SMaRT Therapy

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REGISTRATION FORM

(Please Print)

Today's Date:	**Primary Care Physician:**	**Date Last Seen:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Address:	DOB:	Age:	Sex: ☐ M ☐ F
City: State:	Zip code:	Social Security no.:	Home/Cell Phone #:
E-Mail address:	Employer:	Employers Phone #:	
Spouses name:	Soc Security No:	DOB:	

Referring Physician: _____ Ph#_____

INSURANCE INFORMATION

(Please give your insurance card(s) to receptionist)

Primary Insurance:

Subscriber's name:	Subscriber's S.S #:	Birth date:	Group #:	Policy #:

Patient's Relationship to subscriber:

IN CASE OF EMERGENCY

Name & address:	Relationship to patient:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize SMaRT Therapy and/or insurance company to release any information required for processing my claims.

(x) Patient/Guardian Signature: ***Date:***

SMaRT Therapy – Medical History

Name: _____ Date: _____
Date of birth: _____ Age: ____ Height: _____ Weight: _____ Race: ___
Date of last appointment with referring physician: _____
Date of next appointment with referring physician: _____

SIGNIFICANT MEDICAL HISTORY (Please check all that apply)

__ Heart Disease	__Hepatitis	__Pacemaker	__ High blood press.
__Cancer	__HIV/AIDS	__Implants (metal)	__Arthritis
__Stroke/CVA	__Pregnant	__Asthma	__Osteoporosis
__Diabetes	__Allergies	__Vision/Hearing	__Epilepsy/Seizures

Please list all previous surgeries:

_____

_____

Current Diagnosis:

What are you here to receive physical therapy for?
__Neck __Back __Shoulder/Elbow __Arm/wrist/hand __Hip __Knee __Foot/Ankle
How long have you had your current condition? _____
Have you ever had or are you scheduled to have surgery for your current condition?
___ Yes __ No If yes, When? _____
Have you ever received an injection for this condition? __ Yes __ No
Which of the following diagnosis tests has your physician done for you?
__ X-Ray __CT Scan __Bone scan __MRI __Nerve EMG/NCV
Please list all medications you are currently taking:

_____

_____

Social History:

Are you currently working? __Yes __No where: _____
Duties/Job Description: _____
Are you working: __Full time __Part Time __Retired __Disabled __Temporary Leave
Did your physician give you any restrictions for work? __Yes __No

GOALS:

What things can't you do now because of your current condition that you use to be able to do?

_____

_____

Sports Medicine and Rehab Therapy

SMaRT Physical Therapy

Lee Bishop, PT
Garrett Pye, PT

Clayton Conners, PT
Audrey Jernigan, PT
Nick Child, PTA

Please select all that apply to you:

- o I am currently receiving home health (including any type of nurses coming to the home, therapist, etc.)
- o I have had home health this year. If so, what was the discharge date: _____
- o I am currently receiving or have had massage therapy this year. If so, when was the last treatment _____
- o I am currently having or have had previous therapy at SMaRT PT or at another facility.

If so, at what clinic? _____

o None of these apply to me.

Failure to answer these correctly can result in your insurance not covering our services. If the insurance denies paying us for your physical therapy for any of the above, you will be held responsible for the bill.

By signing below, I agree to the above statement.

_____

SMaRT Therapy

Waycross, Georgia

Patient:_____ Date of Birth_____

AUTHORIZATION

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to SMaRT. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize SMaRT to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____**Date**_____

Are you the Guarantor? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to SMaRT, I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgment of the Physical Therapist.

X Signature_____**Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)

By signing this form ,you acknowledge that SMaRT has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in a various situation .We must attempt to have you sign this form on your first date of service with us after April 14,2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

☐ **I have received a copy of the Privacy Notice of SMaRT Therapy.**

☐ **SMaRT Therapy has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.**

X Signature_____**Date**_____

ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY PERSONAL HEALTH INFO

We at SMaRt value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (Including spouses, parents, children, or any significant others without your written consent). If you want anyone other than your referring physician to have access to your medical information please list their name, address, relation, and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name _____ Relation _____
Name _____ Relation _____
Name _____ Relation _____

X Signature_____**Date**_____

☐ **This will never expire** ☐ **This will expire on** _____

The staff of SMaRT Therapy should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? **Yes__ No __**
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: _____

Employee Signature: _____ Date _____

it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information 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. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

(Vers. M1SSS04) #19129/39129 – ©2004 Medical Arts Press® 1-800-328-2179

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

SMaRT
sportsmedicine and rehabilitation therapy

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 our organization. We need this record to provide you with quality care and to comply with certain legal requirements. 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.

*These privacy practices are currently in effect and will remain in effect until further notice.

Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

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 the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written 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 who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose 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, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. 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.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:

We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if