

OFFICE USE ONLY- RFP/ID VERIFICATION:			
___ Health Ins Card	___ Photo ID		
___ Drivers License	___ Proof of Address		
Date: ___/___/___		Employee Initials: _____	

All-Care Physical Therapy Center

Please fill in all spaces, if not applicable, please put N/A.

Patient Information

Full Name: _____ Birth Date: ___/___/___ Sex: _____

Phone: _____ - _____ - _____ Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ - _____ - _____ Marital Status: _____

Whom may we thank for recommending you to us? _____ Friend Doctor Other

Insurance Information

Was the incident you're coming for related to work or an automobile? (Circle One)

Neither
(Fill out Section A only)

Auto
(Fill out Section A & B)

Work
(Fill out Section B Only)

Section A: Your Health Insurance Information

Primary Insurance

Primary Insurance Carrier: _____ ID#: _____

Primary Insurance Holder: (circle one) self other: _____

Relationship to Patient: _____ Primary Policy Holder Date of Birth: _____

Secondary Insurance

Secondary Insurance Carrier: _____ ID#: _____

Secondary Insurance Holder: (circle one) self other: _____

Relationship to Patient: _____ Secondary Policy Holder Date of Birth: _____

Tertiary Insurance

Tertiary Insurance Carrier: _____ ID#: _____

Primary Insurance Holder: (circle one) self other: _____

Relationship to Patient: _____ Primary Policy Holder Date of Birth: _____

Medicare Patients: Please be advised that Medicare will not pay for a home health aide & physical therapy.

Section B: Workman's Comp Insurance/Automobile Insurance

Please Circle One: Work Auto

Carrier: _____ Policy Holder: _____

Policy Holder Relationship to Patient: _____ Claim #: _____

Case Manager Name: _____ Case Manager Phone: _____

If workman's compensation case, please fill out the following: Work Phone Number: _____ - _____ - _____

Employer: _____ Work Address: _____

City: _____ State: _____ Zip Code: _____

Medical History (Please check all that apply to you.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Recent Fractures | <input type="checkbox"/> Allergies to Aspirin |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Allergies to Heat |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to Cold |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma/Breathing Difficulties |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Bowel/Bladder Abnormalities | <input type="checkbox"/> Falls/Loss of Balance |
| <input type="checkbox"/> Smoking, # of Yrs ___ | <input type="checkbox"/> Liver/Gall Bladder Abnormalities | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin Abnormalities | <input type="checkbox"/> Ringing in your Ears |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Hernia | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Special Diet Guidelines |

Do you have any allergies not listed above? If so, please specify: _____

Are you presently taking any medications? _____ if yes, please list. _____

Is there any additional information in your medical history that we should know?

Employment Information

Are you presently working? _____ What is your occupation? _____
Length of time with work limitations? _____ Any Worker's Comp Case or Litigation? _____

Injury Information

Mechanism of Injury: (please circle all that apply)

Work Related Athletic Motor Vehicle Accident Fall Other: _____

Date of injury, surgery or onset of symptoms: _____ Have you ever experienced these symptoms before? _____

Please specify previous injury & date: _____ Date of Next Doctor Visit: _____

Emergency Contact

Emergency contact: _____ Phone Number: () _____

All-Care Physical Therapy Center offers the services of a Social Worker. If such services apply, please indicate: _____

Payment for Services

Note: All Co-payments are due at time of service. A \$10 fee may be charged for any returned checks.

I have answered all of the above questions accurately to the best of my knowledge. I hereby authorize All-Care Physical Therapy Center to perform upon me the appropriate assessment and treatment related to my condition.

Patient Signature: X _____ **Date:** X ____/____/____

All-Care Physical Therapy Center Notice of Privacy Practices

All-Care Physical Therapy Center is committed to protecting the privacy of our patients. As required by law, we treat all health information confidentially. The following Notice of Privacy Practices describes how medical information about you may be used and disclosed.

Uses and disclosures of Health Information

Pursuant to law, we may use health information about you for your treatment, to obtain payment, for administrative/operational purposes, and to evaluate the quality of care that you receive.

1. We may use or disclose your health information in order to most effectively treat you. This may require the provider to contact your physicians and advise them of your medical condition. It may also be necessary to speak with a care-giver to advise on appropriate care.
2. We may use or disclose your health information in order to obtain payment from an insurance carrier or case manager. Such information will be disclosed on a confidential basis intended only for the addressee.
3. We may use or disclose your health information for administrative/operational purposes. Such information may be used to evaluate the quality of treatment received to insure optimal care. We may also use this information to contact you in the future.

Patient Individual Rights

1. You have the right to review and copy your health information. You must submit requests in writing to the Chief Privacy Officer. There will be a reasonable fee charged for all copying and mailing costs.
2. You have the right to request changes to your health information. Your requests must be made in writing and explain reasoning behind any correction.
3. You have the right to know to whom we have disclosed your health information. We will provide you with a listing of those disclosures upon request.
4. You have the right to request that we restrict or limit the use or disclosure of your health information. We are required to agree to those restrictions. Request for restriction must be made in writing and submitted to the Chief Privacy Officer.
5. You have the right to request that we communicate with you about medical matters in a way or location. Such requests must be submitted in writing.
6. You have the right to receive a copy of this notice upon request.

Complaints

If you are concerned that we have violated your privacy rights or disagree with a decision we made regarding access to your records you may contact the Privacy Officer or send a written complaint to the U.S. Department of Health and Human Services.

Please note that we may amend or alter the Privacy Policies according to HIPAA regulations without notice. A copy of our most current notice will be available upon request.

I acknowledge that I have received a copy of All-Care Physical Therapy Center's Notice of Patient Privacy Practices. I hereby certify that I have read the provisions set for in the consent. I understand and agree to the terms of this consent.

X _____
Patient's Name (Printed)

X _____
Signature of Patient or Representative

X _____
Date

Name of Personal Representative

Relationship to Patient