

REGISTRATION FORM
 (PLEASE PRINT)

| | | | | | | | |
|----------------------------|--|-------------------|---|---|--------------------------|-----------------------|--|
| PATIENT INFORMATION | Patient's last name: | | First: | Middle: | Sex: | Patient Date of Birth | |
| | Street Address | | | City / State/ ZIP Code: | | | |
| | Home Phone: | Cell Phone | Work Phone | Emergency Contact Name, Relationship & Tel #: | | | |
| | Patient Social Security # | | EMAIL | | | | |
| | Accident Related? <input type="checkbox"/> Auto at fault <input type="checkbox"/> Auto No fault <input type="checkbox"/> WC <input type="checkbox"/> Fall <input type="checkbox"/> Sports <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Surgery <input type="checkbox"/> Other(SPECIFY) _____ | | Location of Injury/Accident (SPECIFY) <input type="checkbox"/> VA <input type="checkbox"/> DC <input type="checkbox"/> MD <input type="checkbox"/> Other _____ | | Date of Injury/ Accident | | |
| Referring Physician: | | Tel# | | | Fax # | | |

| | | | | | | |
|-------------------------|----------------------|--|-------------------|----------------|---------------------|--------------------------|
| Health Insurance | Subscriber's Name & | | Social Security # | Date of birth: | Subscriber's Tel #: | Relationship to Patient: |
| | Primary Insurance: | | Policy #: | Group: | Tel # | |
| | Secondary Insurance: | | Policy #: | Group: | Tel # | |

| | | | | | | |
|-------------------------------|---|---------------|------------------|----------------|--------------------|-------|
| Workman's Compensation | Employer Name & Address: | | | Employer Tel # | Employment Status: | |
| | Insurance Name & Address : | | | | Tel # | |
| | Adjustor / Case Manager Name | | | Claim# : | | Tel # |
| | Was Injury Reported Supervisor: <input type="checkbox"/> Yes <input type="checkbox"/> No | Date Reported | Supervisor Name: | | Tel # | |

| | | | | | |
|----------------------|-------------------------------------|--|----------|----------------------|--|
| Auto Accident | Auto Insurance / Lien Company Tel # | | Claim # | Adjuster Name Tel #: | |
| | Attorney Name: | | Phone #: | Fax# | |

| | | | | | |
|------------------|-------------------------------------|--|--------|--------|---------------------|
| Guarantor | Guarantor Name (Responsible Party): | | DOB | Tel #: | Relation to Patient |
| | Address: | | Email: | | |

I certify that the above information is accurate and I authorize Allied Health Solutions (**AHS**) to release the information required to process my claims and authorize my insurance benefits be paid directly to AHS. I understand that I am financially responsible for any remaining balance.

PRINT NAME
 Patient/Parent or Guardian

Signature
 Patient/Parent or Guardian

Date



MEDICAL HISTORY FORM

NAME _____ DATE _____

Are you presently working? Y N

Date of injury / onset _____

Have you experienced these symptoms before? Y N

Have you had a related surgery? Y N

If yes, please give date _____

If female, are you pregnant? Y N

Do you have or have you had any of the following:

| | |
|---|---|
| Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N | Metal Implants/Pacemaker <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chest Pain/Angina <input type="checkbox"/> Y <input type="checkbox"/> N | Fractures <input type="checkbox"/> Y <input type="checkbox"/> N |
| Osteoarthritis <input type="checkbox"/> Y <input type="checkbox"/> N | Dizziness/Fainting <input type="checkbox"/> Y <input type="checkbox"/> N |
| High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Disease <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke <input type="checkbox"/> Y <input type="checkbox"/> N |
| Seizures <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma/Breathing Difficulty <input type="checkbox"/> Y <input type="checkbox"/> N |

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

Do you have any allergies? Y N

If yes, please list _____

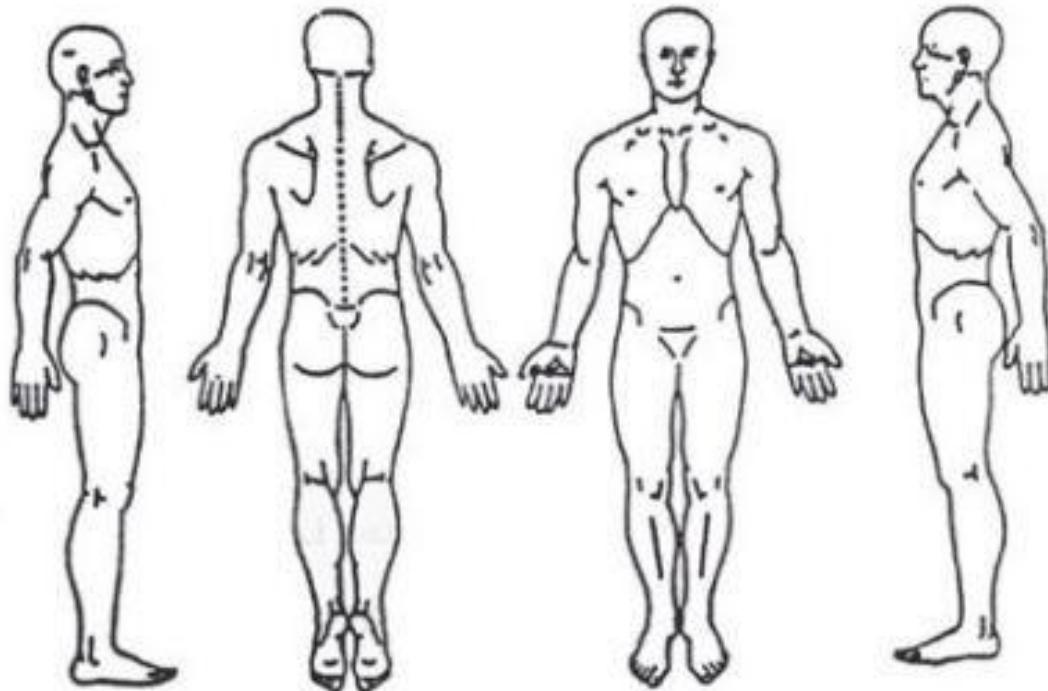
Are you presently taking any medication? Y N

If yes, please list what medication and for what condition

Do you participate in any sports, exercise program or activities on a regular basis? Y N

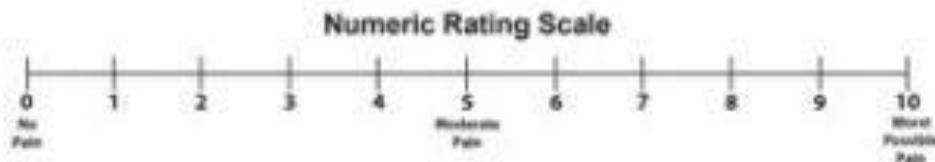
List Additional Information below: _____

Please indicate below where your symptoms are located:



| KEY | |
|--------------------|----------------------------|
| Numbness ===== | Pins and Needles 00000000 |
| Burning Pain XXXXX | Stabbing Pain //////////// |

If you are having pain, please rate the intensity of your pain on the scale below:



Wong-Baker FACES® Pain Rating Scale


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Working modified for adult use. Used with permission.



CONSENT FORM / RELEASE OF INFORMATION

Patient Name _____

CONSENT TO TREATMENT

I consent to the evaluation and treatment by Allied Health Solutions LLC by signing below. I understand that the Therapist will discuss treatment options including any risks or alternatives. I understand that no promises or guarantee regarding the results from such treatment can be made. I acknowledge and understand that I reserve the right to accept or refuse any treatment offered me.

RELEASE OF INFORMATION

I authorize Allied Health Solutions LLC to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my (Doctor) _____, and (Insurance Company) _____ for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

Signature of Patient or Responsible Party

Date

Witness

Date

HIPAA 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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physical/occupational therapist, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physical/occupational therapist's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage our 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. 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 a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Allied Health Solutions, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision accreditation, certifications, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintain compliance programs, and business management and general administrative activities. We may call you in the waiting room by your name when we are ready to see you.

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 states' public health department.

Other Permitted and Required Uses & Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:** Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization. **You may revoke this authorization**, at any time, in writing, except to the extent that your provider or the providers practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the following rights under the federal privacy standards regarding the health information that we maintain about you as listed below:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend and submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of 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 Officer of your complaint. We will not retaliate against you for filing a complaint. Allied Health Solutions, LLC 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 Practices

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.

I have read and understand all above authorizations and policies and I agree to them.

PRINT PATIENT NAME

Signature Patient/Legal Guardian

Date



Patient Financial Agreement

We at Allied Health Solutions LLC (AHS) look forward to providing you quality care as your physical/occupational therapy provider. Although our relationship is with you and not your insurance company we are enrolled as in-network provider with most Insurance so you can avail the In Network Benefits. We do extend the courtesy of submitting claims to your insurance.

Please read our financial policies so that your treatment process is as smooth as possible.

Billing Information

We will attempt to verify your insurance benefits and coverage at the time you begin our professional services. It is your responsibility to provide us with your current & accurate Insurance information and also be aware of your coverage and benefits details, exclusions and limitations. **Our verification is only an estimation of insurance benefits and not a guarantee of payment from your Insurance which will be determined after claims are processed.** You are encouraged to contact your insurance company to verify your benefits and assure that your claims are being processed properly.

- In the event your insurance determines a service to be “not covered”, or you do not have the appropriate authorization or referral, you as the patient, or legal guardian, are responsible for all charges that the payer does not pay on the claim including any denials, deductibles, copayments and co-insurance due you will be responsible for the complete charge.
- In the event your insurance forwards payment directly to you, instead of to Allied Health Solutions, LLC, you are required to immediately deliver such payment with the Explanation of Benefits so we can complete the process.
- You may make payments in the office, phone, mail or online. We accept cash, check, and credit card. There is a service fee of \$35.00 for all returned checks. All accounts that are 90 days past due will be subject to interest at 3%.
- All past due accounts are subject to collection proceedings. You also understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for any costs and court costs, in addition to the outstanding balance. All fees including, but not limited to, collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due to this office. By signing below you agree to be responsible for all cost incurred in the collection of your account.
- **There will be a charge of \$50 to your account for appointments cancelled without 24 hour prior notice,** which will be your responsibility and not billable to your insurance company.

Appointment Information

- Your insurance may require a referral by a physician which should be provided to us on or prior to your initial visit
- It is also your responsibility to monitor the number of authorized visits for physical/occupational therapy.
- We will need a Script from your PCP and may need additional information as required by your Insurance.
- The initial visit will usually last 60 minutes with all subsequent sessions lasting approximately 45-60 minutes. Please arrive promptly for each scheduled appointment.
- Please call at least 24 hours in advance to cancel or change an appointment.

Acknowledgement

I have read and understand all of the above information, and agree to abide by all of its terms and conditions. I hereby authorize the release of any information, including medical information, requested by the insurance company for this or any related claim for reimbursement and authorize payment by such insurance company to Allied Health Solutions, LLC for services rendered. Further, I understand that I am personally responsible for all charges not covered by my insurance company.

PRINT NAME
Patient/Parent or Guardian

Signature
Patient/Parent or Guardian

Date



Physical Therapy Attendance Policy

(Please read thoroughly)

Allied Health Solutions, LLC strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. We ask for your full cooperation with the following policy:

- A scheduled appointment **MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE** or a fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment.
- **ALL PATIENTS, regardless of insurance/third party payor, will be charged a \$50 CANCELLATION FEE for each late, late-canceled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.**
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All of the staff at **Allied Health Solutions, LLC** appreciates your anticipated adherence and cooperation with this policy. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities so please, help us help you!

Patient Acknowledgement/Signature

____ / ____ / ____
Date