PATIENT INFORMATION

PLEASE SIGN AND COMPLETE ALL PAGES

IF PT IS MINOR, ALL SHEETS MUST BE SIGNED BY PARENT OR GUARDIAN

*******COPY OF INSURANCE CARDS AND DRIVERS LICENSE IS REQUIRED*******

TODAY'S DATE: _____

PATIENT'S NAME: _____DOB: _____

ADDRESS: _____ CITY/ST/ZIP: _____

HM PH #: _____ CELL #: _____ SS#: _____ AGE: _____ SEX: _____

STATUS: M S D W EMPLOYER: _____ WORK #: _____

SPOUSE / PARENT (IF MINOR) NAME: _____ PH#: _____

PRIMARY INSURANCE: _____ INSURED NAME: _____

INSURED BIRTH DATE: _____ RELATIONSHIP TO INSURED: _____

SECONDARY INSURANCE: _____ INSURED NAME: _____

INSURED BIRTH DATE: _____ RELATIONSHIP TO INSURED: _____

DATE OF INJURY / SURGERY: _____ REFERRING PHYSICIAN: _____

DATE OF LAST DOCTORS VISIT: _____ NEXT APPT: _____

IS THIS INJURY / SURGERY WORKERS COMP RELATED? _____

IS THIS INJURY / SURGERY AUTO ACCIDENT RELATED? _____

IS SOMEONE ELSE RESPONSIBLE FOR YOUR INJURY? _____

DO YOU HAVE AN ATTORNEY OR CLAIM FOR THIS INJURY? _____

IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS, PLEASE SEE FRONT DESK IMMEDIATELY.

MEDICAL HISTORY

PLEASE CHECK EITHER	**YES**	**NO**
DIABETES		
HIGH BLOOD PRESSURE		
CARDIAC PROBLEMS		
PACEMAKER		
JOINT REPLACEMENT		
ARTHRITIS		
OSTEOPOROSIS		
CANCER		

LIST ANY MAJOR SURGERIES OR OTHER SIGNIFICANT MEDICAL HISTORY NOT LISTED ABOVE:

_____

MEDICATIONS: _____

Saraland Physical Therapy
Patient Authorization

Patient's Name: _____ (please print name)

Release of Information & Consent for Treatment:

All information provided herein is true and correct.
I am aware of my diagnosis and wish to receive treatment at Saraland Physical Therapy.
I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Saraland Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, Rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Saraland Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Patient or Guardian Signature: _____ Date: _____

Assignment of Benefits:

I authorize payment directly to Saraland Physical Therapy for services.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

Patient or Guardian Signature: _____ Date: _____

Payment Guarantee:

I agree to pay Saraland Physical Therapy for the services provided to me or the party named above. If any law, such as worker's compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes it coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction.

Patient or Guardian Signature: _____ Date: _____

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address: 205 Hwy 43 N., Saraland, AL 36571 Attn: Privacy Officer
Phone: 251-679-0015
Fax: 251-679-0091

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 80 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of this Privacy Notice is April 14, 2003.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient or Patient's Representative

_____

Printed Name of Patient's Representative *(if applicable)*

_____

Representative's Relationship to Patient *(if applicable)*

To be completed by Saraland Physical Therapy Services:

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) _____

_____

_____

_____ _____

Signature of Saraland Physical Therapy Representative Date

If you would like email or text appointment reminders please provide your email and/ or cell phone # and carrier.

EMAIL: _____

CELL PHONE #:_____

CELL PHONE CARRIER: _____