Harrison Physical Therapy

Where Healing and Compassion Meet

1149 Stone Drive #500
Harrison, Ohio 45030

Phone: 513-367-9299
Fax: 513-367-1704

www.harrison-pt.com

Registration Paperwork

Forms to be completed:

- Patient Registration Form
- Patient Medical History Form
- Cancellation Policy Form
- Patient Payment Policies Form

Also included here:

- Information for New Patients
- “Notice of Protected Health Information”

Instructions

1) Print and complete Patient Registration Form, Patient Medical History Form, Cancellation Policy Form, Patient Payment Policies Form

2) Sign all forms

3) Bring completed and signed forms to your first therapy appointment along with your photo id and insurance card(s)

If you have any questions about these forms, please contact us at any time.

HARRISON PHYSICAL THERAPY

REGISTRATION FORM for PATIENT INFORMATION

FIRST NAME MI LAST NAME HOME PHONE CELL PHONE

STREET ADDRESS CITY STATE ZIP

EMAIL ADDRESS

☐ MARRIED ☐ SINGLE ☐ STUDENT ☐ RETIRED ☐ WORKING

☐ MALE

☐ FEMALE ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH _____SOCIAL SECURITY _____

HOW DID YOU HEAR ABOUT HARRISON PHYSICAL THERAPY_____

REFERRING PHYSICIAN (What location do you see the doctor?) PRIMARY PHYSICIAN EMERGENCY CONTACT NAME & PHONE #

PATIENT PRIVACY

►May we leave phone messages regarding your appointments or other information regarding your care? ☐ YES ☐ NO

► Someone other than yourself, that we may discuss your condition with, and can make decisions on your behalf regarding your physical therapytreatment_____Phone#_____

ALL PATIENTS

I AUTHORIZE PAYMENT OF MEDICARE &/or INSURANCE BENEFITS BE MADE ON MY BEHALF DIRECTLY TO HARRISON PHYSICAL THERAPY FOR ANY SERVICES FURNISHED TO ME BY EMPLOYED LICENSED PHYSICAL THERAPIST. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION ABOUT ME NEEDED TO DETERMINE THE PAYMENTS FOR RELATED SERVICES.
I VERIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION TO THE BEST OF MY ABILITY.

X_____**DATE**_____

PATIENT SIGNATURE (IF THE PATIENT IS A MINOR, A PARENT SIGNATURE IS REQUIRED)

INJURY INFORMATION

CHECK THE CONDITION THAT APPLIES: ☐ AILMENT ☐ INJURY ☐ ACCIDENT ☐ SURGERY

ONSET DATE OF INJURY OR SURGERY DATE _____
PLACE OF ACCIDENT / INJURY: ☐ WORK ☐ PLAY ☐ HOME ☐ AUTO

DESCRIBE HOW ACCIDENT / INJURY HAPPENED:_____
_____

WORKERS' COMPENSATION PATIENTS ONLY

WORKERS' COMPENSATION CLAIM # _____ ORIGINAL DATE OF ACCIDENT _____

EMPLOYER'S NAME & ADDRESS AT TIME OF ACCIDENT _____

EMPLOYER'S PHONE # _____ IS THIS COMPANY SELF INSURED? YES NO
NAME OF EMPLOYEE WHO HANDLES WORKERS' COMP. CLAIMS FOR THIS COMPANY _____

WORKERS' COMPENSATION NOTE - If your claim goes to a hearing or pending status, you will be responsible for payment

HARRISON PHYSICAL THERAPY
PATIENT MEDICAL HISTORY

Heart Disease: _____ **YES** _____ **NO**
If yes, explain:
_____

Stroke: _____ **YES** _____ **NO**
If yes, explain:
_____

High Blood Pressure: _____ **YES** _____ **NO**
If yes, explain:
_____

Allergies: _____ **YES** _____ **NO**
If yes, explain:
_____

Epileptic/Seizures: _____ **YES** _____ **NO**
If yes, explain:
_____

Present Medications/Supplements/Hormones:
_____

Past Surgeries: _____ **YES** _____ **NO**
If yes, explain:
_____

Cancer: _____ **YES** _____ **NO**
If yes, explain:
_____

Diabetic: _____ **YES** _____ **NO**

Phlebitis: _____ **YES** _____ **NO**

***Female Patients - At present time, are you*:**

Pregnant: _____ **YES** _____ **NO**

Menstruating: _____ **YES** _____ **NO**

I.U.D.: _____ **YES** _____ **NO**

Patient Height: _____ Patient Weight: _____

Previous illness or injuries related to present problem? Give dates:

_____

Any additional medical information: (feel free to attach your own list)

_____

1. **IF AT ANYTIME** you need to discuss information in confidence with our staff regarding your condition, health information or financial information; a private area can be made available. Please inform your therapist.
2. **IF AT ANYTIME** you wish your curtain to be pulled during treatment, please inform a Harrison Physical Therapy staff member.
3. Your therapy may include the opportunity to exercise in our open gym area. **IF AT ANYTIME** you desire not to exercise in our open gym, please inform a Harrison Physical Therapy staff member.

I have read the above statements and completed my medical history to the best of my ability and **I give my consent for physical therapy evaluation and treatment at HARRISON PHYSICAL THERAPY.**

SIGNATURE: _____ **DATE:** _____

Patient Signature (If the patient is a minor, a parent must sign.)

HARRISON PHYSICAL THERAPY
APPOINTMENT CANCELLATION/NO SHOW POLICY

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

Effective February 8, 2010, if you miss your appointment or cancel with less than 24 hours notice, Harrison Physical Therapy, reserves the right to bill you $25.00 for each late cancellation and no show. Insurance will not cover this fee. This fee will be your responsibility.

We do realize that on rare occasions emergencies may arise and we will address these situations with you at that time.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

I have read and understand the Physical Therapy Appointment/No Show Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of the Physical Therapy Appointment/No Show Policy.

Printed Name of Patient Date

Signature of Patient or Responsible Party (if a minor) Relationship to Patient (if a minor)

HARRISON PHYSICAL THERAPY
PATIENT PAYMENT POLICIES

Please sign each line with your full signature

_____ I understand that it is the **patient's responsibility** to check if physical therapy is a covered item in their policy.

_____ IT IS THE POLICY OF THIS OFFICE THAT AT THE BEGINNING OF EACH PHYSICAL THERAPY VISIT, THE PATIENT MUST PAY THE PORTION OF HIS/HER BILL THAT THE INSURANCE COMPANY DOES NOT PAY (co-pay or percentage). If your insurance company pays more of your charges than expected, we will reimburse you after we receive full payment from them.

_____ I am aware that if there is litigation pending, and if I have medical insurance, Harrison Physical Therapy will fill claims with my medical insurance carrier. If I do *not* have medical insurance, I am responsible for payment of my bill with **regular monthly** payments and that Harrison Physical Therapy will not wait until the case is settled for payment.

_____ I have received a copy of "Information for New Patients" which includes the policies for Harrison Physical Therapy, **INCLUDING THE CANCELLATION POLICY.**

_____ I have been given a copy of Harrison Physical Therapy's "Notice of Protected Health Information."

HARRISON PHYSICAL THERAPY
INFORMATION FOR NEW PATIENTS

We will be glad to contact your Insurance Company to verify that this is a covered service, and we ask that you do the same so that you are aware of your physical therapy benefits. Also, remember, you are ultimately responsible for all services provided to you.

- **INSURANCE COVERAGE:** We require that the percentage of your bill that insurance will not cover be paid on the day of service. This includes the deductible and co-pay.

- **NO INSURANCE:** You must make arrangements for payment of your bills prior to beginning physical therapy. ***Regular payments are required.***

- **WORKERS' COMPENSATION:** Patient should be aware that they are still responsible for payment if Workers' Comp. rejects the claim. **If claims go to a hearing or pending status, we will file you your medical insurance or regular payments will be required.**

- **IF THERE IS LITIGATION INVOLVED:** We require a $50.00 minimum payment on your first visit, and a reasonable weekly payment thereafter. We will bill your auto & medical insurance. *Regular monthly payments are required.*

- **AUTO INSURANCE:** When auto insurance is the payor of a claim due to injury/car accident (when NO litigation is involved), we will wait a reasonable time for the auto insurance to pay. If no payments are made in 60 days, we will bill you, the patient. You may arrange a payment plan with the billing secretary.

- **CANCELLATIONS:** If cancellation of an appointment is necessary, please call 24 hours ahead of time. If you miss 3 of your scheduled physical therapy visits, *we reserve the right to* **cancel all remaining scheduled appointments** *for the duration of a patient's physical therapy treatment.*

- **NON-DISCRIMINATION:** It is the policy of Harrison Physical Therapy to provide services to all persons without regard to race, color, national origin, handicap or HIV/Medical status.

- **CLOTHING:** For patients having physical therapy on their knees, legs, back and ankles, we ask that you bring/wear shorts and tennis shoes. If you are coming in for a shoulder injury, we suggest that you wear a tank top or muscle shirt. If you will be doing exercises during your treatment, please dress so that you will be able to move freely.

PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION. WE ARE HERE TO HELP YOU!

HARRISON PHYSICAL THERAPY

1149 STONE DR #500
HARRISON, OHIO 45030
513-367-9299

NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

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

PLEASE REVIEW IT CAREFULLY

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and accountability Act of 1996 set forth at 42 CFR **§** 160.101 el seq. (the "Privacy Regulations"), Harrison Physical Therapy ("the Practice" is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain. Should such terms change, we will mail a revised Notice to the mailing address most recently listed in your medical records.

Permitted Uses and Disclosures of Your Health Information

1) Uses and Disclosures with Patient Consent: Under the Privacy Regulations, we are permitted with your written consent, to use and disclose your health information for the following purposes:

    a. Treatment. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

    b. Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims reimbursement, medical data processing and reimbursement. This information may be released to an insurance company, third party payors or other authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

    c. Health Care Operations. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditations, certification, licensing or credentialing activities and for education purposes.

2) Uses and Disclosures With Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3) Uses and Disclosures With Patient Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4) Uses and Disclosures Without Patient Consent, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

   a. Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.

   b. Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

   c. Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

   d. Regulatory Agencies. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

   e. Judicial and Administrative Proceedings. We may disclose your health information in judicial and administrative proceedings, as well as in response to an order of a court, administration tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

   f. Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.

   g. Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

   h. Research. Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

   i. Threats to Health and Safety. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public.

   j. Military/Veterans. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

   k. Workers' Compensation. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

   l. Marketing. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

   m. Appointment Reminders. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our clinic.

   n. Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5) Uses and Disclosures to Business Associates. With the proper consent or authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1) Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree to such a request. If, however, we agree to the requested restriction, it is binding on us.

2) Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For

example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3) Right to Verbally Object. You have the right to verbally object to certain disclosures that are routinely made without any Consent or Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4) Right to Seek an Amendment of Your Health Information. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5) Right to an Accounting of Disclosure of Your Health Information. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment, or health care operations, disclosures to you based on your consent, authorization or other means permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to our compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6) Right to Confidential Communications. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7) Right to Revoke Your Consent and/or Authorization. You have the right to revoke your consent or authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses and disclosures prior to the receipt of the revocation.

8) Right to Receive Copy of this Notice. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact Tim Lees at 513-367-9299. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact Tim Lees at 513-367-9299. All complaints must be submitted to the Practice in writing at 1149 Stone Drive #500, Harrison, Ohio 45030. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is April 14, 2003.