

REGISTRATION

Legal Name: _____ Sex: _____ D.O.B. _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

S M W D (Please circle) SS#: _____ TDL#: _____

Email Address: _____ Cell Phone _____

By providing your email address you are giving consent to receive our newsletter. If not interested, check here

Occupation: _____ Employer: _____

Work Phone #: _____

** If Responsible party is different than above, please fill out the following information.

Responsible Party: _____ Relation: _____ SS#: _____

D.O.B. _____ Home address: _____

Employer: _____ Work Phone #: _____

Primary Ins. Policy: _____ Group #: _____

Claims Phone #: _____ Relationship to Insured _____

Insured's Legal Name: _____ ID#: _____ D.O.B. _____

Secondary Ins. Policy: _____ Group #: _____

Claims Phone #: _____ Relationship to Insured _____

Insured's Legal Name: _____ ID#: _____ D.O.B. _____

Neighbor or relative not living with you: _____ Relation: _____

Phone #: _____

PROFESSIONAL SERVICES MUST BE PAID AT THE TIME THEY ARE RENDERED.

Assignment of benefits: I hereby authorize payment directly to ProActive Physical Therapy Centers of benefits due me for services described above. I understand I am financially responsible for charges not covered by this authorization.

Release of information: I hereby authorize ProActive Physical Therapy Centers to release any information required to process this claim form.

Date

Signature

Patient Information

Today's Date: ____/____/____

Name: _____ Height: _____ Weight: _____ lbs.

DOB: ____/____/____ Age: _____ Job description: _____

Referring Physician: _____

Describe how you injured yourself. If not from an injury, describe when and in what part of your body the pain or dysfunction started:

If you recently had surgery for this condition, please list date of surgery:

Describe the problems or limitations you are having now:

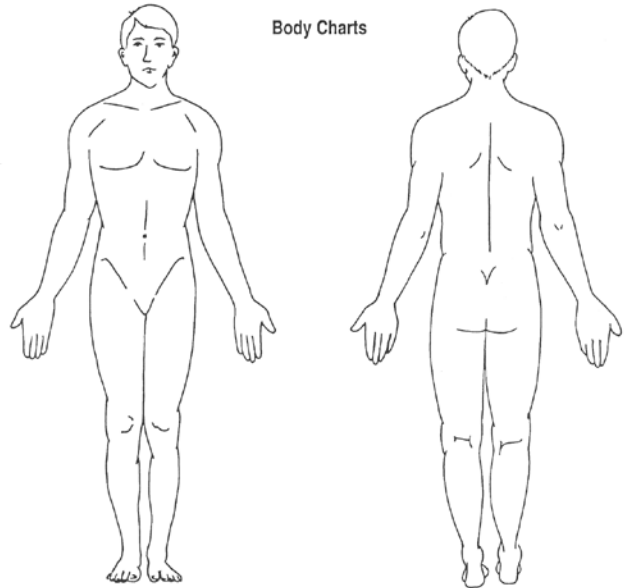
Have you had any previous treatment for this injury (i.e., medications, therapy, surgery)? If so, briefly describe when and the results of the treatment:

Please list your current medications, if any (i.e., heart meds, pain medication, muscle relaxants.)

If you are allergic to any medications, please list

Please list any other medical conditions?
(i.e., pregnancy, heart problems, diabetes, seizures, etc.)

Body Charts



(Put an X at your area(s) of pain on the diagrams)

How did you hear about us?: Please check below.

Current/former Patient _____ if so, please name the Patient _____

Newspaper/Flyer Ad _____ Drive By _____ Word of Mouth _____

You are a Previous Patient _____ Yellow Pages _____ Sports Outreach _____ Internet _____

Other Source _____

Referral from Doctor? If so, name the Doctor _____

Did Doctor mention us specifically by name? _____ If not, who at their office? _____

HIPAA PRIVACY POLICY

In compliance with a newly enacted Federal Law, The Health Insurance Portability and Accountability Act (HIPAA), ProActive Physical Therapy is informing you of your privacy rights. Please review the information below.

What is HIPAA? HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). PHI is confidential information about a patient, including demographic information.

What are my rights under HIPAA? Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

- You have a right to inspect and obtain a copy of your PHI. We will respond to your request within 30 days. In most cases your request will be honored and a copy of your PHI will be mailed to you.
- You have a right to request an amendment of PHI. If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.
- You have the right to know what disclosure(s) of your PHI have been made. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/correctional facilities, or disclosures made prior to April 14, 2003.
- You have a right to request confidential communications of PHI. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.
- You have a right to request restrictions on the use and disclosure of PHI, however we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.
- You have a right to receive a hard copy of this notice. This notice can also be accessed on our website www.ProActivePhysicalTherapy.com.

How will ProActive Physical Therapy Use and Disclose PHI under HIPAA? HIPAA allows us to use and disclose your PHI for the purposes of Treatment, Payment and Healthcare Operations. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of Treatment, Payment and Healthcare Operations. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

Disclosure to those Involved in the Individual's Care when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.

Uses and Disclosures Required by Law- As required by law we are required to use and disclose PHI for the following reasons:

- Use and Disclose PHI for Public Health Activities - Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
- Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence - Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse.
- Uses and Disclosure of Health Oversight Activities - We may use and release PHI to be used for audits, investigations, licensure issues, etc.
- Disclosure for Judicial and Administrative Proceedings - We may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.
- Disclosure for Law Enforcement Purposes - We may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
- Uses and Disclosures Related to Decedents - We may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
- Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations - We may use and release PHI in order to facilitate organ, eye or tissue donations.
- Uses and Disclosures to Avert a Serious Threat to Health or Safety - We may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
- Uses and Disclosures for Specialized Government Functions - We may use and release PHI for military/veterans activities and national security/intelligence activities.

- Use and Disclosure of PHI in Emergency Situations - In the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.
- Uses and Disclosures of PHI for Marketing Purposes - ProActive Physical Therapy will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
- Uses and Disclosures of PHI for Research Purposes – We do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
- Uses and Disclosures requiring the Patients Authorization - We must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

What does HIPAA require of ProActive Physical Therapy? ProActive Physical Therapy must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

Where can I file a privacy complaint? If you feel your privacy rights have been violated, you may file a complaint in writing with ProActive Physical Therapy’s Compliance Officer, at 10223 W. Broadway Suite B, Pearland, TX 77584. You may also file a complaint with the Secretary of the US Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Receipt of Notice of Privacy Practices Form

Effective April 14, 2003, I, _____, hereby acknowledge receipt of ProActive Physical Therapy’s Notice of Privacy Practices. ProActive Physical Therapy will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand ProActive Physical Therapy has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for ProActive Physical Therapy to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to ProActive Physical Therapy.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____

Print name