HEALDSBURG PHYSICAL THERAPY/ANGELA GARCIA-COOK
REGISTRATION FORM

DATE_____PHONE (HOME)_____(CELL)_____

NAME_____ Social Security #:_____

Mailing address:_____

Street address (IF PO BOX)_____

SEX: (CIRCLE ONE) M F AGE:_____BIRTH DATE_____DL#_____

EMAIL _____(Circle one) Single Married Widowed

Date of injury/symptoms:_____ Work related: Y N AUTO: Y N

Have you had physical therapy this year? Y N WHERE/#VISITS_____

Employer: _____Occupation:_____
(if minor, parent info)

Business address:_____Phone #_____

Emergency contact:_____Phone #_____

DO WE HAVE PERMISSION TO CONTACT THIS PERSON IF NECESSARY? Y N

Current Medications: _____

Prior Surgeries: _____

Allergies: _____

CIRLCE ANY OF THE FOLLOWING THAT APPLY TO YOU:

Diabetes	Y N	Heart disease	Y N	Hernia	Y N
High blood pressure	Y N	Pacemaker	Y N	Nervous Disorder	Y N
Heart Attack	Y N	Seizures	Y N	Kidney Problems	Y N
Cancer	Y N	Pregnant	Y N	Any Metal Implants	Y N

The person signing this financial policy will be responsible for the bill. We will be happy to bill your health insurance and Medicare. Statements are routinely mailed to the patient on the first of each month. Payment in full is expected within 30 days of statement unless arrangements have been made. Please ask if you have any questions.

ASSIGNMENT OF BENEFITS: I request payment of authorized Medicare/Insurance benefits be made to Angela Garcia-Cook/Healdsburg Physical Therapy for any services furnished me. I authorize any holder of medical information about me to release to my insurance carrier all information needed to determine benefits payable for related services. I understand my signature here requests that payment be made and authorizes release of information necessary to pay the claim. Coinsurance, deductibles and non-covered services are based upon the charges and determination of the insurance carrier.

SIGNATURE:_____DATE:_____
(If patient is a minor, a parent must sign)

HEALDSBURG PHYSICAL THERAPY
ANGELA GARCIA-COOK, P.T.
465 "B" MARCH AVENUE
HEALDSBURG, CA 95448
(707) 433-5219

ATTENTION:

BECAUSE OUR APPOINTMENTS ARE SCHEDULED IN 1HOUR INCREMENTS, IT IS IMPERATIVE THAT WE HAVE 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT.

A FEE OF $30.00 WILL BE CHARGED FOR ALL MISSED APPOINTMENTS IF NOT CANCELLED 24 HOURS IN ADVANCE.

IF YOU HAVE MISSED AN APPOINTMENT AND FUTURE APPOINTMENTS HAVE BEEN SCHEDULED, THEY WILL BE CANCELLED UNLESS WE HEAR FROM YOU TO CONFIRM YOUR NEXT APPOINTMENT.

SIGNED:_____ DATE:_____

HEALDSBURG PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

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

Healdsburg Physical Therapy

Healdsburg Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein. .

USES AND DISCLOSURES OF HEALTH INFORMATION

Healdsburg Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Healdsburg Physical Therapy may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

Healdsburg Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, Healdsburg Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. .

Healdsburg Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our office. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment. and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Healdsburg Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Healdsburg Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our office at the address listed below. You may also send a written complaint to the US Departnlent of Health and Human Services. For further information on Healdsburg Physical Therapy's health information practices, or if you have a complaint, please contact the our office:

HEALDSBURG PHYSICAL THERAPY
465 "B" MARCH AVENUE
HEALDSBURG, CA 95448

EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM

HIPAA Compliance Policies and Procedures Protected Health Information

Healdsburg Physical Therapy will not use or disclose protected health information without the consent or authorization of its patients for purposes other than treatment, billing, or operations related to treatment and billing. All personnel will understand and be able to identify the elements of protected health information.

Procedure:

1. Protected health information is any individually identifiable information contained in the patient's medical record or files. This includes the patient's name, address, diagnosis, chart notes, lab results, treatment plan, insurance or financial information.

2. Every chart should contain a signed consent form from the patient that authorizes or prohibits the practice from using or disclosing protected health information.

3. Personnel may use and disclose protected health information for treatment, billing or operations related to treatment and billing without patient consent. Any other use of protected health information must be authorized by the patient and documented in the chart.

4. It is expected that personnel who release protected health information for any reason will release only the minimum amount of information necessary based on the purpose of the request. For example, if an insurance company requests chart notes for the purpose of reviewing a claim, only the notes specific to that date of service and procedure under review should be released.

5. If protected health information is used or disclosed for any other purpose than treatment, billing, or operations related to treatment and billing, the information must be "de-identified" by removing any and all information that would distinguish the individual's record from a group.