

OFFICE USE ONLY	
___ F/B of Ins. Card Copied	___ Script Rcvd
RFP/ID VERIFICATION:	
___ Health Ins. Card	___ Photo ID
___ Drivers License	___ Proof of Address
Date: ___/___/___	Employee Initials: ___

All-Care Physical Therapy Center

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

Patient Information

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

Address: _____ City: _____

State: ___ Zip Code: _____ Primary Phone: _____ - _____ - _____ Secondary Phone: _____ - _____ - _____

Alternative Phone(s): _____ E-Mail: _____

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

Whom may we thank for recommending you to us? Name: _____ Friend Doctor Other
(Circle One)

Insurance Information

Payment Services:

- All co-payments are due at time of service. A \$25 fee may be charged for any returned checks.
- **Medicare Patients:** Please be advised that Medicare will *not* pay for a home health aide & physical therapy at the same time.

Is the reason for physical therapy related to work or an automobile? (✓ one below)

- Neither. (Fill out Section A only)
- Automobile. (Fill out Section A & B)
- Work. (Fill out Section A & B)

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: _____

All-Care Physical Therapy Center, LLC

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. **We encourage you to read it in full.**

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.

HIPAA ACKNOWLEDGEMENT & AUTHORIZATION FORM

OFFICE USE ONLY- INABILITY TO SIGN:
 Individual Refused Emergency
 Communication Barrier
 Other: _____

I, _____ (Patient Full Name), born on ____/____/____ (Date of Birth), with social security number ____ - ____ - ____ (Social Security Number), acknowledge that I have received a copy of All-Care Physical Therapy Center's Notice of Privacy Practices that discusses how we may use your protected health information.

By signing this form, I further authorize All-Care Physical Therapy Center, L.L.C to disclose my protected health & billing information to the following recipients based on the criteria of full, partial or basic information disclosure:

Note: Check & fill in all disclosures that are acceptable to you. If you **do not check** any disclosure below we will **not** be able to **leave** you a **voice phone** message. However, you do not have to list the doctor's name that appears on prescription for physical therapy since we are legally authorized to disclose information.

FULL: All-Care Physical Therapy Center, LLC will disclose detailed information to the voicemail/recipient.

PARTIAL: All-Care Physical Therapy Center, LLC will leave All-Care's name, reason for the call & call back number.

BASIC: All-Care Physical Therapy Center, LLC will leave call back phone number only, **not** All-Care's name.

	RECIPIENT DISCLOSURE	FULL	PARTIAL	BASIC
√	Example: 000-000-0000	√		
	My Home Phone(s): _____			
	My Cell Phone(s): _____			
	My Work's Name: _____ My Work Phone: _____			
	My E-Mail(s): _____			
	Spouse/Partner Name: _____ Phone: _____			
	Father Name: _____ Phone: _____			
	Mother Name: _____ Phone: _____			
	Son/Daughter Name: _____ Phone: _____			
	Other Name: _____ Phone(s): _____			
	Address: _____			
	Purpose of use/disclosure: _____			

I understand that once All-Care discloses my Personal Health Information (PHI) to the above recipient(s), All-Care cannot guarantee that the recipient(s) will not disclose my PHI to a third party. The third party may not be required to abide by the authorization or applicable federal and state laws governing the use of my health information. I may revoke this authorization at any time by notifying All-Care in writing to Billing Department, All-Care Physical Therapy Center, and LLC, 67 Lacey Road, Whiting, New Jersey, 08759. However, I do understand that revoking this authorization will not have any effect on any information already used or disclosed by All-Care prior to All-Care receiving my written notice. In addition, revoking authorization will not affect the start, continuation or quality of my treatment at All-Care. If you believe your privacy has been violated, or you disagree with a decision we made about access to your protected health information, you may contact the All-Care Privacy Officer at 732-849-0700 or 866-31-HIPPA.

I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize All-Care to use or disclose my PHI in the manner described above.

The following person(s) are NOT authorized to receive ANY health information:

Print Name: _____ Relationship: _____
 Print Name: _____ Relationship: _____

Signature of Patient or Legally Authorized Representative	Date
All-Care Employee Name	All-Care Employee Signature
	Date

TERM OF AUTHORIZATION: This authorization will remain in effect for the course of your treatment unless otherwise specified below: (Please initial the applicable box.)

From the date of this authorization until the _____ day of _____, 20__
 Until the following event occurs: _____