7088 University Court
Montgomery, AL 36117
Phone: 334.396.1400
Fax: 334.396.2727

Premier Physical Therapy

Feel Free to Move

Last Name: _____ First Name: _____ M.I.: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ SSN: _____
Home #: _____ Cell #: _____ Work #: _____
Email: _____
Sex: Male / Female Marital Status: S / M / D / W
Employer / School: _____
Emergency Contact: _____ Relationship: _____
Emergency #: _____
Date of Accident / Injury: _____ State of Accident: _____
Accident Related to: ( ) Work ( ) Automobile ( ) Other
Description of How Injury Happened: _____
_____

Insurance Information

Primary Insurance Co.: _____
Subscriber Name: _____ SSN: _____
Date of Birth: _____ Relationship to Patient: _____
Policy ID #: _____ Group #: _____
Secondary Insurance Co.: _____
Subscriber Name: _____ SSN: _____
Date of Birth: _____ Relationship to Patient: _____
Policy ID #: _____ Group #: _____

I authorize that payment by insurance be made directly to Premier Physical Therapy on my behalf for any services furnished to me. I authorize the release of any medical information about me to Health Care Financing Administrator and its agents any information to determine benefits payable for related services. I further recognize that if payment is made directly to me by the insurance company, the amount received is the property of Premier Physical Therapy and should be paid to them immediately. I hereby authorize Premier Physical Therapy and its agents to render to me treatment as deemed appropriate and as prescribed by my physician. I understand that I am fully responsible for any unpaid charges and if, for any reason, the account should become delinquent, I will be responsible for any collection cost including attorney fees.

Signature: _____ ***Date:*** _____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, a progress report will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from the credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Premier Physical Therapy. For example, information on the treatment you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses & Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical

condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- ǒ The right to request restrictions on the use and disclosure of your protected health information.
- ǒ The right to receive confidential communications concerning your medical condition and treatment.
- ǒ The right to inspect and obtain a copy of your protected health information.
- ǒ The right to amend and submit corrections of your protected health information.
- ǒ The right to receive information of how and to whom your protected health information has been disclosed.
- ǒ The right to receive a printed copy of this notice.

Premier Physical Therapy Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Policies

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Complaints

If you would like to submit a comment, a complaint, or you feel that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to our office manager. You will not be penalized or otherwise retaliated against for filing a complaint.

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Effective Date

This notice is effective on or after December 9, 2011. By signing below, I acknowledge that I have received and read the Privacy Notice of Premier Physical Therapy.

_____ _____

Patient Signature Date

Premier Physical Therapy
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Authorization for Treatment

Rehabilitation is a patient care/service in response to a wide range of medical care/service needs of patients of all ages regardless of color, race, creed, national origin, or disability.

The purpose of medical care is to treat disease, injury, and disability by examination, testing, and use of procedures in the aid of diagnosis or treatment to obtain information needed in diagnosing examination of patients; to prevent or minimize residual physically disability and to aid patients in achieving their maximum potential within their capabilities; and to accelerate functional recovery. Because of this nature of services provided, you may be asked to partially disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure, and/or request the presence of another person of the same gender.

There are certain inherent risks with medical treatment. With certain rehabilitative therapeutic procedures and indicated physical activities, there is a possibility that you may experience muscle soreness, discomfort, or increased pain. These are often expected responses to treatment, especially with initial visits, but should be short term in length. 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 abnormal discomfort in any other part of your body. The treating medical practitioner will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. The clinic reserves the right to restrict visitors and outside communication at any time during your medical treatment to ensure you receive the maximum therapeutic value from treatment. The law requires all staff members to report any evidence of abuse, neglect, and/or exploitation of patients. Should you observe any abuse, neglect, or exploitation by any individual in the clinic, you are encouraged to report such actions immediately. Should you wish to file a complaint or grievance for any reason, you will be provided, in written form, with the names and addresses of appropriate individuals and protective agencies, and if necessary, be given the appropriate privacy to complete your communication with those individuals/agencies.

Based on the information above, I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of care/services as it is established. I acknowledge that I have read the Authorization for Treatment and authorize release of medical information and appropriate third parties.

NOTICE: Do not use or tamper with any equipment without a staff member present.

_____ _____

Patient Signature Date

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Please take a moment to review our payment policies. Our receptionist or business administrator will be happy to answer any questions you may have.

Payment Policies

All charges that you incur at our office are your responsibility. You may pay for your charges at each visit or choose to use our insurance filing service. There is no extra charge for this service, however, you must agree to the following terms:

On your first visit, you will be required to pay any co-pay amounts outlined in your insurance policy. We request that you pay your co-pay each visit.

Our office will file all insurance claims for you. Your insurance company must allow you to have reimbursement payments sent directly to us. If your insurance company does not allow this, we require that you pay for all treatment at the time of service.

Financial Responsibility

We will bill your insurance company after each visit and use our best efforts to obtain each payment. However, any unpaid charges after 60 days after billing will become your responsibility to pay. We will send you a monthly statement which will notify you of any charges that your insurance declines to pay, all payments made by you and/or your insurance company, and your present balance.

Benefits

The insurance benefits have been explained to me. I understand that verification of benefits is not a guarantee of payment. I also understand that I am responsible for all supplies issued to me including but not limited to crutches, electrodes, bandages, compression garments, theraband, putty, exercise balls, bandaging, etc.

If you have any questions regarding your bill or payment responsibilities, please ask our billing manager.

Please initial one:

_____ I would like to use the filing services of this clinic and agree to the terms listed above.

_____ I would like to file my own insurance and will pay my bill in full each visit

_____ _____

Patient Signature Date

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We at Premier Physical Therapy value you as a patient and respect your times. If you are unable to keep your appointment, please notify us as soon as possible at 334-396-1400.

We reserve the right to charge a $25 fee for missed appointments.

Thank you for choosing Premier!

_____ _____

Patient Signature Date

MEDICAL HISTORY SCREENING FORM

To best serve your needs and understand your medical condition, please complete the following. Thank you for your patience!

Please circle yes or no and list where appropriate

Have you or any immediate family member ever been told you have or are you aware of symptoms related to:

	Patient	Family
Cancer?	Yes / No	Yes / No
Diabetes?	Yes / No	Yes / No
High blood pressure?	Yes / No	Yes / No
Heart disease / Heart attack?	Yes / No	Yes / No
Angina / Chest pain?	Yes / No	Yes / No
Stroke?	Yes / No	Yes / No
Osteoporosis or Osteopenia?	Yes / No	Yes / No
Osteoarthritis?	Yes / No	Yes / No
Rheumatoid arthritis?	Yes / No	Yes / No
Other? _____	Yes / No	Yes / No

Do you have a history of:

Allergies?	Yes / No	Headaches?	Yes / No
Bronchitis?	Yes / No	Kidney Disease?	Yes / No
Rheumatic Fever?	Yes / No	Ulcers?	Yes / No
STD?	Yes/ No	Seizures?	Yes / No
Nervous Disorder?	Yes / No	Hernia?	Yes / No
Metal Implants?	Yes / No	Pacemaker?	Yes / No
Dizziness?	Yes / No	Balance Problems?	Yes / No
Are you pregnant?	Yes / No	Sensitive to Heat/Ice?	Yes / No
Are you under stress?		Yes/ No	
Are your symptoms getting:		Worse / Same / Improving	
Do you have a problem with:		Vision / Hearing / Speech	
Do you drink alcohol?		Yes_____ per week / No	
Do you or have you ever smoked?		Yes / No	
Last medical exam?		Date: _____	

In the past three months, have you had or did you experience:

A change in your health?	Yes / No	Nausea / vomiting?	Yes / No
Fever / chills / sweats?	Yes / No	Weight change?	Yes / No
Numbness or tingling?	Yes / No	Changes in appetite?	Yes / No
Difficulty swallowing?	Yes / No	Shortness of breath?	Yes / No
Dizziness?	Yes / No	Urinary Tract Infection?	Yes / No
Bladder/bowel dysfunction?	Yes / No		

Patient Signature: _____ **Date:** _____

NAME: _____ **DATE:** _____

MEDICATION LIST

Please list **ALL** medications including herbal, OTC, and vitamins/supplements.

Medications	What is your dosage and how often do you take it?	In what form is your medication? (pill, liquid, suppository, inhaler, ointment, patch, etc.)