# MAIN STREET PHYSICAL THERAPY

## Physical Therapy in a Fun Tropical Setting

REGISTRATION FORM(Please Print)

| **Today's date:** | **Therapist:** | **Location:** |
|---|---|---|

**PATIENT INFORMATION**

| **Patient's last name:** | **First:** | **Middle:** | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|
| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| **Address:** | Social Security # | Home phone # Cell Phone: | | | |
| **P.O. box:** | City: | State: | ZIP Code: | | |

**Employer Name & Address:**
**Phone # & Occupation:**

**Referring Physician: Name:** **Phone #:**
**Address:**

Primary Doctor: Name: Phone#

**Diagnosis:** **Date Last Seen:**

**Patient's E-mail address:** **Next Doctor's Appointment:**

**RESPONSIBLE PARTY/POWER OF ATTORNEY (IF DIFFERENT FROM PATIENT)**

| Last name: Circle one: Spouse Mother Father POA | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|
| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| Street address (if different) | Social Security # | Home phone # | | | |
| P.O. box: | City: | State: | ZIP Code: | | |
| Occupation: | Employer: | Employer phone # | | | |

**INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD AND I.D. TO RECEPTIONIST)**

**Primary Insurance** Insurance Phone #

ID# GROUP# Insurance Address:

Subscriber's name: Subscriber's S.S. no.: Birth date:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

**Secondary Insurance** Insurance Phone #

ID# GROUP# Insurance Address:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

**Auto Injury** ☐ **Yes** ☐ **No** **Work Injury Claim** ☐ **Yes** ☐ **No** **Attorney Information** ☐ **Yes** ☐ **No**

Auto Insurance/ Workers Comp Insurance/Attorney Firm:

Address: Phone No. Fax No.

Adjuster/Claim Manager: **Date of Accident/Injury:** Claim#

**Attorney Information** ☐ **Yes** ☐ **No** **Name of Firm:**

**IN CASE OF EMERGENCY**

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone # | Work phone #/Cell Phone |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Main Street Physical Therapy or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date:*

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# HEALTH QUESTIONAIRE

**Please answer** the following **questions based on your current conditions:**

1. When did your injury/illness/problem begin?

FOR OFFICE USE ONLY

2. Have you been hospitalized or had surgery for your problem? Yes/No
   If yes, please give dates: hospitalized from ________to______. Surgery on __________

3. Have you received any treatment or physical therapy for this condition or a similar condition previously? Yes/No
   If yes, please give dates:

4. Which positions or activities make your condition worse?

5. Which positions or activities make your condition better?

6. Are your symptoms worse in the morning or at night?

7. Please list any other medical conditions (examples: heart attack, high blood pressure, diabetes, etc.)

8. What are the names of your current medications and dosages (including prescription, over-the-counter, herbals, vitamin/mineral/dietary/health supplements)? Use back if more space is needed, or give us a written list.

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**HEALTH QUESTIONAIRE CONTINUED**

9. Have you had any special tests performed regarding this condition? (for example, x-ray, MRI, etc.) If so, please list:

10. Are you currently employed? Yes/No
    If so: job tittle ___________________ Duties__________________________

    Is your condition related to your employment? Yes/No

11. How is your general health?

12. Have you fallen in the last year? Yes/No If yes: how many times?__
    Did you injure anything? Yes/No
    Describe the fall and injury if any:

13. Please shade in on the body chart areas where you are <u>currently</u> having symptoms or complaints: (for example, pain, numbness tingling, stiffness, weakness)
    Circle the words that describe your symptoms:
    sharp, dull, ache, stiff, weak, other:----

DO SYMPTOMS INCREASE WITH:

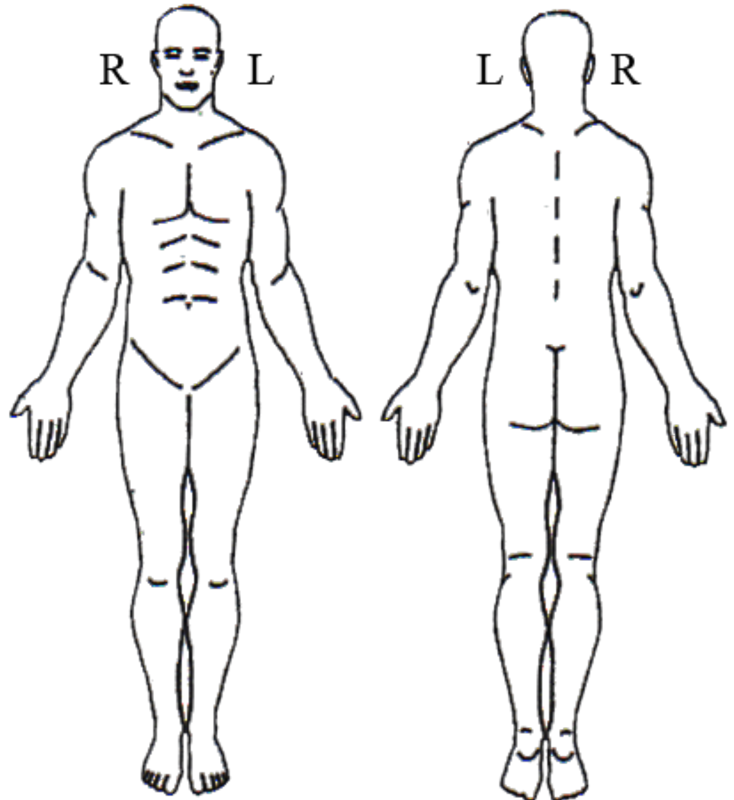
| | | |
|---|---|---|
| COUGHING | YES | NO |
| SNEEZING | YES | NO |
| BOWEL MOVEMENTS | YES | NO |

DO YOU HAVE ANY NUMBNESS?
YES NO

IF YES WHERE? ________________

TINGLING/PINS/NEEDLES? Yes No

IF YES WHERE? ________________




I verify that the above information is complete and accurate to the best of my knowledge.

______________________________________________________________
Signature (patient or representative) Date

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## MAIN STREET PHYSICAL THERAPY CONSENT FOR CARE

I grant permission to Main Street Physical Therapy, P.C. to perform examinations and medical and therapeutic procedures professionally deemed necessary or advisable for my diagnosis and treatment.

## CONSENT FOR RELEASE OF INFORMATION

I authorize Main Street Physical Therapy, P.C. to release:

1. Any or all of my/the patient's medical information from and to referring physicians, health care providers, insurance companies, and other third party sponsors to facilitate healthcare, processing of claims and audit payments for treatment.
2. Basic patient information regarding date and time of appointment(s) to family members (parents, spouses, adult children, guardians), and caregivers.

## FINANCIAL AGREEMENT

All patients, with the exception of Mercy Care, Evercare, APIPA, AHCCCS, and Industrial will be responsible for payment.

If this is a private insurance claim, I agree to be responsible for the full amount of charges, from the date of delivery, if my insurance does not pay for the charges in a timely manner, or if I fail to provide within thirty (30) days the information necessary to submit the claim for payment. I will notify you of any changes in insurance status. I further understand that the benefits information quoted does not guarantee payment until the claim is submitted and reviewed for medical justification and benefits determination.

This offices does accept Medicare and Tricare assignment. I agree to pay all copayments or co-insurance amounts not reimbursed under the medical insurance part of the Medicare part B program and/or secondary insurance for services rendered. For your insurance to be billed, a valid prescription and proper insurance information is required at the time services are rendered. A new prescription is required every 30 days for Medicare patients.

I have read, understand, and accept the terms above:

Signature:__________________________________________Date:_________________

If signed by person other than patient, please provide relationship to patient

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# MAIN STREET PHYSICAL THERAPY
# NO-SHOW/CANCELLATION POLICY

We strive to provide all of our patients with the best care possible and use our/your time efficiently. Therefore, we do not over-schedule appointments. When scheduling your appointments, please remember the following:

- We ask that you show consideration to your therapist and other patients (that may need the appointments) and notify us 24 hours in advance if you must cancel your appointment. Cancellation without 24-hour notice or no-showing for your appointment will result in a $25 fee to your account, which your insurance will not pay for. All missed appointments will be documented in your medical record.
- We allow up to 2 missed visits, as we understand that situations occur beyond your control.
- If you no-show 3 visits you will be discharged for non-compliance and your physician will be notified.
- If you cancel 3 visits, you may be discharged. This will be determined on a case-by-case basis.
- Please remember that we can be flexible with rescheduling, but we ***must hear from you.*** Our office number is (928) 343-7828 or you may leave voice messages after hours at (928) 343-7828. If a voice message is left, our office will call you on the next business day to confirm that your message was received.

I have received and understand the no-show/cancellation policy for Main Street Physical Therapy

___

Patient Signature Date

**Notice of Privacy Practices**

I, ______________________________________have read and received
A copy of the Notice of Privacy Practices.

______________________________________________________________________________
Signature                                                                                    Date

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# NOTICE OF PRIVACY PRACTICES

**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.**

**1) Uses and Disclosures** We, Main Street Physical Therapy, will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

**Treatment** includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

**Payment** includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

**Other Special Uses**

Main Street Physical Therapy may use your PHI to send you an appointment reminder.

**Uses and Disclosures Required by Law**

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

**2) Your Privacy Rights**

**Restrictions**

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

**Confidential Communications**

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

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# NOTICE OF PRIVACY PRACTICES CONTINUED

**Access to PHI**

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

**Amendments**

You have the right to request an amendment to be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

**Accounting of Disclosures**

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment or health care operations or for which we have obtained authorization.

**Complaints**

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

**Our Duty To Protect Your Privacy**

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you seek treatment from us.

**Privacy Contact**

If you would like more information about our privacy practices or to file a complaint you may contact:

Mark Plante or Rebecca Sizemore
381 S. Main Street
Yuma, AZ 85364
(928) 343-7828

**EFFECTIVE DATE**

This Notice will take effect on April 14, 2003.
Updated February 28, 2012

Source: American Physical Therapy Association