Physical Therapy & Sports Medicine

PATIENT REGISTRATION

Name _____ Date of Birth _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Cell Phone _____ ☐ Accepts Texts Home/Work Phone _____

Employer/School _____ ☐ Married ☐ Single ☐ Divorced

Email _____ ☐ Please email statements (Go Green!)

Referral Source/ Name _____ Emergency Contact _____

Primary Care Physician (first, last name) _____ ☐ Send PT updates to my physician

CANCELLATION POLICY

There is a $65 charge for appointments cancelled without 24 hours advanced notice. Cancellation for Monday appointments must be made on Friday to avoid charges. Please see the late cancellation fee letter.

HIPPA PRIVACY POLICY

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

By signing below you verify that all information you have provided is correct and current. You have read and understand the above conditions of the Cancellation Policy and Privacy Policy.

Signature (Patient or Parent if Minor) _____ **Date** _____