towne physical therapy centre
drtowne@townephysicaltherapy.com
Phone (954) 776-9997 Fax (954) 491-1927

Patient Information

Please Print

Date: _____

Patient Name: _____

Parent/Guardian Name: _____

Age: _____

Date of Birth: _____

Address: _____

City:_____ State:_____ Zip: _____

Other Address: _____

City: _____ State:_____ Zip: _____

Home Phone #: (_____)_____

Cell Phone #: (_____)_____

Work #: (_____)_____

Most likely reached at: _____

Emergency Contact Name:_____ Relation: _____

Contact Address and Phone:_____

MEDICAL HISTORY								
	Y	N		Y	N		Y	N
High/Low Blood Pressure			Parkinson's Disease			Macular Degeneration		
Coronary Artery Disease			Asthma			Osteoarthritis		
Aortic Aneurysm			Shortness of Breath			Rheumatoid Arthritis		
Peripheral Vascular Disease			Emphysema			Fibromyalgia		
Heart Attack			Cancer			Psoriasis/Eczema		
Arrhythmia			Kidney Disease			Lupus		
Seizure Disorder			Urinary Tract/Disease			HIV positive/AIDS		
Stroke (CVA or TIA)			Prostate Disease			Osteoporosis/ Osteopenia		
Neuropathy			GI Problems/Disease			Fractures		
Diabetes			Ulcer			Spinal Stenosis		
Hypoglycemia			Diverticulitis			Degenerative Disc Disease		
Hypothyroidism/Hyperthyroidism			Liver Disease			Disc Herniation/Bulge		
Vertigo			Gall Bladder Disease			Difficulty hearing?		
Balance Problems – Inner Ear			Headaches (Tension/Migraine)			Difficulty seeing?		
Balance Problems – Other			Glaucoma			High Cholesterol		

SURGICAL HISTORY								
	Y	DATE		Y	DATE		Y	DATE R/L
Tonsillectomy			Angioplasty			Cervical Surgery		
Appendectomy			Pacemaker			Lumbar Surgery		
D & C			Thyroid			Shoulder Surgery		
Hysterectomy			Gall Bladder			Elbow Surgery		
C-Section			Liver			Wrist Surgery		
Mastectomy R/L			Kidney			Hand Surgery		
Breast Reconstruction R/L			Gastrointestinal			Hip Surgery		
Breast Augmentation R/L			Bariatric Bypass			Knee Surgery		
Prostate			Cataract R/L			Ankle Surgery		
Cardiac Bypass			Eye – Other R/L			Foot Surgery		
Cardiac Catheter					Other:			

SOCIAL HISTORY							
	Y	N	OCC		Y	N	OCC
Do you have stress?				Do you drink?			
Do you smoke?				Do you exercise?			

Allergies/Medicine: _____ **Allergies/Other:** _____

_____ _____

Signature ***Date***

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History of Current Episode

Name: _____ Age: _____

Nature of Problem: _____

Date of Onset: _____ Date of Current Surgery (if applicable):_____

Mechanism of Onset: _____

Is this episode due to an Automobile Accident? _____ Work-Related Injury? _____

Current Pain Level

Please circle: 0 *1 2 3 4 5 6 7 8 9 10*
(no pain) *(ER)*

Where did the pain start? _____ Where did pain spread? _____

Does pain prevent you from sleeping/awaken you? _____

Do you have any numbness/tingling? _____

Do you have difficulty sitting/standing/walking? _____

Is your pain better/worse/same throughout the day? Morning: _____ Mid-Day: _____ Night: _____

Current medications: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Have you previously received physical therapy in the current calendar year? Yes _____ No _____

If yes, approximately how long? _____

Is there litigation associated with this episode? Yes _____ No _____

Attorney: _____ Phone/Fax: _____

***Signature*_____ *Date* _____**

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Authorization/Consent/Financial Policy

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Towne Physical Therapy Centre is hereby authorized to disclose all or any part of the medical record of the patient named in the registration as per patient request. The authorization is effective for three years from the date of service and may be revoked with written notification

CONSENT FOR MEDICAL TREATMENT

The undersigned hereby consents to any therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of Towne Physical Therapy Centre as to the results of any treatment given or performed.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge a ***non-negotiable*** flat fee for services rendered. You are responsible for payment. **By my signature below, I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered.**

SCHEDULING AND MISSED APPOINTMENTS

It is the patient's responsibility to make and confirm their appointments (date and time). We are unable to guarantee standing appointments but will make every effort to schedule appropriately so that a patient never has an extended wait to see a therapist. If you are unable to attend an appointment, we ask that you call 24 hours in advance to let us know. By calling us, you will allow us to make the appropriate changes to the schedule.

A $150 cancellation fee will be charged for missed appointments without 24 hour notice.

MEDICAL EMERGENCIES

It is our policy to call 911 in case of medical emergencies.

I certify that I have read and understand fully the above information.

_____	_____	_____
Signature of Patient or Responsible Party	Print Name	Date
_____	_____	_____
Signature of Parent or Guardian	Print Name	Date

rev 2015

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HIPAA COMPLIANCE
Privacy and Confidentiality
Towne Physical Therapy Centre
(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.)

How We Will Use or Disclose Your Health Information:

1. **Treatment:** We will use your health information for treatment. Information will be recorded by health care professional, to determine the course of treatment. Members of the health care team will record actions and observations. Physicians will know how you are responding to treatment. We will provide your physician or subsequent health providers with copies of reports to assist with your treatment after discharge.
2. **Payment**: We will use your health information for payment. Reimbursement is due at the time of services rendered. The information on or accompanying the bill may include information that identifies you as well as the health care provided.
3. **Health Care Operations**: We will use your health information for regular health operations. Quality Improvement Teams may use information in your health record to assess the care and outcome in your case and others like it. This will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.
4. **Business Associates:** There are some services provided in our facility through contracts with Business Associates. Business Associates may be accountants, consultants, billing services, transcription services, and attorneys. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform their job. We require the Business Associate to appropriately safeguard your health information.
5. **Communication with Family:** The health care professionals may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
6. **Food and Drug Administration:** The health care facility may disclose to the FDA health information to adverse events with respect to product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.
7. **Public Health:** As required by law, the health care facility may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
8. **Law Enforcement:** The health care facility may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
9. **Report:** When a work force member or business associate believes in good faith that the health care facility has engaged in unlawful conduct or otherwise violated professional or clinical standards and may potentially be endangering one or more patients, workers or the public health authority or attorney.
10. Any other use or disclosure other than stated above will be made only with your written authorization and that authorization may be revoked by you in writing.
11. We may contact you to provide appointment information and we may provide information related to treatment alternative or other health related benefits and services that may be of interest to you.
12. This notice covering the privacy of your protected health information is required by law.
13. This healthcare facility is required to abide by the terms of this notice which is currently in effect.

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HIPAA COMPLIANCE
PRIVACY AND CONFIDENTIALITY

Although your health record is the physical property of the health care facility, the information in your records belongs to you. You have the following rights:

- You may request that the health care facility NOT use or disclose your health information for a particular related treatment, payment, the facility's general health care operations, and/or to a particular family member, other relative or close friend. Although we will consider your request, please be aware we are no obligation to accept it or to abide by it. For more information about this right, see code 45 of Federal Regulations (C.F.R.)164.522(a). The facility may contact you to provide appointment reminders. You have the right to receive confidential communications of your protected health information. As a caveat please understand that communications between staff and patients during therapeutic exercises may be compromised given the physical plant.

- If you are dissatisfied with the manner which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the health care facility's Privacy Officer. We will attempt to accommodate all reasonable requests. For more information about this right, see 24 C.F.R. 164.522 (b).

- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the periods established by law. If you request copies, the health care facility will charge you a reasonable and cost-based fee. For more information, see 45 C.F.R. 164.524. Upon written or verbal request of a patient, a release of records form is to be provided to the patient for his or her signature; this form should be provided to the patient as expeditiously as possible; after receipt of the executed records release, a copy of the requested patient records is to be provided to the patient in the manner designated by the patient; such record copies are to be provided within 14 days of receipt of the executed release and in no case, later than 30 days after receipt of the release.

- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing and must provide a reason to support the amendment. For more information, see 45 C.F.R 164.526.

- You may request that we provide you with a written accounting of all disclosures made by us during the time for which you request. Such requests must be made in writing. Accounting will not apply to the following: disclosures made for reasons of treatments, payment or health care operations, disclosures made to you or your legal representative or any other individual involved in your care: disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes. You will not be charged for your first account request, any requests thereafter will be charged at a reasonable fee. For more information, see 164.524. No other disclosures or uses of your medical records will be made other than stated in this document without your written authorization, see 164.520 sub (b) sub (ii) (E).

- You have a right to obtain a paper copy of this document.

- You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

If you have any questions and would like additional information, you may contact the health care facility's Privacy Officer.

If you believe that your privacy rights have been violated, you may file a complaint with the health care facility. These complaints must be filed in writing on a form provided by the health care facility. The form can be obtained from the Privacy Officer and returned to the Privacy Officer. You may also file a complaint with the secretary of the federal Department of Health and Human Services. There will be no retaliation for filing a complaint. There will be no changes in this privacy practice without a written notice provided to you setting forth any change: HIPPA Compliance Officer: Mary Ann Towne, D.P.T. 954-776-9997 Towne Physical Therapy Centre

Signature _____ Date _____
Revised 2/04/15

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Date: _____

To Whom It May Concern:

Please release my most current diagnostic report(s) to Towne Physical Therapy Centre as follows:

X-Ray _____
MRI _____
Cat Scan _____
Other _____

On the following:

Neck _____	Back___
Shoulder___	Hip____
Elbow_____	Knee___
Wrist/Hand___	Foot/Ankle____

Other_____

Thank You,

_____
Print Name

_____
DOB:

_____
Signature