

CHILTON COUNTY PHYSICAL THERAPY
PATIENT DEMOGRAPHIC SHEET

NAME: _____

ADDRESS: _____

PRIMARY PHONE: _____

EMAIL: _____

REMINDER: TEXT PHONE CALL EMAIL

DOB ___/___/___ SSN ___-___-___

REFERRING MD: _____

DIAGNOSIS: _____

HOME HEALTH: _____

RECENT PT (WHERE/ # VISITS): _____

PRIMARY INS: _____

CONTRACT#: _____ GROUP _____

SECONDARY INS: _____

CONTRACT#: _____ GROUP _____

IF YOU NO SHOW TWO TIMES, THE FOLLOWING VISITS SCHEDULED
WILL BE CANCELLED AND IF YOU ARE MORE THAN 15 MINUTES LATE
FOR YOUR APPOINTMENT IT WILL BE RESCHEDULED. PLEASE

INITIAL _____

Patient Name: _____

Please read, date and sign the bottom portion.

Verification of Insurance Coverage

Primary Insurance

Name of Insurance Company: _____

Policy Number: _____

Pre-certification Required? _____

Deductible/ Remaining: _____

Copay/Co-Insurance: _____

Limitation: _____

Secondary Insurance (if applicable)

Name of Insurance Company: _____

Policy Number: _____

Agreement

Our agreement is with you, not your insurance company. Although we will assist you in submitting your claim to your insurance carrier, you are ultimately responsible for the service you receive. Payment to our office is neither contingent nor dependent upon your insurance carrier. You will be responsible for all deductibles, co-pays, co-insurances and any charges not covered at 100% unless a previous arrangement has been made. I have read and understand my financial responsibilities under this policy of Chilton County Physical Therapy.

Adding Collection Fees To Account Balances:

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right to claim exemption under the laws of the Constitution of the State of Alabama and any other State.

*** Consent To Contact Debtors On Their Cell Phones:***

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Chilton County Physical Therapy and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. 1/We have read this disclosure and agree that Chilton County Physical Therapy, its employees and/or agents may contact me/us as described above.

Patient (or Responsible Party) Signature

Date

Medical History

Today's Date _____

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Who referred you to us? _____

Marital Status: _____ Number of children: _____ Occupation: _____

Drug Allergies: _____

Other Allergies: (Please Circle) Iodine Latex Tape Other: _____

Hand dominance: (Please Circle) Right Left Height: _____ Weight: _____

Previous Surgeries

Knee (type/year) _____ Back/Neck (type/year) _____

Hip (type/year) _____ Heart (type/year) _____

Shoulder (type/year) _____ Hernia (where/year) _____

Foot/Ankle (type/year) _____ Cosmetic (type/year) _____

Hospital Admissions (non-surgical): _____

Do you use tobacco products? ___ No ___ Yes ___ # Packs per Day

Do you drink alcohol? ___ No ___ Yes ___ Drinks per Week

Are you pregnant? ___ No ___ Yes

Current Medications

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Have you ever had or experienced or currently experiencing:

- | | | |
|--------------------------|---------------------------------|-------------------------------------|
| ___ Y ___ N Gout | ___ Y ___ N Heart Attack | ___ Y ___ N Rheumatoid Arthritis |
| ___ Y ___ N AIDS | ___ Y ___ N High Blood Pressure | ___ Y ___ N Cancer, year _____ |
| ___ Y ___ N Blood Clots | ___ Y ___ N A Fib | ___ Y ___ N Stroke, year _____ |
| ___ Y ___ N Diabetes | ___ Y ___ N Pacemaker | ___ Y ___ N Macular Degeneration |
| ___ Y ___ N Dizziness | ___ Y ___ N CHF | ___ Y ___ N Shortness of Breath |
| ___ Y ___ N Epilepsy | ___ Y ___ N Neuropathy | ___ Y ___ N Unexplained Weight Loss |
| ___ Y ___ N Hearing Loss | ___ Y ___ N Migraine Headaches | ___ Y ___ N Parkinson's |
| ___ Y ___ N Alzheimer's | ___ Y ___ N Dementia | ___ Y ___ N Fibromyalgia |
| Other _____ | ___ Y ___ N Osteoarthritis | ___ Y ___ N Muscular Dystrophy |

Today's Visit: Length of Symptoms: ___ Days ___ Weeks ___ Months ___ Years

Have you ever had similar symptoms before? ___ Y ___ N

Where is your pain? _____

Have you had previous treatment for this problem? ___ Y ___ N By who? _____

Did you have an accident or injury? ___ Y ___ N Accident /Injury Date: _____

Where did it happen? (i.e., home, work, car accident, etc.) _____

Signature _____ Date _____

**Chilton County Physical Therapy
2030 Lay Dam Road
Clanton, AL 35045**

Phone: (205)755-6110

www.chiltoncountyppt.com

Fax: (205)755-6108

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 THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose you PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control you PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

**Abuse and Neglect
Emergencies
National Security**

**Judicial and Administrative Proceedings
Law Enforcement
Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Katie Kinne, at 2030 Lay Dam Road Clanton, AL 35045

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Katie Kinne, our Privacy Officer, at 2030 Lay Dam Road Clanton, AL 35045, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D. C. 20201, or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint.

The effective date of this Notice is 10/25/2014.

Please list anyone we are allowed to give information to:

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

Patient Signature _____



Consent for Care Form

This insurance information has been recorded based on the benefits and eligibility supplied to us by your insurance carrier, and is not a guarantee of payment. Estimated coverage information is given, as a courtesy to our patients. Though, it is not a release of total responsibility for the account balance. It is our policy to bill your insurance carrier; although, you, the patient, are responsible for the entire bill when services are provided to you. The above doesn't apply to patients considered Workers Compensation; however, as compensation you may be held responsible for the charges, in the event your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Chilton County Physical Therapy. I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If further therapy is required beyond the authorization period, I will follow-up to make sure that any additional authorization has been obtained from the insurance carrier prior to additional treatment. If I incur rehabilitation without authorization from my carrier, I will be responsible for the charges in full as well as any non-covered services. I will also be liable for all treatment that exceeds what is allowed by my insurance plan. It is my responsibility to ensure this information remains valid throughout my treatment.

Patient Signature _____

Date _____

Consent for Care and Treatment

I, the undersigned, agree and give consent to Chilton County Physical Therapy to supply medical care and treatment, considering the necessary and proper diagnosis of their physical condition.

Patient Signature _____

Date _____

CHILTON COUNTY PHYSICAL THERAPY

AS OF AUGUST 1, 2019 THERE WILL BE A CHARGE OF \$35.00 ADDED TO YOUR ACCOUNT FOR ALL APPOINTMENTS NOT CANCELLED 24 HOURS BEFORE YOUR APPOINTMENT TIME.

THANK YOU

PLEASE SIGN AND DATE
