CHILTON COUNTY PHYSICAL THERAPY
PATIENT DEMOGRAPHIC SHEET

NAME:______________________________

ADDRESS:____________________________

PRIMARY PHONE-______________________

DOB___/___/___   SSN____-____-____

REFERRING MD________________________

DIAGNOSIS: __________________________

LAST MD VISIT________________________

HOME HEALTH ________________________

RECENT PT (WHERE/ # VISITS_____________

PRIMARY INS:_________________________

CONTRACT#:______________GROUP_______

SECONDARY INS:_______________________

CONTRACT#:______________GROUP_______

IF YOU NO SHOW TWO TIMES, THE FOLLOWING VISITS SCHEDULED WILL BE CANCELLED AND IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR APPOINTMENT IT WILL BE RESCHEDULED. PLEASE INITIAL_________

Patient Name: ______________________________

Please read, date and sign the bottom portion.

Verification of Insurance Coverage

Primary Insurance

Name of Insurance Company: ______________________

Policy Number: ______________________

Pre-certification Required? ______________________

Deductible/ Remaining: ______________________

Copay/Co-Insurance: ______________________

Limitation: ______________________

Secondary Insurance (if applicable)

Name of Insurance Company: ______________________

Policy Number: ______________________

Pre-certification Required? ______________________

Deductible/ Remaining: ______________________

Copay/Co-Insurance: ______________________

Limitation: ______________________

Agreement

Date: ______________________

Our agreement is with you, not your insurance company. Although we will assist you in submitting your claim to your insurance carrier, you are ultimately responsible for the service you receive. Payment to our office is neither contingent nor dependent upon your insurance carrier. You will be responsible for all deductibles, co-pays, co-insurances and any charges not covered at 100% unless a previous arrangement has been made. I have read and understand my financial responsibilities under this policy of Chilton County Physical Therapy.

Patient (or Responsible Party)
Signature______________________________

Medical History

Today's Date ______________

Name: ______________________________ Date of Birth: ______________

Primary Care Physician: ______________ Who referred you to us? ______________

Marital Status: ______________ Number of Children: ______ Occupation: ______________

Drug Allergies: ______________________________

Other Allergies: (Please Circle). Iodine Latex Tape Other: ______________

Hand Dominance: (Please Circle) Right Left Height: ______ Weight: ______

Present Medications	Medical Problems (i.e., diabetes, hypertension, etc.)	Previous Surgeries	Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Hospital Admissions (non-surgical): ______________________________

Do you use tobacco products? _____No _____Yes _____# Packs per Day

Do you drink alcohol? _____No _____Yes _____# Drinks per Week

Are you pregnant? _____No _____Yes

Have you ever had or experienced or are currently experiencing:

____Y ____N Vision/Eye Problems
____Y ____N Migraine Headaches
____Y ____N Epilepsy
____Y ____N Dizziness
____Y ____N Blood Clots
____Y ____N Tuberculosis
____Y ____N Heart Attack
____Y ____N Diabetes
____Y ____N Weight Loss
____Y ____N Blood in Stool
____Y ____N Thyroid Disease

____Y ____N Blood in Urine
____Y ____N Skin Rash
____Y ____N Hearing Loss
____Y ____N Irregular Heartbeat
____Y ____N Shortness of Breath
____Y ____N Wheezing
____Y ____N Pneumonia
____Y ____N Stroke
____Y ____N High Blood Pressure
____Y ____N Swelling Feet/Ankles
____Y ____N Vomiting of Blood

____Y ____N Kidney Stones
____Y ____N Bleeding Disorder
____Y ____N Arthritis
____Y ____N AIDS
____Y ____N Depression
____Y ____N Anxiety
____Y ____N Cancer
____Y ____N Gout
____Y ____N Numbness

Family History:

____Y ____N High Blood Pressure ____Y ____N Anesthetic Complications ____Y ____N Diabetes

____Y ____N Heart Disease ____Y ____N Cancer Other ______________

Today's Visit: Length of Symptoms: _____ Days _____ Weeks _____Months _____Years

Have you ever had similar symptoms before? _____Y _____N

Where is your pain? ______________________________

Have you had previous treatment for this problem? _____Y _____N By Who? ______________

Did you have an accident of injury? _____Y _____N Accident/Injury Date: ______________

Where did it happen? ______________________ (i.e., home, work, car accident, etc.)

Signature ______________________________ Date ______________

Chilton County Physical Therapy
405 Ollie Ave
Clanton, Al 35045

Phone: (205)755-6110 www.chiltoncountypt.com Fax: (205)755-6108

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

- Abuse and Neglect
- Emergencies
- National Security
- Judicial and Administrative Proceedings
- Law Enforcement
- Public Safety (Duty to Warn)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Courtnay Dunn, at 405 Ollie Ave Clanton, Al 35045:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** . You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Courtnay Dunn, our Privacy Officer, at 405 Ollie Ave Clanton, AL 35045, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is 10/25/2014.

Patient Signature: ______________________

Please list anyone we are allowed To give information to:

Consent for Care Form

This insurance information has been recorded based on the benefits and eligibility supplied to us by your insurance carrier, and is not a guarantee of payment. Estimated coverage information is given, as a courtesy to our patients. Though, it is not a release of total responsibility for the account balance. It is our policy to bill your insurance carrier; although, you, the patient, are responsible for the entire bill when services are provided to you. The above doesn't apply to patients considered Workers Compensation; however, as compensation you may be held responsible for the charges, in the event your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Chilton County Physical Therapy. I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If further therapy is required beyond the authorization period, I will follow-up to make sure that any additional authorization has been obtained from the insurance carrier prior to additional treatment. If I incur rehabilitation without authorization from my carrier, I will be responsible for the charges in full as well as any non-covered services. I will also be liable for all treatment that exceeds what is allowed by my insurance plan. It is my responsibility to ensure this information remains valid throughout my treatment.

Patient Signature_______________________ Date__________

Consent for Care and Treatment

I, the undersigned, agree and give consent to Chilton County Physical Therapy to supply medical care and treatment, considering the necessary and proper diagnosis of their physical condition.

Patient Signature_______________________ Date__________

CHILTON COUNTY PHYSICAL THERAPY

AS OF AUGUST 1, 2019 THERE WILL BE A CHARGE OF $35.00 ADDED TO YOUR ACCOUNT FOR ALL APPOINTMENTS NOT CANCELLED 24 HOURS BEFORE YOUR APPOINTMENT TIME.

THANK YOU

PLEASE SIGN AND DATE

________________________________ ____________