Patient Registration Form

Todays Date:_____

Personal Info

_____ Male/Female
Last Name First Name Age

_____
Street Address City State Zip

(_____)_____(_____)_____
Home Phone Cellular Phone

_____(____)_____
Emergency Contact Person Phone # How is this person related to you

_____(____)_____
Occupation Employer Name Phone#

My condition is related to:____Work injury___Auto Accident____Other_____

Date of accident or injury_____Date of Birth_____ ___Single___Married

Work Status:__Currently Employed___Retired____Disabled___Student(P/T__F/T)___Other

Referral Info

_____
How did you hear about us?
Who should we thank for the referral?

_____
Referring Physician Name

_____
Primary Physician Name

Do you have a follow-up appointment with the physician?_____

If yes, when?_____

Communication

How would you like to receive appointment confirmations?

Please check all that apply:

_____ Phone Call_____E-mail

_____Text messages

Medical History Form

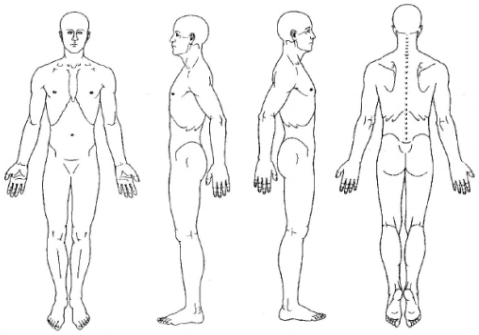
Date _____
Name_____
Occupation_____Currently Working? Yes/No
Rehabilitation goals _____
_____
Current Restrictions_____

History of Current Injury

Date of Injury or Estimated Onset___/___/_____ Date of Surgery___/___/_____

Cause of injury/symptoms _____
_____

Tell us about your pain



Please use the diagram to indicate the location of your symptoms and check the appropriate words below that best describe your pain/symptoms

__Dull Ache	__Sharp/Stabbing	__Stiffness
__Burning	__Numbness/Tingling	__Radiating
__Throbbing	__Constant	__Intermittent
__Weakness	__Swelling	

Other:_____

Rate the severity of your pain on a scale of 0 to 10
(0=no symptoms, 10= severe requiring visit to ER)
Current ___/10 Worst___/10 Best___/10

Are your symptoms getting ___Better ___Worse ___Same
Do your symptoms ease when you rest in a comfortable position? ___Yes___No
Do your symptoms disrupt your sleep?___Yes___No
Have you recently had a fever, infection, or other illness?___Yes___No
What makes you feel worse_____
What makes you feel better_____

Previous treatments for this condition

- Injections
- Medications
- Physical Therapy
- Surgery

Recent Diagnostic Studies

- X-Ray
- MRI
- Bone Scan
- CT Scan
- EMG

Medical History *Please mark below if you have been diagnosed with or received medical treatment for any of the following conditions*

- Diabetes
- High Blood Pressure
- Heart Condition
- Heart Attack
- Pacemaker
- Stroke or TIA
- Cancer _____
- Seizure or Epilepsy
- Rheumatoid Arthritis
- Other Arthritic Conditions_____
- Osteoporosis or Osteopenia
- Neurological Condition_____
- Severe Headache or Migraine
- Dizziness or Frequent Falls
- Thyroid Condition
- Kidney Disease
- Bowel or Bladder Disorder
- Circulatory Problems or DVT
- Peripheral Neuropathy
- Anemia
- Asthma
- Pulmonary Condition
- Smoking ___packs per day
- Alcohol or Chemical Dependency
- Depression
- Anxiety
- Fibromyalgia
- Prior Fractures_____
- Latex Sensitive
- Hearing Loss
- Vision Problems
- Sleep Disorder

Do you ever feel unsafe in your home or threatened by a family member? Yes___No___

Are you now or could you possible be pregnant? Yes___ No___

Any recent changes in sleep quality, energy level, or uninterested in things you enjoy? Yes___No___
Do you regularly exercise? Yes__No__
#of days/week_____-

Please mark any of the following that are **New or Unusual for you:**

- Unexplained weight loss/gain
- Night Sweats
- Difficulty breathing
- Regular cough
- Heartburn/indigestion
- Heart racing/palpitations
- Excessive bleeding or easy bruising
- Skin Rash
- Constipation/Diarrhea
- Blood in stools or urine
- Problems urinating or incontinence
- Arm or leg swelling

Are you currently taking any of the following **Over the Counter medications**?

- Aspirin
- Advil, Motrin, or Ibuprofen
- Aleve
- Decongestants or Antihistamines
- Tylenol
- Antacid
- Laxatives
- Supplements/Vitamins

Please list your current prescription medications_____
_____
_____

Prior surgeries with approximate dates_____

_____
Patient Signature

ACTION PHYSICAL THERAPY
3443 Huntingdon Pike suite 2 Huntingdon Valley, PA 19006
215-947-3443 phone 215-947-4141 fax

Patient Authorization Record

Initial here	
	Authorization for Treatment I hereby give authorization for the performance of such rehabilitation procedures as permitted by *Action Physical Therapy* Statutes under the appropriate scope of practice that are, in the judgment of my therapist, deemed necessary.
	Authorization for Release of Information I agree that Action Physical Therapy may provide information from my medical record to persons involved in my medical care. I authorize the release of medical information necessary to obtain payment of any benefits available to me to Action Physical Therapy for services rendered. I agree that Action Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment I authorize that direct payment of any benefits available to me be released to Action Physical Therapy for services rendered.
	Patient Agreement I agree to pay *Action Physical Therapy* charges for services rendered to me during my course of treatment. I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit.
	Medicare, Medicaid, and Similar Benefits I agree that the information given to *Action Physical Therapy* in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *Action Physical Therapy* may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation I agree that the information given to *Action Physical Therapy* in applying for benefits under Workers Compensation is complete and accurate. I agree that *Action Physical Therapy* may give intermediary's information necessary to process claims.

_____

Patient signature Date

_____

Printed patient name Witness Signature Date

_____

Signature of Legal Representative/POA

Action Physical Therapy 2019 Cancellation Policy

Our clinic is now enforcing a strict cancellation policy as of 1/1/2019

If you cancel your appointment without giving at least **24 hours notice** or no show to an appointment, a **$30 late cancellation/no show fee will be applied to your account**. We realize that emergencies and scheduling conflicts can arise; therefore this fee can be waived with a doctor's note or receipt from a pharmacy in the case of illness and on a case by case basis for personal/family emergencies. For any patients who show up **15 minutes late to his/her appointment, the appointment will have to be rescheduled and the $30 fee will be enforced**. We need at least 24 hours' notice to be able to fill any open appointments from patient cancellations. The charges will be your responsibility and must be paid on your next visit. This cancellation policy is in place out of respect to our therapists as well as our patients, as advance notice for cancellations gives us an opportunity to provide an open appointment time to someone else who needs treatment.

- **3 same day cancellations** during your treatment will result in being placed on our same day cancellation list, at which time you will not be able to hold scheduled appointments. You will be able to call in same day to see if we have available appointments or we can take down which days/times work better for you and call you if we have any cancellations.
- **2 no shows** during your care will result in your case being discharged from our clinic.

Patient's Signature: _____Date:_____

Please complete the following if the patient is *a minor or unable to consent.*

Name of person legally authorized to sign for this patient:

_____

Relationship to patient: _____

Signature of Authorized Person: _____ Date:_____

Action Physical Therapy Important Company Policies

We strive to provide you the best-personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully, initial all the underlines.

Cell phones must be shut OFF or silent. We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

Children requiring supervision are NOT allowed to attend sessions with you. You may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly, you may bring them in. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Important Notice from the Federal Government: "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. You may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA].

Home care *(for Medicare patients only*). I understand that **Medicare does not pay for outpatient Physical Therapy if it occurs at the same time as a Home Care episode.** I understand that I will be personally responsible for payment in full of all charges for physical therapy services if Medicare does not cover it due to having a home care episode.

Patient's Signature:_____ Date:_____

Please complete the following if the patient is *a minor or unable to consent.*

Name of person legally authorized to sign for this patient:

_____

Relationship to patient:_____

Signature of Authorized Person:_____

Date:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

(1) **Patient's Printed Name**:

_____
Last First Initial or Other

Date of Birth: ____/_____/___ Insurance # exactly as on card (including letters)_____

(2) Action Physical Therapy will only disclose the protected health information you want disclosed.

Check only one box to tell Action PT the specific information you want disclosed/released:

☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)

☐ Limited information (complete ALL Sections)

☐ ALL records regarding my care at Action PT to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination _____ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History _____ Treatments _____Other _____

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Other: _____

(5) Check only one box indicating how long Action PT can use this authorization:

☐ Disclose my information indefinitely (as long as Action PT has custody of my files)

☐ Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_____ I understand that this authorization does not expire unless I have indicated an expiration date above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_____ I understand that if I give authorization I may revoke it at any time by notifying this Action PT in writing
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if Action PT requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ Action PT will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

_____ **or** _____

Signature of Patient **Date** **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**

Action Physical Therapy Patient Contact Sheet

Please fill in the following information (and please check all that apply and provide contact info)

Cell phone_____ Home phone_____

____OK to leave messages with detailed information HOME ___ CELL___

____OK to leave messages with callback information only HOME____ CELL____

____OK to text regarding important office information (i.e. Office closing, Emergencies etc.)

E-mail communication_____

Keep up to date with everything that is going on at Action Physical Therapy! We send out valuable wellness information and update you on upcoming events including our workshop and health fair educational programs...oh, and we give away cool things too!

Also, if there are any emergencies at the office (snow closing, your therapist calls in sick), we want to let you know. Your email safe with us… We promise we NEVER share of sell your email to anyone else. And, you can unsubscribe from our list at any time by clicking on “Unsubscribe” at the bottom of ANY email.

I understand that the use of cell phones/home phone and email will be method of communication as a patient at Action Physical Therapy. I am allowing Action Physical Therapy to use these methods of communication in the future for any communication needs they may have.

Patient Signature_____

Today’s Date_____

HIPAA Notice of Privacy Practices
Action Physical Therapy
3443 Huntingdon Pike suite 2, Huntingdon Valley, PA 19006
215-947-3443 phone 215-947-4141 fax
www.actionphysicaltherapy.com

Effective Date: *07/24/2013*

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.

If you have any questions about this notice, please contact Paul Berman at 215-9473443.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in

procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Paul Berman. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Paul Berman.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Paul Berman.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Paul Berman. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Paul Berman. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.actionphysicaltherapy.com To obtain a paper copy of this notice, please ask the receptionist at the time of you appointment.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Paul Berman. All complaints must be made in writing. **You will not be penalized for filing a complaint**.