ADVANCED HEALTH SYSTEMS

Physical Therapy and Sports Medicine
940 Buena Vista, Amarillo, Texas 79106

Patient Information and Registration Form
This Information is Confidential

Patient's Full Name: ___________________________ Last Four SS#: ___________ Date: ___________

Permanent Address: ________________________ City: _____________ State: _____ Zip: __________

Home Phone: (____) __________________ Date of Birth: _____________ Age: _____ Sex: M F

Cell Phone: (____) __________________ Date of Onset / Injury: ___________________________

Are you currently receiving any other medical treatment for the same condition: Y N

If YES circle all that apply: Speech Therapy Occupational Therapy Home Health

Chiropractic Other: ________________

Have you received any medical treatment for the same or another condition this year: Y N

If YES circle all that apply: Speech Therapy Occupational Therapy Physical Therapy

Home Health Chiropractic Other: ________________

Was This A Job Related Injury? Y N **Claim #** ________________ If YES, do you have legal representation: Name of Attorney: _______________________ Phone Number: ___________________

Was This A Motor Vehicle Accident? Y N **Claim #** ________________ If YES, do you have legal representation: Name of Attorney: _______________________ Phone Number: ___________________

EMPLOYER INFORMATION

Employer: ____ Phone: (____) __________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: ____ Relationship: ________________________

Home / Cell Phone: ________________________ Work Phone: _______________________________

If patient is under the age of 18, Parent or Legal Guardian must sign below giving consent for the above named patient to receive Physical Therapy treatments.

Parent / Legal Guardian Signature: ____

AUTHORIZATION FOR TREATMENT

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages, five days a week.

The purpose of physical therapy is to treat disease, injury, and disability by evaluation, examination, testing, and use of rehabilitative procedures, manipulations, massage, exercises, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment; to obtain for the physician information needed in diagnosing, and evaluation of patients; to prevent or minimize residual physical and mental disability; to aid the patient in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of the functional recovery. All procedures will 'be thoroughly explained to you before you are asked to perform them.

You are not expected to experience any increase in your current level of pain or discomfort. You should attempt to stop each procedure before you experience any increase in your current level of pain or discomfort. You are expected to cooperate fully with the evaluation and stop any test or treatment before any increase in your current level of pain or discomfort.

There are certain inherent risks with Physical Therapy Treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty that could cause an increase in your current level of pain or discomfort, or an aggravation to your existing injury.

There is also a possibility that you could experience a new injury, but this risk is small and you will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will also be able to stop treatment if you feel any discomfort in any other part of your body. The evaluator will take every precaution to insure that you are protected from any potentially hazardous situations and you will never be forced to perform any procedure that you do not wish to perform.

I acknowledge that I have read and understand the Authorization for Treatment. Based on the above information, I agree to cooperate fully and to participate in all physical therapy procedures and to comply with the plan of care as it is established. Also, if I am currently pregnant or receiving, or have ever received treatment for any malignancies, I will be certain to disclose this information to the physical therapist.

Date ________________ Patient's Signature ____________________________________

Date _________________ Witness Signature ____________________________________

HIPPA 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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the 'physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care, services. For example, obtaining approval for physical therapy treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for treatment.

Health Care Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of healthcare students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected, health information to healthcare students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use at disclose your protected health information in the flowing situations, without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. **Other Permitted and Required Uses and Disclosures**: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or payment. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object, or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (806) 358-7474.

Signature below is only an acknowledgement that you have received this notice of our Privacy Practices.

______________________________	______________________________	______________
Print Name	Patient's Signature	Date

ADVANCED HEALTH SYSTEMS

No-Show / Cancellation Policy

At Advanced Health Systems, we want you to get the most out of your physical therapy visits. Your physical therapist will recommend a specific number of visits per week for your program. A recent study has shown that patients who adhere to their physical therapy plan of care increase their ability to have success from physical therapy by 93%. Even one missed visit can significantly decrease your success and result in a more chronic problem. We strongly stress the importance of keeping all scheduled appointments to achieve your personal physical therapy goals.

Helping each and every patient get the results they need is very important to Advanced Health Systems. Our schedule is very full and certain time slots are not always available to patients who need them. For this reason we have a 24-hour cancellation policy in effect. If you cannot make a scheduled appointment, for any reason, we require 24 hours' notice of the cancellation. When you call we will assist you in rescheduling this appointment because getting you results is our main goal.

<u>Please read the following policy to better help us, help you.</u>

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.

2. We require that you cancel any appointment that you cannot make with no less than 24 hours' notice. We will get you rescheduled at that time. If you know you cannot make your appointment and it is after our business hours, please note that you can still call as we roll our phones every night and will receive your message. Calling after hours and leaving a message the day before is better than calling the morning of your appointment.

3. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.

4. For all appointments, we expect that you will arrive on time, dressed for your session, and ready to begin at your scheduled treatment time.

5. While traffic can be unpredictable, we expect that you will call us immediately if you are running late for your scheduled appointment so we can be prepared for your late arrival.

6. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.

7. Please note we charge a $50 fee for NO-SHOWs and CANCELLATIONs without a 24 hour notice. Your insurance provider WILL NOT be responsible for missed visit fee(s). It is YOUR responsibility to pay any outstanding fee(s) BEFORE being rescheduled for another appointment. To avoid any unnecessary fee(s), please contact our office before the 24 hour deadline.

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

______________________	______________________	__________
Patient Signature	Patient Name	Date