ACTIVE
PHYSICAL THERAPY
A STEP IN THE RIGHT DIRECTION

Registration Form
Please Print. Patients under the age of 18 need to have a parent/guardian complete and sign.

Patient Name (Last, First, Middle Initial) ______________________ **Date of Injury** __ /__ /____

Social Security # ______________ **Date of Birth** ______________ **Cause of Injury (check one)**

Age _________ **Sex: Male** ☐ **Female** ☐ **Marital Status** ____________ ______ Auto Accident

Guardian (If patient minor) ______________________ ______ Workers Compensation

Guardian Date of Birth ______________ ______ Other

Address ______________________ **Apartment #** ____________

City ______________ **State** ______ **Zip** ______

Home Phone # ____________ **Cell Phone #** ____________ **Email** ____________

Employer ______________ City ____________ State ______ Zip ____________

Employer Phone # ______________

Referring Physician ______________ **Primary Care Physician** ______________

How did you hear about us? ______________________

Primary Health Insurance Company ______________________

Policy # ______________ Group # ______________

Policy Holder Name ______________ Date of Birth ____________ Relationship to Patient ________

Policy Holder Social Security # ______________

Secondary Health Insurance Company ______________________

Policy # ______________ Group # ______________

Policy Holder Name ______________ Date of Birth ____________ Relationship to Patient ________

Policy Holder Social Security # ______________

Emergency Contact & Relationship ______________ **Phone #** ______________

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. **IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT.** In the event the account is turned over for collections, the collection fees and /or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy.

______________________ ____________
Patient/Guardian Signature **Date**

____
Print Name

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Billing Department: PO Box 419666 Boston, MA. 02241
Phone (410) 970-8190· Fax (410) 313-8314

ASSIGNMENT OF BENEFITS

I hereby instruct and direct ______________________________ insurance company to pay by check made out and mailed to:

Active Physical Therapy Services
PO Box 419666
Boston, MA. 02241-9666

If my current policy prohibits direct payment to this practice, I hereby also instruct and direct you to make the check to me and mail it as follows:

Patient Name ______________________________
C/o Active Physical Therapy Services
PO Box 419666
Boston, MA. 02241-9666

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Active Physical Therapy Services to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient/Guardian Signature: ______________________________ **Date:** ____________________

Print Name: ______________________________

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Consent for Release of Medical Information	**Patient/Guardian Initials** ___________

I authorize the release of my medical records to Active Physical Therapy from the following physician(s):

Physician ______________________________ Physician ______________________________

Address ______________________________ Address ______________________________

City, State Zip ______________________________ City, State Zip ______________________________

I authorize Active Physical Therapy to release my medical records to the following people:

- ☐ Spouse ______________________________
- ☐ Child(ren) ______________________________
  ____
  ____
- ☐ Attorney ______________________________
- ☐ Other ______________________________

If you would like to allow anyone else to discuss your bill with Active Physical Therapy please list them here:

____

Patient/Guardian Signature ______________________________ Date ______________________________

Print Name ______________________________

Consent for Treatment of a Minor	**Patient/Guardian Initials** ___________

As a parent and/or legal guardian, I authorize Active Physical Therapy to treat the minor patient named below while I am not present.

Patient Name ______________________________

Parent/Legal Guardian Signature ______________________________ Date ______________________________

Print name ______________________________

No Show/Cancellation & Returned Check Fee	**Patient/Guardian Initials** ___________

We realize circumstances might cause you to miss a scheduled appointment; however, to provide the best care and service to each patient, we ask that you notify us 24 hours in advance to cancel your appointment. We will be more than willing to reschedule your appointment for a different time on the scheduled day OR within 24 hours.

Please be aware that failure of proper notification could result in a No Show/Cancellation fee of $25.00.

There is also a $25.00 charge for all returned checks.

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Medical History/Questionnaire

Please print all information.

Patient Name ______________________________

What body part(s) are you seeking treatment for? ______________________________ ☐ Right ☐ Left

What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other ______________

When did your symptoms begin? __ / __ / ____

Have you had surgery for this injury? ☐ Yes ☐ No Type of Surgery ____________________ Date ______________

Have you previously had physical therapy for this injury? ☐ Yes ☐ No If yes, what company? ______________________

On a scale of 1-10 (10 being the worst) how severe is your pain? (circle) 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

What do you expect to gain/accomplish from receiving physical therapy?

____

____

List any operations or surgeries you have had:

____

____

List any medications you are currently taking:

____

____

List any allergies and describe any drug reactions:

____

____

Do you currently have any of the following? Check all that apply. **If none apply check here** ☐

- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Seizures
- ☐ Arthritis/Swollen Joints
- ☐ Gout
- ☐ Severe or Frequent Headaches
- ☐ Dizziness or Faintness
- ☐ Weight Loss/Energy Loss
- ☐ Hernia
- ☐ Allergies
- ☐ Any Pins or Metal Implants
- ☐ Joint Replacement
- ☐ Fatigue
- ☐ Heart Murmur
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Sleeping Problems
- ☐ Numbness or Tingling

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED IS CORRECT

Signature ______________________________ **Date** ______________________________

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice.

We are required to abide by the terms of this Notice of Privacy Practices that takes effect on April 14, 2003. We reserve the right to revise the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by contacting our billing department at (410) 970-8190.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We will use 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to physicians who may be treating you.

Payment: Your protected health information will be used, as needed, to seek payment for your health care services provided by us or by another provider. This disclosure includes our billing department, attorneys, insurance companies and collections agency that may become involved in the process of mailing statements and/or collecting unpaid balances.

Health Care Operations: We can use and share your health information to run our practice, improve your care and contact you when necessary. Our company operates under the Minimum Necessary Standard that limits employees' access to your health information needed to perform their jobs.

Required by Law: We will share information about you when required by law. This includes with the Department of Health and Human Services if it wants see that we're complying with federal privacy laws.

Other Disclosures: We are allowed or required to share your information in other ways including: help with public health and safety issues, health emergencies, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, workers' compensation claims, military activity, health oversight agencies and national security.

Marketing Activities: We will not disclose your information for marketing purposes unless you have provided written authorization to do so.

YOUR PRIVACY RIGHTS AS OUR PATIENT

You have the right to inspect and copy your protected health information. There are some limited exceptions under federal law. Upon request, we will provide a copy of your medical record and other health information usually within 30 days.

You have the right to amend your protected health information if you feel it is inaccurate or incomplete. Your request must be in writing and include an explanation of why your information should be amended. We may deny your request and will provide a reason for the denial within 60 days.

You have the right to request confidential communications from us by alternative means or at an alternative location. We will agree to all reasonable requests.

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, payment or health care operations. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request. If our office 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 health care professional.

You have the right to receive an accounting of the times we've shared your health information for six years prior to the date of your request, who we shared it with and why. We will include all disclosures except for those regarding treatment, payment and healthcare operations that are routine.

You have a right to obtain a paper copy of this notice from us, upon request. We will promptly provide you with a paper copy.

You have the right to file a complaint with us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We support your right to privacy and will not retaliate against you for filing a complaint.

This notice was published and becomes effective on **January 4, 2016.**

Your signature below is an acknowledgement that you have received this HIPAA Notice of Privacy Practices.

Patient Name (Print):________________________ **Date:**________________

Patient/Parent or Legal Guardian Signature:______________________________