WELCOME!!

Date_____/ _____/ _____

Patient Information

Name_____ _____
Last First Middle SS#

Street Address_____

City, State, ZIP_____

Phone # (home)_____(work)_____(cell)_____

Can we call you at work? ___Yes ___No DOB_____/_____/_____ Age_____ Sex: ___Female ___Male

E-Mail Address:_____

Occupation: _____Employer_____

How did you hear about our practice?_____

Emergency contact: _____Relation: _____

Emergency contact phone #: Primary _____ Secondary_____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self) _____

Do you have health insurance? ____Yes ____No Do you have secondary insurance ____Yes ____No

Primary Insurance_____

Secondary Insurance _____

*Please Provide This Office With A Copy of Your Insurance Card (s) and Drivers License

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance with _____
and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO JONES PT: PHYSICAL THERAPHY AND PHYSCIAL TRAINING INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physical therapist to release all information necessary, including diagnosis and the records of any exams or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions:

SIGNATURE (x) _____DATE_____

Consent to Care

Patient Name:_____

A patient coming to the physical therapist gives him/her permission and authority to care for the patient in accordance with appropriate test; diagnosis; and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies; may render the patient susceptible for injury. The physical therapist, of course, will not provide specific health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physical therapist.

I have read and understand the foregoing.

Patient's Signature_____Date_____

CONSENT NOTICE FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Purpose: This consent/notice describe how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We deserve the right to change our practices. Should we change our practices, we will mail a revised notice to the address you have supplied.

You will be supplied with all of our current rules.

_____ _____/ _____/_____

Patient's Signature of Understanding and Acceptance of HIPPA form Date

Financial Office Policies

1. All patients are on a cash basis until our staff may verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
4. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefit and or lien authorizing payments to be sent to the provider.
5. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
6. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a weekly basis. Any such plan or arrangements will be discussed during your report of findings.
7. This office does not warrant or guarantee that your insurance will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient insured.
8. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.
9. This office will submit an insurance claim one time. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
10. If this office enters into a lien with the patient and their attorney, the agreement is law abiding and can be used in court to collect all fees related to services rendered.
11. If your account should go to collection for any reason, it will be the patient's responsibility for any court cost, attorney fees, and/or collection cost incurred in collecting the account balance.
12. I authorize the release of any medical or other records or information necessary to process any claims from this office.
13. All insurance payments are applied to your account as long as any balance is due, regardless of which company issues a check first. This means refunds are made only after your balance is completed and cleared with this office.
14. If you receive correspondence of checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is on assignment to this office.
15. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
16. This office accepts personal checks and cash.
17. If you have any questions concerning this or any other matter, please speak with the front desk person prior to seeing the physical therapist.
18. Please be advised that if you **do not** show up to a scheduled appointment on the second occurrence you will be removed from the regular schedule.
19. Please be advised that copies of medical records will be **$15.00 to $20.00**.

Thank you for your cooperation on this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____/_____/_____

Patient Signature (or Responsible Party) Date

REVIEW OF SYSTEMS
Have you had or do you experience?

Cardiovascular System	**YES**	**NO**
Elevated cholesterol	___	___
Sweating associated with pain	___	___
Palpitations	___	___
Swelling of extremities	___	___
History of smoking	___	___
Orthopnea (difficulty breathing)	___	___
Pacemaker	___	___
Hypertension	___	___

G.I. System	**YES**	**NO**
Difficulty swallowing	___	___
Heartburn	___	___
Jaundice (yellow appearance)	___	___
Specific food intolerance	___	___
Constipation	___	___
Diarrhea	___	___
Change in color of stool	___	___
Rectal bleeding	___	___
Gall bladder problems	___	___
Liver problems	___	___

G.U. System	**YES**	**NO**
Dysuria (painful urination)	___	___
Hematuria (blood in urine)	___	___
Incontinence	___	___
Frequency of urination	___	___
Urinary urgency	___	___
Post menopausal vaginal bleeding	___	___
Painful intercourse	___	___
Hx of STD	___	___
Date of Last Period ___/___/___		

Pulmonary System	**YES**	**NO**
Dyspnea (labored breathing)	___	___
Wheezing	___	___
Prolonged cough	___	___
Sputum production	___	___
Amount/Color:		
_____		

Endocrine System	**YES**	**NO**
Excessive thirst	___	___
Excessive hunger	___	___
Polyuria (large volume of urine)	___	___
Excessive sweating	___	___
Fatigue	___	___
Weakness	___	___
Thyroid problems	___	___

Neurological System	**YES**	**NO**
Ataxia (poor muscle coordination)	___	___
Memory lapses	___	___
Confusion	___	___
Head Trauma	___	___
Neurological disorder	___	___
Tremors	___	___
Slurred speech patterns	___	___
Hearing/Visual disturbances	___	___

	YES	**NO**
Other Systems		
ENT (ears, nose, throat)	___	___
Integumentary (skin)	___	___
Lymphatic	___	___
Psychiatric	___	___
Musculoskeletal	___	___
Cancer	___	___
Type: _____		

235 E. Ponce de Leon Ave • Suite 160 • Decatur, GA 30030 • 404-377-9107 • FAX 404-377-9109

Jones PT: Physical Therapy and Physical Training

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Decatur, GA 30030

Phone: 404-377-9107
Fax: 404-377-9109
E-mail: JonesPTPT@aol.com

HIPPA POLICY - Information Privacy

CONSENT/ NOTICE FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
PURPOSE: This consent/ notice describe how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We deserve the right to change our practices. Should we change our practices, we will mail a revised notice to the address you have supplied.
We understand that medical, personal, and financial information about you is valuable and must be safeguarded. We are committed to protecting this vital information about you. We create designated record sets to, to provide you with quality of care and services, including (but not limited to) financial/billing information and clinical health information. We need this type of information to provide you with an adequate diagnosis (es) and treatment plan as well as to comply with certain federal and state requirements.
Under the Health Insurance Portability and Accountability Act (HIPPA) of 1996, we are required to provide to you the following:

- Detailed notice/ notification (upon your request) of all our information practices, patient rights regarding confidentiality of your information, and the uses/ disclosers of your information;
- An accounting of the disclosures made to others for the purposes other that treatment, payment, healthcare operations;
- Informed consent related to the disclosure of information for purposes of treatment, payment, healthcare operations with the opportunity for you to limit or restrict certain disclosures;
- Specific authorization for release or your information for purposes other than treatment, payment, healthcare operations;

Our facilities compliance with the patient's "Right to Know" provision, under this legislation, ensures that
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Our facilities compliance with the patient's "Right to Know" provision, under this legislation, ensures that you will be able to access your records, obtain
photocopies, and amend/correct the information as
directed by law. You have the right to revoke your
consent at any time by notify our compliance officer verbally and/ or in writing. If you have concerns or would like to report an alleged violation of your
information confidentially/security, please notify any member of our staff or contact our Privacy Officer, Mandisa Jones (404) 377-9107.
How we use and disclose information about you:
For Treatment purposes: In our ongoing efforts to provide quality of care, we may use your information to assure prompt and adequate medical diagnosis, treatment, therapy, supplies, medication, services, and/or medical equipment. We may disclose health information to doctors, specialist (such as podiatrist, cardiologist, oncologist, neurologist, etc.) nurses (including but not limited to licensed practical nurses, registered nurses, clinical nurse practitioners, etc.), hospitals, and transport company/ ambulance service. This disclosure maybe within the facility or outside of the faciityin either written or electronic communication.
For Payment purposes: We may use and disclose
personal and medical information about you so that healthcare services and treatment you receive may be collected from an insurance company and/or third party. Likewise, if you are a member of the military, we may need to disclose certain medical and per-

sonal information to the Department of Veterans Affairs to determine if you are eligible for benefits.
For Healthcare operations purposes: We may use and disclose information about you for various types of healthcare operations. These uses and disclosures are necessary for the individual care and/or performance of our staff in certain types of illnesses/conditions. We may remove information that identifies you from this set of medical information so that others may use it to study healthcare and healthcare delivery without learning who the specific patients are. Our facility uses a patient sign in sheet. This sign in sheet is located at the front desk of our facility and can be see by others. We are also in the practice of calling the patients name aloud when the therapist or other member of our staff is ready for that patient. We may also disclose information to medical equipment suppliers, orthotics/prosthetics, etc.
For health oversight activities: we may disclose medical information to consultants or other agencies authorized by law or corporate policies. These oversight activities may include but not limited to, audit investigation, inspection, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil right laws.
For lawsuit and disputes: If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order. We may disclose medical information about you in response to subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if it efforts have been made to tell you about the requestor to obtain an order protecting the information requested.
For law enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we able to obtain the person's agreement;
- About a death we believe may be the result of a criminal conduct;
- About criminal conduct at nursing facility;
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity and/or description or location or the person who committed the crime

Coroners, medical examiners, and funeral directors: we may disclose information to coroner or medical examiner to identify the deceased or determine cause of death.

Your Rights Regarding Medical Information Users and Disclosures:
Right to review /inspect/receive copies: You have the right to review or inspect your health information and receive photocopies of the information that may used to make decisions about your care. Usually information includes both medical and billing records. To inspect and or receive photocopies of your medical information, you must contact our privacy officer, Mandisa Jones. If you request a copy of the information, we may charge a fee for the cost of coping, mailing, or other supplies associated with your request. Twenty-four(24) hours advance notice is required for review/inspection of your medical information. If you would like copies, it necessary that you provide us with forty-eight(48) hours advance notice.
We may deny your request to review/inspect and receive copies in some circumstances. To assist you in review of you're your information, we recommend that one of our staff (such as physical therapist or privacy officer) review the information with you. This co-review would help you in locating information within the chart. It would also help in understanding the handwriting and medical terms written within the clinical record. We would also like to be able to follow up any concerns that you might have after the review/inspection of your information.
If you are denied access to the medical information, you may request that the denial be reviewed. An objective team of privacy-minded officials will review the request, and will comply with the outcome of the review.
Right to amend/correct: I feel that medical information we have about you is incorrect or incomplete, you may ask us to amend or correct the information. You have the right to request an amendment/correction as long as the is kept by our facility. All requests for amendment/correction of medical information must be directed to the privacy officer.
We may deny your request for an amendment if that information.

- Was not created by us, unless the person or entity that that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by our facility;
- Is accurate or complete
- Is irrelevant to the issue/concern raised.

Right to an accounting of disclosures: you have the right to request on "accounting of disclosures". This accounting is a list of the information which is disclosed about you. To request an "accounting of disclosures" you must contact the privacy officer of our facility. Your request must state a time period which may not be longer than six years. The first list you request within a 12-month period will be free of charge. For additional lists, we may charge you the costs of providing the list according to the "customary" or "normal" copying charges.
Right to request confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you or your representative at work or by mail. Please contact the privacy officer to request such arrangements. We will accommodate all reasonable request. Your request must specify how or when you wish to be contacted.
Right to revoke: You have the right to revoke this consent, writing, except to the that this facility has already taken action in reliance

thereon. Your revocation, however, may result in this facility's inability to provide treatment, care, and services.
Reporting complaints/allegations: If you believe your privacy rights have been violated, you may file a complaint with our facility or the office of Civil Rights. All complaints must be submitted in writing. You will not be penalized for filling a complaint.

- To file a complaint with our facility, contact:
  Mandisa Jones, Privacy Officer at (404)377-9107