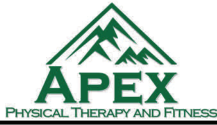


Registration Form

PATIENT INFORMATION:

First Name: ___________________Middle:_____ Last: ________________________________Birth Date ___/___/___

Address: __________________________ City: _____________________State: ___ Zip: __________Age: __________

Social Security Number _________-_______-_________ Sex: ___Male ___Female

Marital Status (please circle): Single Married Widowed Separated Divorced

Are you employed? ___yes___ no ___retired Are you disabled? ___yes ___no Reason: ______________________

Occupation (former occupation, if retired):____

Employer:____________________________ Employer Address:____

CONTACT INFORMATION:

Home #:_______________________________ Work #: ________________________________ EXT. _______________

Cell #:_________________________________ Email: ____

My preferred method to reach me during the day is: home /cell /work /email

In case of emergency, contact:

Name: ____ Relationship: _________________________

Home #: ______________________ Work#:____________________________ Cell#______________________________

Primary Care Doctors Name: ___________________________________ Phone #:_______________________________

CANCELLATION/NO SHOW POLICY:

If you do not provide 24 hours notice to cancel an appointment, or you do not attend a scheduled appointment, you will be charged a no-show/cancellation fee of $30.00.

We will not impose this fee with weather related cancellations.

ASSIGNMENT OF BENEFITS:

I authorize Apex Physical Therapy & Fitness, Inc. to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

I authorize release of any information related to any claims to all my insurance companies or other relevant parties.

I understand that I am individually responsible for my bill and agree to pay all charges for services and items provided to me as well as attorney fees incurred by Apex Physical Therapy and Fitness in the collection of charges and services. If I am unable to execute this form then the guardian/attorney-in-fact acting on my behalf is responsible for the same obligation

I understand that I am individually responsible to pay co pays or deductibles. If I am unable to execute this form then the guardian/ attorney-in-fact acting on my behalf is responsible for the same obligation

I authorize payment of health benefits otherwise payable to me, directly to Apex Physical Therapy & Fitness, Inc.

I permit a copy of this authorization to be used in place of the original.

This "Signature on File" is valid for one year from the date indicated below.

____ ___________________

Signature of Patient, Beneficiary or Guardian Date

HEALTH INSURANCE:

Do you have health insurance? ___ yes ___ no If yes, please fill out below:

Insurance Name: ______________________ Name of insured: ______________________

DOB of insured: ______________________ Relationship to insured: ______________________

Patient ID#:______________________ Group# (if any): ______________

RESPONSIBLE PARTY:

Please fill out below if someone other than yourself is responsible for paying any bills incurred AND you do not have health insurance. The responsible party will also be responsible for any attorney's fees associated with the collections costs associated with non-payment of bills.

Name of person responsible for payment of services: ______________________________

Relationship to patient: ______________________Phone #:______________________

Address:____

AUTO INSURANCE INFORMATION:

Is this injury related to an auto accident? yes no If yes, please fill out below:

Date of Injury: ___/___/___

Name of your Auto Insurance (or the car you where in):

Auto insurance name: ______________________ Name of insured: ______________

Policy #:______________________ Claim #/ID#: ______________

Name of adjuster: ______________________ Phone #: ______________

Name of the Auto Insurance for the other car:

Auto insurance name: ______________________ Name of insured: ______________

Policy #:______________________ Claim #/ID#: ______________

Name of adjuster: ______________________ Phone #: ______________

WORKERS COMPENSATION:

Is this injury related to a workers compensation claim? ___ Yes ___ No If yes, please fill out below:

Date of Injury: ___/___/___

Insurance Name: ______________________ Claim#:______________________

Name of Adjustor: ______________________ Phone#:______________________

ATTORNEY INFORMATION:

Is there an Attorney involved? ___Yes ___No If yes, please fill out below:

Attorney's Name: ______________________ Phone#: ______________________

Address: ____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of information during the course of my treatment at Apex Physical Therapy & Fitness, Inc. including but not limited to medical records, verbal and written communications to my insurance company, doctors, and third party payers.

I have received and read a copy of Apex Physical Therapy & Fitness, Inc.'s privacy procedures.

____ ___________________

Patient Signature or Legal Guardian Date

We thank you for filling out this form completely. The therapist will review this information at your appointment and you will have the opportunity to discuss any questions, concerns or clarifications.

CURRENT COMPLAINT:

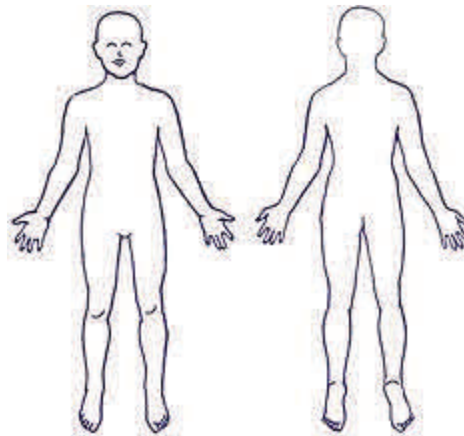
When did your injury occur? _____/______/______

What is your main complaint?____

____

____

Using the body diagram below please mark the areas where you are having problems:



Please rate your pain on the scale from 1-10, circle one number below that describes your pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain Uncomfortable Worst Pain Imaginable

Has this or something similar happened in the past? yes no

If yes, explain past episodes:

GENERAL HEALTH INFORMATION:

What is the date of your last physical? ____________________

Do you smoke? ___ yes ___ no

Do you exercise beyond normal daily activities and chores? yes no

If so, what:____

MEDICAL HISTORY:

Please check (___) if you have or had any of these medical issues:

___Heart Attack
___Heart problems/disease
___Cancer
___High cholesterol
___Osteoporosis
___Lung problems
___Head injury
___Seizures/epilepsy
___Hepatitis
___Artificial Bones Joints
___Developmental or growth problems

___________Angina
___________Migraines
___________High blood pressure
___________Psychological Disorder
___________Broken bones/fractures
___________Diabetes/high sugar
___________Multiple sclerosis
___________ Skin diseases/problems
___________Ulcers/stomach problems
___________Pacemaker

___Heart murmur
___Stroke
___Circulation problems
___Arthritis
___Blood Disorders/Anemia
___Hypoglycemia/low sugar
___Muscular dystrophy
___Depression
___Asthma

If you checked yes to any of the above, please explain:

SURGERIES:

Please list all past surgeries and the date of surgery:

SYMPTOMS:

Please check if you have had any of the following symptoms in the past year:

Check all that apply

___Chest pain ___Heart palpitations ___Cough hoarseness

___Shortness of breath ___Dizziness/LOC ___Coordination problems

___Excessive Weakness ___Loss of balance ___Difficulty walking

___Joint pain or swelling ___Pain at night ___Difficulty sleeping

___Loss of appetite ___Nausea/vomiting ___Difficulty swallowing

___Vision Problem ___Weight loss/gain ___Hearing problems

___Fever/chills/sweats ___Headaches

___Bowel problems (constipation/loss of control)

___Urinary problems (leakage/retention)

Other: ____

OTHER CLINICAL TESTS:

Please check if you have had any of the following:

___ CT Scan/CAT Scan ___ Ultrasound ___ EEG (electroencephalogram)

___ EKG (electrocardiogram) ___ MRI ___ EMG (electromyogram)

___Myelogram ___ Nerve Conduction Velocity

MEDICATIONS:

*Please list all of the medications and amounts that you are taking (over the counter and prescribed):

____

____

____

SIGNATURE:

I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. I hereby give my consent for physical therapy treatment and services at Apex Physical Therapy & Fitness, Inc.

Patient's or Legal Guardian's Name: ________________________________

(Please Print)

Patient's or Legal Guardian's Signature: ____________________________ Date: ______________

Apex Physical Therapy & Fitness, Inc.
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.

This notice takes effect on January 1, 2014 and remains in effect until we replace it.

Our Pledge Regarding Medical Information:
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at Apex Physical Therapy & Fitness, Inc. We need this record to provide you with quality care and to comply with the federal Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and HIPAA regulations, 45 CFR Part 160 and 164. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

<u>YOUR INDIVIDUAL RIGHTS</u>
1. You Have a Right to: 1. Look at or get copies (electronic or paper) of your medical information. We will provide a copy within 30 days of written request. We may deny your request to inspect and copy in certain limited circumstances. If we deny your request you may have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review. Copy fees may be charged to you for such copies at a rate specified in NH RSA 332-I:1(I). We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other State of Federal needs-based benefit program.
2. Receive a list with which we shared your information.
3. Request that we place additional restrictions on our use or disclosure of your medical information.
4. Choose somebody to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
5. Request that we change/correct your medical information. We may deny your request if the request is not in writing, if the information and accurate and complete, or if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation within 60 days. You may respond with a statement of disagreement that will be added to the information that you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. Receive a copy of this privacy notice. We will provide you with a paper copy of this notice at any time.
7. File a complaint if you believe your privacy rights have been violated. You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-877-696-6775. We will not retaliate against you for filing a complaint.
8. Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will accommodate any reasonable requests.

<u>OUR LEGAL DUTY:</u>
Law Requires Us to:
1. Not reveal confidential communications or information without your consent, unless provided for by law or by the need to protect your welfare or the public interest. (NH RSA 332-I:2.)
2. Obtain your written consent to release information to anyone not otherwise authorized by law to receive it. (NH RSA 151:21 & 151:21-b.)

3. Provide you with this notice describing our legal duties, privacy practices, and your rights regarding this information.
4. Abide by the terms of the notice that is now in effect.

WE HAVE THE RIGHT TO:
1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before that changes.
3. Reveal confidential communications and information when provided for by law or by need to protect your welfare or the public interest. (NH RSA 332-I:2.)

NOTICE OF CHANGE TO PRIVACY PRACTICES:
1. If there are any significant changes in our privacy practices, we will change this notice and make the new notice available upon request. The revised practices will be applied to all protected health information that we maintain.

USE AND DISCLOSURE OF MEDICAL INFORMATION:

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. We will not use or disclose your medical information for any purpose not listed below, without your specific authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you. We may also share medical information about your to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use or disclose your health information to determine and remit proper payment for health care treatment or services you receive, or to receive payment for health care treatment provided to you at Rockingham County Long Term Care Services. For example, your health information may be used to determine eligibility for coverage, billing, claims management and collection activities.

FOR THE FACILITY: We may use and disclose your medical information for our facilities operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting certificates, licenses and credentials needed to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and for use by our facility, we may use and disclose medical information for the following purposes.

NOTIFICATION: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location and general condition. If you are present we will get your permission, if possible, before we share.
In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS: We can use or share health information about you for workers' compensation claims under NH RSA 281-A, law enforcement purposes or with a law enforcement official. It may also be shared with health oversight agencies for activities authorized by law. We may also share information for special government functions such as military, national security, and presidential protective services.

DECEDENTS: Your health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

LEGAL COMPLIANCE: We may disclose medical information to comply with applicable law. For example to respond to regulatory authorities responsible for oversight of government benefit programs or courts in the course of judicial or administrative proceedings: and to law enforcement officials during an investigation. We may also, as required by law, disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or a possible victim of other crimes.

Apex Physical Therapy & Fitness, Inc.
NOTICE OF PRIVACY PRACTICES

QUESTIONS AND COMPLAINTS

If you have and questions about this notice or if you think that we may have violated your privacy rights, please contact by phone or in writing:

Meaghan Bonin, DPT
199 State Route 101, PO Box 253, Amherst, NH 03031
Phone: 603-249-3337

You may also submit a written complaint to the U.S. Department of Health and Human Services at 200 Independence Ave., SW, Washington, DC 20201. You will not be penalized or otherwise retaliated against for filing a complaint.

ACKNOWLEDGEMENT
I have obtained the Notice of Privacy Practices and have had the opportunity to review it.

Patient's or Legal Guardian's Name: ____
(Please Print)

Patient's or Legal Guardian's Signature: ____

Date: ________________________
This Notice is effective on or after January 1, 2014