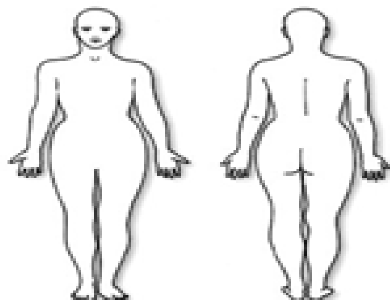
Back in Action PHYSICAL THERAPY

PATIENT REGISTRATION

Patient Name: ______________________________(First)______________(MI)________________________________(Last)
Date of Birth: _____/_____/______ SSN: ______-________-________ Sex: □ M □ F
Mailing Address: ____________________________ City: ______________________ State: _____ Zip: _____________
Phone: (_____)______-__________ Cell: (_____)______-__________ Email: ________________________________
Employer: ____ Employer Phone: _______________________________
Referring Physician: _______________________________ Phone: ______________________________________
How did you hear about us? □ Dr. Referral □ Magazine □ Internet □ Friend □ Employee
Please circle if this condition resulted from and of the following: Work Injury Motor Vehicle Accident Other Accident
Is there currently a claim or lawsuit open or pending regarding this injury? □Yes □ No If yes, please provide the name and phone number to your attorney: _______________________________ Phone: (______)______-__________
Who shall we call in an Emergency? ____Phone: (______)______-__________
Reason for Visit:____
When did your current symptoms begin? (Month/day/year)____
What makes your symptoms worse/better? ____
Have you had any treatment for your current symptoms? ____

Pain Description:

Please shade the areas where you have symptoms:



Rate your current pain on a scale from 0-10 by circling the corresponding number 0-10 (0 = no pain; 10 = requires emergency care)

Current	Best	Worst
10	10	10
9	9	9
8	8	8
7	7	7
6	6	6
5	5	5
4	4	4
3	3	3
2	2	2
1	1	1
0	0	0

Circle the works that most accurately describe your pain:

Shooting **Throbbing** **Deep Aching** **Tingling** **Burning** **Stabbing** **Sharp** **Numbness**

Personal Medical History: Please circle any of the following conditions which you currently have or have had:

Osteoporosis	YES	NO
Cardiac	YES	NO
Cancer	YES	NO
Allergies	YES	NO
Thyroid Problems	YES	NO
Pacemaker	YES	NO
COPD	YES	NO
Vascular Diseases	YES	NO
High Blood Pressure	YES	NO
Diabetes	YES	NO
Arthritis (Rheumatoid/Osteo)	YES	NO
Liver Disease	YES	NO
Psychological/Emotional Problems	YES	NO

Other Medical Problems/ Hospitalizations: ____
____
____

Medications: ____
____

NOTICE OF PRIVACY PRACTICES

Back in Action is required, by law, to maintain the privacy and confidentiality of your medical record information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. This document describes how you can access your medical information, and how this information can be used or transferred. Please review the information listed below.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION:

TREATMENT: Back in Action reserves the right to disclose patient health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

- In order to ensure that we provide our patients with the highest quality of care, back in action reserves the right to seek consultation regarding patient condition from additional health care providers associated with the Back in Action.

PAYMENT: In order to assist in timely reimbursement a patient's insurance provider may receive health information records regarding patient treatment at Back in Action.

- As a courtesy to our patients, we will submit an itemized billing statement to the patient's insurance carrier for the purpose of payment to Back in Action for health care services rendered. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services rendered.

WORKERS COMPENSATION: In order to comply with State Workers' Compensation Laws, Back in Action reserves the right to provide patient information regarding Workers Compensation treatment to the Workers Compensation Agency.

EMERGENCIES: Back in Action may disclose patient health information to notify or assist in notifying a specified family member or other persons the patient has deemed responsible for their care regarding their medical condition or in the event of an emergency or death.

PUBLIC HEALTH: As required by law, Back in Action may disclose patient health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: Back in Action may disclose health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT: Back in Action may disclose patient health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court or subpoena, and other law enforcement purposes.

DECEASED PERSONS: Back in Action may disclose patient health information to coroners or medical examiners

ORGAN DONATION: Back in Action may disclose patient health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH: Back in Action may disclose patient health information to researchers conducting research that has been approved by the institutional Review Board.

PUBLIC SAFETY: In order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public it may be necessary to disclose patient health information to appropriate agencies.

SPECIALIZED GOVERNMENT AGENCIES: Back in action may disclose patient health information for military, national security, prisoner and government benefits purposes.

MARKETING: Back in Action may contact you for marketing purposes or fund raising purposes, as described below:

- As a courtesy to our patients, it is our policy to contact you prior to your scheduled appointment to remind you of your appointment. No personal health information will be disclosed other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment. We also send out recall postcards, Thank You cards, Welcome cards and occasional workshop fliers. No personal health information will be disclosed on this correspondence.

- It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and time, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of sponsored fund-raising events.

CHANGE OF OWNERSHIP: In the event that Back in Action is sold or merged with another organization, patient health information/records will become property of the new owner.

PATIENT HEALTH INFORMATION RIGHTS: You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Back in Action is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information. You have a right to request that Back in Action amend your protected health information. Please be advised, however, that Back in Action is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Back in Action. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES: Back in Action reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Back in Action is required by law to comply with this Notice. Back in Action by calling this office at (480)513-4801. You may make an appointment for a personal conference in person or by telephone within 2 working days.

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COMPLAINTS: Complaints about your Privacy right or how Back in Action has handled your health information should be directed to The Back In Action Clinic Manager by calling (480)513-4801. You may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, OFFICE OF CIVIL RIGHTS
200 INDEPENDENCE AVENUE, S. W. (ROOM 509F HHH BUILDING WASHINGTON, D.C. 20201

ACKNOWLEDGEMENT OF RECEIPT NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I am eligible to receive a current copy of Back in Action's "NOTICE OF PRIVACY PRACTICES", revision date 4-11-03. As required by the Privacy Regulations, Back in Action has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction. **If requested**

By the Privacy Regulations, I am aware that Back in Action has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices.

FINANCIAL POLICY AGREEMENT:

1. ASSIGNMENT OF BENEFITS: I authorize and instruct my insurance company to reimburse BACK IN ACTION, LLC (Practice) directly for all services rendered. This is a direct assignment of my rights and benefits under my insurance policy. This payment will not exceed my indebtedness to the Practice and I agree to pay the balance of the services rendered.
2. INSURANCE BENEFITS: As a courtesy, the Practice or its designated entity, will bill your insurance for all covered services. If my insurance does not pay within 60 days of receipt of a claim, the outstanding balance for all services rendered with non-contracted insurances will become the patient's responsibility and will be due in 30 days.
3. VERIFICATION OF BENEFITS: The Practice will attempt to verify my benefits with my insurance company. However, it is my responsibility to understand my plan benefits.
4. CO-PAYMENTS: All co-payments must be paid up-front. I understand that your contract with the insurance company obligates you to collect the co-payments at the time of service. If I am unable to pay my co-payment, the Practice will reschedule my appointment or offer financial hardship
5. DEDUCTIBLE: The Practice will verify if my deductible has been met. If my deductible has not been met, I agree to pay the balance of the deductible.
6. CO-INSURANCE: I understand I may have a co-insurance portion based on my benefits. I agree to pay my co-insurance balance
7. NON-COVERED SERVICES: Insurance companies have different coverage benefits. If a service rendered by the Practice is considered a Non-covered service by my insurance, I agree to pay for all non-covered services in full.
8. OUT-OF-NETWORK BENEFITS: If the Practice does not participate or accept my health insurance plan, I agree that the Practice will bill my Insurance for out-of-network benefits. The Practice is not contractually obligated to accept what my insurance allows and therefore will be responsible for the remainder of what my insurance does not pay.
9. DENIED OR PENDING CLAIMS: Insurance companies routinely deny or pend claims for various reasons. If after the Practice has appealed the claim but remains denied or pended, the balance of the claim will be billed to the patient. Ultimately, the patient is responsible for any unpaid claims. It is best that the patient contact their insurance company directly and try to resolve any dispute.
10. SELF-PAY: If I have no insurance coverage or have no out-of-network benefits, I agree to pay the total amount of $ 75.00 for services rendered in full.
11. SECONDARY INSURANCE: The Practice will automatically file claims to secondary insurance when they are Medicare primary.
12. MOTOR VEHICLE ACCIDENT (MVA) AND/OR LIEN CASES: It is the Practice's policy that all MVA patients provide information on their health insurance, motor vehicle insurance, the other party's motor vehicle insurance, and the Attorney (if represented by an Atty.). A signed Lien agreement will also be required. I understand that the Practice will first bill my regular health insurance for all services rendered then send my attorney the balance for settlement. If I am not represented by an Atty., then the Practice will bill my motor vehicle insurance company. I am ultimately responsible for any unpaid balances.
13. WORKER'S COMPENSATION CASES: All workers' compensation cases have to be reported to the appropriate person or entity. I will need to provide the following information: WC insurance info, Case Worker/Contact person's name and number, claim number, date of injury, employer info and any more info required by the Practice. The Practice will not balance bill the Patient unless it is determined by WC that the injury was not work related.
14. LATE PAYMENT AND COLLECTIONS: If payment for patient due balances is not received on time, a late payment fee of $30.00 will be assessed on my account. If my account is turned over to an outside collection agency due to non-payment, then a collection administrative fee equal to 30%, but no less than $30.00, of the outstanding balance will be assessed on my account.
15. RETURNED CHECKS: If my check payment is returned for any reason, a returned check charge of $30.00 will be charged to my account. The Practice will then require that all payments be made by cash or credit card.
16. NO SHOW AND LATE CANCELLATIONS: If I "Cancel" or "No Show" without a 24 hour notice. There is a fee of $20.00 that will be charged per offence and 2 or more missed appointments will result in a permanent Discharge. These fees are my responsibility and cannot be billed to my Insurance. Medicare, AHCCCS, Worker's Compensation and Lien Cases will not be billed but may be discharged for non-compliance.
17. PATIENT RECORDS: I understand there is a processing fee for request of my patient records.

I have read, understand and agree to the terms of this financial policy agreement and give CONSENT FOR TREATMENT

I understand that I have been referred for Physical Therapy treatment and rehabilitation to Back in Action of Scottsdale. My physical therapist at Back In Action of Scottsdale has described to me my individual treatment plan. I understand that I have the right to ask and have answered any questions prior to receiving any treatment, including risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. I also understand that I have the right to refuse any treatment prescribed by my physician or recommended by my therapist. By signing this agreement, I consent to have Back In Action of Scottsdale provide treatment and care as prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Back In Action of Scottsdale provide treatment and care as prescribed by my physician and/or recommended by my therapist.

PATIENT/GUARDIAN SIGNATURE:____ **DATE:** ____________________