortness of Breath	
Heart Surgery		Ankles		Dizziness	
Discomfort in Chest		Hips		Kidney Disease	
Angina		Shoulders		Thyroid Problems	
High cholesterol		Abdomen		Difficulty Breathing	
High triglycerides		Low Back		Labored Breathing	
Ankle Swelling		Mid Back		Lung Problems	
High Blood Pressure		Neck		Cancer	
		Head		Depression	
Family History				Anxiety	
Heart Attack				Visual Impairment	
Heart Disease				Hearing Impairment	
High Blood Pressure		Surgical History		Cigarette Smoker	
Diabetes		Low Back		Former Smoker	
Other:		Mid Back		Seizures	
		Neck		Diabetes	
		Shoulder		Tuberculosis	
Bones and Joints		Abdomen		Hepatitis	
Fracture		Hip		Latex Allergy	
Osteoporosis		Knee		Other Allergies	
Osteoarthritis		Ankle		Pregnant	
Scoliosis		Foot		Kidney Problems	
Fibromyalgia		Other:		Epilepsy	
Rheumatoid Arthritis				Fibromyalgia	
Dropped Arches/Feet				Headaches	
Hip Replacement					
Knee Replacement					
Shoulder Replacement					
Deg. Joint Disease					

Have you had surgery for your condition? Y N If yes, please give approximate date: _____

Have you had any injections for your condition? Y N If yes, please give approximate date: _____

Please list any diagnostic tests you have had for this condition: _____

Please list any **medications** that you are taking: _____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset: _____ **Best pain since onset:** _____ **Today's pain:** _____

In the space below, please list several activities that you are unable to do or are having difficulty with as a result of problem.

Activity	Initial					
1						
2						
3						
4						
5						
Additional:						
Additional:						

Total score = sum of the activity scores/number of activities
 Minimum detectable change (90%CI) for average score = 2 points
 Minimum detectable change (90%CI) for single activity score = 3 points
 PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. *Physiotherapy Canada*, 47, 258-263.
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(Date and Score) _____

Therapist's comments: _____

Therapist Signature: _____ Date: _____

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To the best of my knowledge and belief, the information I have given is complete and true. I have received a copy of the Consent for Treatment, Assignment of Benefits, and Payment Responsibility Form, as well as the Financial Policy Form.

Patient Signature: _____ Date: _____

 Legal Guardian Signature (If patient is a minor) Date: _____



**CONSENT FOR TREATMENT, ASSIGNMENT OF MEDICAL BENEFITS
AND PAYMENT RESPONSIBILITY.**

1. **MEDICAL CONSENT:** The undersigned hereby authorize provider to render to Patient physical therapy, occupational therapy or other related services (collectively referred to as “Services”) that Provider, or Patient’s treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider’s rendition of Services. The undersigned acknowledges that no guarantees have been made as to the results of assessment and treatment.
2. **PAYMENT FOR SERVICES:** The undersigned understands that payment is expected at the time of service for all Services. Insurance will be filed for services rendered. Patients with Medicare, Medicaid, and other Managed Care Contracts with whom we have agreements will be honored for all visits. CO-PAYS are expected at the time of service.
3. **LIABILITY CLAIMS:** Assistance will be given to provide the patient with necessary forms for filing, but payment is expected at the time of service.
4. **MEDICAL RECORDS RELEASE:** The Patient or the guarantor of the account hereby authorizes Provider to release Patient’s medical record (including any information furnished Provider or obtained by Provider in connection with Patient’s treatment) to any referring physician, insurance company, health care facility or governmental agency (including the Social Security Administration or any of its intermediaries or carriers) requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker’s compensation claims to both carrier and employer.
5. **MEDICAL INSURANCE BENEFITS:** The undersigned, hereby assigns to Provider all private medical insurance benefits (primary, secondary and medi-gap providers) or other benefits to which Patient may be entitled for any Services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of Patient.
6. **MEDICARE AND MEDICAID AUTHORIZATION:** I certify that the information given by me in applying for payment under TITLES XVII AND XIX of the Social Security Act is correct and I request payment of authorized benefits to be made in my behalf. I authorize Provider to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information about me needed for Medicare claim, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treat to the utilization and quality control peer review organization responsible for reviewing the medical care furnished to me. I further state under both titles that I do not have any other insurance that is to be filed primary over my Medicare and/or Medicaid.
7. **FINANCIAL RESPONSIBILITY:** I acknowledge full responsibility for Services rendered and agree to make definite financial arrangements for payment. I understand that the charges made for the Services may not be covered in full by my health insurance and therefore I am solely responsible for payment of all uncovered Services. I further request that payment be made directly to “Provider” according to assignment of benefits. If payment arrangements have not been made or full payment is not received in 60 days from the date of service, your account may be turned over to an attorney or collection agency. I understand that should the account be sent to an attorney or collection agency, I will be responsible for any and all extra costs or fees incurred. I understand there will be a charge of \$20 for any returned checks.
8. **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:** By signing this form you acknowledge that you have been offered and/or are in receipt of the Notice of Privacy Practices.

Guarantor/Patient Signature

Date

NOTICE OF HIPPA 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.

This notice takes effect on April 1, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and service you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right Too:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by sending a letter to the contact person listed at the end of this notice. If you request copies we will charge you \$15.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions
3. Request that we place additional restrictions on our use of disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different location. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you wanted changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information that you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people your name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services.

- To file a complaint, submit your complaint in writing to: InCreMedical LLC, 9732 Prairie Ave. Highland, IN 46322.
- **You will not be penalized for filing a complaint.**

OTHER USES FOR HEALTH INFORMATION:

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provide to you.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission we will share only the health information that is directly necessary for your health care according to our professional judgment. We will use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoenas, a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institutions under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspection, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law.



Financial Policy

Thank you for choosing Orthopedic Physical Therapy Specialists, LLC as your physical therapy provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship.

Our Financial Policy is as stated:

- All co-pays and deductibles are due at the time of service.
- Payment is due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss this with our Front Office Coordinator.
- We accept cash, checks, or credit cards.
- If any portion of your account balance exceeds 60 days you will be responsible for this amount.

INSURANCE

We accept Medicare, all major insurance and numerous PPO and managed care contracts. Please be aware that some, and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Orthopedic Physical Therapy Specialists, LLC will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of benefits. If this occurs, you will be responsible to pay all fees. If you need assistance in obtaining a referral, please ask our Front Office Coordinator. If payment arrangements have not been made or full payment is not received in 60 days from the date of service, your account may be turned over to an attorney or collection agency. I understand that should the account be sent to an attorney or collection agency, I will be responsible for any and all extra costs or fees incurred.

Please be advised that if you are paying by check, we charge a \$20 fee for returned checks.

Thank you for understanding our financial policies. If you have any questions or concerns, our Front Office Coordinator will be happy to discuss them with you.

I have read the above policies and agree to them. I authorize Orthopedic Physical Therapy Specialists, LLC to provide me with physical therapy services and to furnish information to my insurance company, worker's compensation carrier or attorney concerning my injury and treatment. I understand that I am financially responsible for payment of all services not covered by my insurance carrier.

I authorize payment of benefits directly to Orthopedic Physical Therapy Specialists, LLC for services provided.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

THERAPIST SIGNATURE

DATE



Cancellation, Tardiness, and No Show Policy

Consistent attendance of all therapy sessions is very important and cancellations/no-shows are highly discouraged. You will be provided with a scheduling card with the dates of your appointments. Please arrive on time for your appointment. If you are more than 15 minutes late for your appointment, you may be asked to wait until your therapist is available or more likely, to reschedule your appointment and have a cancellation recorded for that day.

All cancellations and “no show” appointments will be recorded in your chart.

In the event you must cancel an appointment, you will need to call at least 2 hours in advance. This notice is necessary in order to allow the availability of the time slot for other patient’s needing an appointment.

The accumulation of three cancellations and/or no-shows will result in discharge from the therapy program. You will be required to obtain a new referral from your physician before any further appointments can be scheduled.

We appreciate your cooperation in helping us help you and others!

Patient Signature

Date