Initial Eval: _____

PATIENT REGISTRATION

Patient Information

Patient Full Name:_____ SS#/DL#:_____

Mailing Address:_____ City/State/Zip:_____

Home Phone #:_____ Cell Phone #:_____Age:_____ Birth Date:_____

Would you like to receive an automatic appointment reminder? If yes, Circle One: **Email / Text**

Email address: _____ **Cell Carrier**: _____ Martial Status: M D W S

Employer: _____ Currently Working: _____ Work Phone #:_____

Emergency Contact Name, Relationship, & Phone #:_____

Reason for Therapy

Problem Description: _____ Onset Date/Accident Date/Surgery Date:_____

Referring Doctor & Phone #: _____ Primary Care Physician & Phone #: _____

Was this an injury at work? Y/N If Yes, **Name/Phone # of Case Manager**: _____/_____

Auto Accident? Y/N If yes, what state: _____ Other Accident in which someone else is at fault? Y/N

Will you be seeking reimbursement for your out of pocket expenses from a third party? Y/N

Insurance Information / Please bring your insurance card(s) to your first appointment.

Primary Insurance Company:_____ Secondary Insurance Company: _____

If insurance is in spouse or parent name, please provide the following:

Policyholder Name:_____ Policyholder Date of Birth: _____

Relationship to Patient: _____ Policyholder SSN: _____

Medicare Patients: Medicare has limited your outpatient therapy to $_____ per calendar year.

Have you received physical, speech, or occupational therapy services this year? _____

Are you currently receiving (or recently completed) any home health care? _____

If patient is a minor, please provide the following responsible party information:

Responsible Party Name: _____Date of Birth: _____Phone#: _____

Relationship to Patient: _____ Address: _____

If Medicaid, please provide school name: _____

MEDICAL INFORMATION

Patient Name:_____ Next Doctor's Appt:_____

Diagnosis:_____ Onset/Accident/Surgery Date:_____

Are you diabetic? _____ Yes _____ No If yes, do you take insulin? _____ Yes _____ No

Have you ever had surgery? _____ Yes _____ No

If yes, please list_____

_____

Do you suffer from dizziness, fainting, seizures, or convulsions? _____ Yes _____ No

If yes, please explain_____

Do you have high blood pressure? _____ Yes _____ No

If yes , please explain_____

Do you have a heart condition? _____ Yes _____ No Please list: _____

Do you have a pacemaker? _____ Yes _____ No

Have you ever had a blood clot or phlebitis? _____ Yes _____ No

If yes, where and when _____

Are you currently or have you in the past received treatment for cancer? _____ Yes _____ No

If yes, when_____

Do you have any other health problems? _____ Yes _____ No

If yes, please describe_____

Are you or could you be pregnant? _____ Yes _____ No

Patient or Legal Guardian Signature: _____ Date: _____

Patient Name _____

Date _____

Current Medications List (Prescription, non-prescription, vitamins, herbals)

Medication	Dosage	Frequency	Reason

Known Medication Allergies:

STEWART PHYSICAL THERAPY CONSENT FORM

CONSENT TO TREAT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical or occupational therapist employed by or under contract with Stewart Physical Therapy. I understand that I will be informed of the nature and purpose of the procedures, evaluation and plan of treatment. I will also be informed of the expected benefits and possible complications or discomfort, which may result from skilled physical therapy care.

I understand that there is not a guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain/discomfort or aggravate my condition. I have been given the opportunity to discuss my condition with the treating therapist. I consent and authorize Stewart Physical Therapy Clinics, Inc (including students in training) to administer treatment under the direction and supervision of the physical or occupational therapist. **Initials_____**

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Stewart Physical Therapy to release medical information necessary to process insurance claim(s) on my behalf for services rendered. I request payment of any medical insurance, auto insurance, or liability proceeds or settlements to be made directly to Stewart Physical Therapy. I understand that I am responsible for any balance remaining after insurance or settlement from all sources. I agree to pay any remaining balance within 30 days. If I fail to pay any remaining balance due, Stewart Physical Therapy will have the right, to the extent allowed by law, to be paid back by me for all costs and expenses incurred in collecting sums due and in enforcing my agreement to pay, including but not limited to, reasonable attorneys fees. **Initials_____**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
NOTICE OF PRIVACY PRACTICES

I have read the Stewart Physical Therapy Patient Consent for Use and Disclosure of Protected Health Information/Notice of Privacy Practices. I acknowledge receiving a copy and understand that at any time I may ask questions concerning my privacy rights and how Stewart Physical Therapy may use and disclose my protected health information. **Initials_____**

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I have read and received a copy of the Financial Policy and understand Stewart Physical Therapy has not guaranteed payment by my insurance company only quoted what was relayed to them by my insurance company. In addition, I understand that any check received may be deposited electronically and a $30 fee will be added to my bill for any returned check. **Initials_____**

CANCELLATION/NO SHOW

During your evaluation, you and your therapist will establish goals for your recovery. These goals are based on your participation in your therapy appointments. If you must cancel your scheduled appointment, we request a 24 hour notice. We reserve the right to charge you a $25 cancellation/no show fee if you habitually cancel or no show to your scheduled appointments. **Initials_____**

EMERGENCY PREPAREDNESS

Stewart Physical Therapy staff have made me aware of the Evacuation Plans and Procedures in the event of an emergency. **Initials_____**

_____

Patient/Legal Guardian Signature **Date**

_____

Patient Name

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY STEWART PHYSICAL THERAPY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve you care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share you information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

  Respond to lawsuits and legal actions: We can share your health information to respond to a court or administrative order, or in response to a subpoena.

  Research: We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Stewart Physical Therapy Privacy Officer
Email Address: bdealpt@stewartpt.com Phone Number: 877-229-5532

AUTHORIZATION TO DISCUSS
PROTECTED HEALTH INFORMATION (PHI)

Name: _____ Date of Birth ____/____/____

PLEASE CHOOSE ONE OF THE OPTIONS BELOW

- I DO NOT give permission for my protected health information (PHI) to be discussed with anyone other than myself.
- I DO give Stewart Physical Therapy authorization to discuss my protected health information (PHI) with the individual(s) I have indicated below:

Name	Relationship	DOB	Appointments	Financials	Medical Records
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No

Rights of the Patient:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in force and effect until revoked by the patient or patient representative

_____ _____

Patient / Authorized Representative Signature Date