# REHAB CORE PHYSICAL THERAPY P.C.

## Patient Registration

| | | | |
|---|---|---|---|
| Should we thank any individual for referring you to us? | | | Date |
| Referring Doctor | Address: | | Phone: |
| Full Name: | DOB | Age | □ Male □ Female |
| Address: | | | |
| City | State | Zip code | |
| Home Phone | Work Phone: | Mobile: | |
| Email Address: | | | |
| Emergency Contact Name: | Relationship | Emergency Contact Number: | |

## Insurance Information

| | | |
|---|---|---|
| Primary Insurance Carrier: | Group Number: | ID Number: |
| Primary Insured: | Employer Name: | |
| Business Address: | | |
| Employee Date of Birth: | Employee Social Security: | |

| | | |
|---|---|---|
| Are you covered by a secondary carrier: □ Yes □ No | | |
| Secondary Insurance Carrier: | Group Number: | ID Number: |
| Primary Insured: | Employer Name: | |
| Business Address: | | |
| Employee Date of Birth: | Employee Social Security: | |

## Financial Responsibility

| | |
|---|---|
| Person responsible for Account: □ Self □ Spouse □ Parent □ Other | |
| Name: | Phone Number: |
| Address: | |

**Signature: _____ Date: _____**

# REHAB CORE PHYSICAL THERAPY P.C.

## Consent for Outpatient Physical Therapy Treatment

### *Authorization*

I hereby authorize Harleen Bawa, licensed Physical Therapist to provide medical care and administer such treatment as deemed necessary or advisable and prescribed to the named patient or myself each time presenting to this facility. To the extent possible I have been informed of the risks and complications as well as the potential benefits that may occur and alternatives that may be available.

I acknowledge that no guarantee or assurances have been made to me concerning the results intended from my treatment.

I confirm that I have read and fully understand the above statements.

Date: _____

Patient Name: _____

Patient Signature: _____

Relative or Guardian (if patient is under age 18): _____

Relationship (If signed by person other than patient): _____

### *Release of Information*

I permit to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for collection of benefits or payment of charges or to discuss. Further, I permit to disclose all or part of the above patient's medical records to any healthcare provider for providing treatment.

Please Initial _____

### *Communication*

I consent Rehab Core Physical Therapy P.C. to call my home or other alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care.

I consent Rehab Core Physical Therapy P.C. to communicate with me using electronic mail (email). I understand that responses and replies sent to email may be hours or days apart. As such, acute conditions should never be addressed using email. Further, I understand and acknowledge that there are inherent privacy risks when communication is over the internet as there is no way to ensure that email is completely tamper-resistant.

Please Initial _____

### *Medicare Patients*

I authorize any holder of medical information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this or any related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I also understand that it is my responsibility to obtain a new prescription from my doctor after the first 90 days, every 30 days from the date of the original prescriptions.

Please Initial ____

# REHAB CORE PHYSICAL THERAPY P.C.

## HIPPA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

- By the law, consent is not required to discuss our medical treatment with your other doctors or health care providers. This allows, also for the prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, none is needed in the course of carrying out health care operations, such as assessment or in communications with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or government entity without your written consent.
- Specific authorization is requested to disclose protected information in a non-routine circumstance, such as to your employer for use in marketing a product to you.
- Medical information about you may be related for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical record, and you may amend the record, if you believe it to be incomplete or inaccurate.
- You have the right to review when and to whom your information was related.
- You may suggest additional restrictions with regards to certain uses and disclosures, if you wish.
- Portions of this notice may be modified, as long as you are notified.
- Should you believe that your rights have been compromised you may report the violation, without penalty to you to this office or to the Secretary of Health.
- The law requires that you acknowledge the receipt of this notice.

Signature: _____ Date: _____

Patient Name : _____ Relationship to Patient: _____