Patient Information Sheet:

Date: _____
Last Name: _____
First Name: _____
Street: _____City: _____
State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell: _____
E-mail: _____
I'd like to receive the newsletter: Yes____ No____
Birth Date: _____
Whom may we thank for referring you to us? _____

Insurance Information:
Name of insured: _____
Birth Date: _____
Relationship to Patient: _____
ID #: _____
Group #: _____
Insurance Company Name: _____
Provider Phone #: _____

General Medical History

Please check the box if you have experienced the following:

- ☐ DIABETES
- ☐ PACEMAKER
- ☐ HIGH BLOOD PRESSURE
- ☐ BONE DISEASE
- ☐ CHRONIC HEADACHES
- ☐ KIDNEY PROBLEMS
- ☐ NERVOUS DISORDERS
- ☐ HERNIA
- ☐ PINS & NEEDLES
- ☐ FRACTURES (BROKEN BONES)
- ☐ CIRCULATORY DISEASE
- ☐ BLADDER IRREGULARITIES
- ☐ BOWEL IRREGULARITIES
- ☐ CHEST PAIN/HEART PALPITATIONS/SHORTNESS OF BREATH
- ☐ BALANCE/COORDINATION
- ☐ FOOD AND/OR DRUG ALLERGIES
- ☐ SENSITIVITY TO COLD
- ☐ SENSITIVITY TO HEAT
- ☐ ALLERGIES
- ☐ PREVIOUS SURGERY
- ☐ SEIZURES
- ☐ METAL IMPLANTS
- ☐ DIZZINESS
- ☐ CANCER
- ☐ PROSTATITIS
- ☐ OSTEOPOROSIS
- ☐ CYSTITIS
- ☐ RECENT WEIGHT LOSS
- ☐ VASCULAR DISEASE
- ☐ OTHER
- ☐ SMOKING

If you checked any of the above, please explain:

_____

_____

Please list any current medications and for what condition:

_____

_____

HIPAA: Notice of Privacy Practices

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

Your Rights:

• You can ask to see or obtain an electronic or paper copy of your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete.

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address than the one listed as your primary.

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

• You can ask for a list of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• You can complain if you feel we have violated your rights by contacting us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

• *If you are not able to tell us your preference about sharing your information, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

• We never share your information for marketing purposes and sale of your information unless you give us written permission

We typically use or share your health information in the following ways:

Treat you*: We can use your information and share it with other professionals who are treating you. Ex: A doctor treating you for an injury asks us about your overall health condition.*

Run our organization*: We can use and share your health organization information to run our practice, improve your care, and contact you when necessary. Ex: We use health information about you to manage your treatment and services.*

Bill for your services: *We can use and share your health information to bill and get payment from health plans or other entities. Ex: We give information about you to your health insurance plan so it will pay for your services*

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you give us permission in writing. If you do, you may change your mind at any time.

_____
Please print your name

_____ _____
Signature Date

HIPAA Privacy Authorization Form

I authorize Zion Physical Therapy to use and disclose the protected health information described below to _____(Your medical doctor)

This authorization for release of information covers □ all past, present, and future periods.

Extent of Authorization

□ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)

_____
Please print your name

_____ _____
Signature Date

Acknowledgement of Financial & Privacy Practice Policies

Dear Patients:

Welcome to our office! Our goal is to provide the highest standard of patient care; thus, it is essential that we establish a clear understanding of our Financial and Privacy Policy with our patients. Should you have questions or concerns about our fees, policies, or privacy practices, please do not hesitate to ask.

Out Of Network Insurance - As a courtesy, we will gladly submit claims to your insurance carrier for reimbursement consideration. Zion Physical Therapy is committed to maximizing your insurance benefits and will work closely with you and your insurance carrier for the best results.

Self-Pay Patients - We request payment in full at the time of service and will provide you with a receipt for your records if desired.

Medicare - Zion Physical Therapy is a non-participating provider with Medicare. As a courtesy, we will bill for you. You will have a copay for each visit, depending on insurance reimbursement. By law, Medicare requires that we charge you this copay.

Cancellation Policy - We understand that you may need to cancel due to unexpected events. However, we ask that you contact our office as soon as possible to cancel or reschedule your appointment. In the event that you do not provide us with 24 hours notice, you may be subject to a $150 cancellation fee. In addition, we ask that you arrive promptly for your appointment as we often have another patient right after you.

Agreement - I authorize my insurance benefits to be paid directly to Zion Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Zion Physical Therapy and my insurance company to release any information required to process my claims. I understand that by signing this consent form, I am giving my consent for your use and disclosure of my protected health information in order to carry out treatment, payment activities, and health care operations.

Patient Signature _____ Date _____

Print Name _____