ADVANCED ORTHOPAEDIC
Physical Therapy PSC

Patient Registration Form

Name _____ Birth Date_____
First MI Last

Address_____
Street City State Zip

Phone (with area code)

Cell_____Home_____Work_____

Sex: Male/Female Marital Status: Single Married Divorced Widowed

Email Address _____

Employer_____Occupation_____

Referring Physician _____Date of Next Visit_____

Parent (if patient is under 18) Emergency Contact Name_____

Phone Number _____ Relationship to Patient_____

Have you had any other Physical Therapy, Occupational Therapy, or Chiropractic Visits this year?

Yes_____ No _____ If yes, how many? _____

Are you currently being treated by Home Health? _____

INSURANCE INFORMATION: Please present your card to the front desk

PLEASE be advised, our office only files claims with YOUR PRIMARY INSURANCE

Primary Insurance Name _____

IF YOU WOULD LIKE A COPY OF OUR NOTICE OF PRIVACY PRACTICES, PLEASE LET THE FRONT DESK KNOW AND THEY WILL GET YOU A COPY

Patient Name:_____

Patient Consent Form

I give Advanced Orthopaedic Physical Therapy my consent to use or disclose my protected health information to conduct my treatment, to obtain payment from my insurance companies, and for health care operations like quality reviews.

I acknowledge that I have been given a copy of Advanced Orthopaedic Physical Therapy's Privacy Practices.

I understand that Advanced Orthopaedic Physical Therapy has a right to change their privacy practices and that I may obtain any revised notices at Advanced Orthopaedic Physical Therapy's office.

I understand that I have the right to request a copy of my health disclosure report at any time. I also agree that I have the right to request a restriction of how my protected health information is used.

I understand that I may revoke this consent at any time, by making a request in writing.

Signature _____ Date _____

(Patient, parent, or legal guardian)

If signed by a patient representative, state relationship _____

Advanced Orthopaedic Physical Therapy, PSC

9400 Williamsburg Plaza, Suite 100

Louisville, KY 40222

Phone: 502.412.4486

Fax: 502.412.4490

Patient Name:_____

Patient Medical History

To the best of your knowledge, do you have or have you had:

1. High Blood Pressure	yes	no	25. Thyroid Problems	yes	no
2. Chest Pains/Angina /Heart	yes	no	26. Polio/Muscle Disease	yes	no
3. High Cholesterol	yes	no	27. Seizures	yes	no
4. Pacemaker	yes	no	28. Chronic/Migraine	yes	no
5. Shortness of Breath	yes	no	29. TMJ Disorders	yes	no
6. History of Smoking	yes	no	30. Chills/Fevers Sweats	yes	no
7. Lung Problems	yes	no	31. Swelling of Extremities	yes	no
8. Emphysema/Asthma	yes	no	32. Osteoporosis	yes	no
9. Bleeding/Bruising	yes	no	33. Depression	yes	no
10. Anemia	yes	no	34. Fibromyalgia	yes	no
11 Diabetes	yes	no	35. Chronic Fatigue Syndrome	yes	no
12. Hypoglycemia	yes	no	36. Lyme's Disease	yes	no
13. Lightheadedness/Dizziness	yes	no	37. Cancer/Tumors/Growths	yes	no
14. Blood Disorders	yes	no	38. Are you pregnant?	yes	no
15. Concussion	yes	no	39. Gynecological Disorders	yes	no
16. Fainting Disorders	yes	no	40. Bladder Incontinence	yes	no
17. Anxiety/Panic Attacks	yes	no	41. Bowel Incontinence	yes	no
18. Arthritis/Joint Pain	yes	no	42. Diarrhea/Nausea/Vomiting	yes	no
19. Artificial Joints	yes	no	43. Unexplained Weight Loss	yes	no
20. Kidney Disease/Stones	yes	no	44. Other _____		
21. Hepatitis	yes	no	**UNDER 18 ONLY**:		
22. Spinal Cord Injury	yes	no	45. Immunizations Current	yes	no
23. Traumatic Brain Injury	yes	no			

Fractures: Please list body part and the date the fracture occurred

_____

_____

Height _____ Weight _____

Do you have any metal implants?

If so, where? _____

Do you smoke?

How much per day?_____

Do you exercise regularly?

How often? _____

Are you currently pregnant: _____

Patient Name:_____

Patient Medical History Page 2

Regarding your current condition:

(Please rate your pain) 0 1 2 3 4 5 6 7 8 9 10

no pain ***worst pain***

Do you have any "pins and needles" or numbness in your extremities? Yes ( ) No ( )

Do you have any weakness in your arms or legs? Yes ( ) No ( )

Do you have any coordination or balance problems? Yes ( ) No ( )

Do you have difficulty walking? Yes ( ) No ( )

Do you experience dizziness or vertigo with a change in position? Yes ( ) No ( )

Have you experienced headaches as a result of your condition? Yes ( ) No ( )

Were you injured in a work-related incident? Yes ( ) No ( )

Please list all current medications:

_____

Please list all surgeries/dates: (use back of page if necessary):

_____

Please check recent diagnostic tests performed:

X-Ray ( ) MRI ( ) CT Scan ( ) Bone Scan ( ) Bone Density ( ) EMG ( ) Ultrasound ( )

Please briefly describe your chief complaint

_____

_____

_____

I believe all information to be true and complete:

Patient Signature: _____ Date: _____

Patient Name:_____

Patient Guidelines

To receive maximum benefit from your rehabilitation program, it is of utmost importance that you attend all of your therapy appointments and follow your home exercise instructions.

Please allow travel time to ensure that you are present at the time of your scheduled appointment. If you are more than 10 minutes after your scheduled appointment time, we have the right to cancel your appointment and charge a $35 fee.

If you are unable to keep your appointment, you must notify our front office (502.412.4486) at least 24 hours prior to your scheduled appointment – cancellations without sufficient notice will result in a $35 fee for missing your appointment.

Due to our busy schedule, you are requested to schedule your appointments one (1) week in advance.

Please be aware that your appointments may generally be on any day of the week and do not have to be set up in a specific pattern. For example, if you are to receive treatment three times per week, the appointments do not have to be on Monday, Wednesday, and Friday.

Also, please be advised that should your regular therapist be unavailable at the time that you wish to schedule an appointment, one of our other therapists can see you for your therapy. All our therapists are excellent and trained to perform scheduled therapy techniques on every patient.

We will bill your primary insurance only. AOPT does not file claims with secondary insurance carriers. If you need a claim form from our office to file your secondary coverage, please contact our billing office for their assistance (502.412.4486). We collect copays and estimates to go towards your deductible at the time of service. A $2.00 processing fee will be charged to all credit cards to help cover the cost of credit card processing fees.

Statements are sent out monthly. Your statement will show any activity on your account within the prior 30 days. Should you have questions once you receive your statement, please contact our billing office (502.412.4486).

Your cooperation is appreciated. We look forward to working with you and obtaining optimal results from your rehabilitation program. Should you have any questions regarding this form, please ask us.

Signature _____ Date _____

Patient Name:_____

Notice of Privacy Practices Patient Acknowledgement

Confidential Communication Authorization

_____ _____
Print Patients Name Date

I_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

have received this office's NOTICE OF PRIVACY PRACTICES and consent to the use and disclosure of my

personal health information as outlined in the NOTICE OF PRIVACY PRACTICES.

COMMUNICATIONS

May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we leave a message for you at home or on your mobile phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If Yes, please name the family members allowed: _____
_____

Please specify who we may contact regarding your physical therapy matters or billing issues.

Home Phone

Give information to spouse	YES	NO	N/A
Give information to a parent/guardian	YES	NO	N/A
Give information to a child	YES	NO	N/A
Leave information on voice mail	YES	NO	N/A

E-Mail

Email information to personal email	YES	NO	N/A

Mail

Send information addressed to you (may include postcards)	YES	NO	N/A

Patient Signature_____ Date_____

Patient Name:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided the law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes to our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer**.** Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other people you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Patient Name:_____

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Breach Notification. The office will notify patients in writing should a breach in their protected information occur.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards, or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 1.00 for each page and the staff time charged will be $ 50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore, these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment, or healthcare operations. You can request non-routine disclosures going back 6 years. Information prior to that date would not have to be released.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS

If you have any questions or would like additional information regarding our Privacy Practices, please contact our Privacy Officer and we will be happy to assist you.

HOW TO CONTACT US

Practice Name: Advanced Orthopaedic Physical Therapy, PSC
Privacy Officer: Haven Fuchs
Address: 9400 Williamsburg Plaza, Suite 100, Louisville, KY 40223
Telephone: 502.412.4486
Fax: 502.412.4490

Patient Name:_____