Patient Registration Form

LAST NAME	FIRST	MI	PREFERRED NAME

SOCIAL SECURITY #	DATE OF BIRTH	AGE

MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE
EMPLOYMENT STATUS EMPLOYED ( ) FULL TIME STUDENT ( ) PART TIME STUDENT ( ) N/A ( )	MALE ( ) FEMALE ( )	MARITAL STATUS SINGLE ( ) MARRIED ( ) OTHER ( )

EMPLOYER NAME/SCHOOL NAME	TITLE/POSITON
E-MAIL ADDRESS	HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT, LEGAL GUARDIAN, INSURED INFORMATION

LAST NAME	FIRST	MI	HOME PHONE

ADDRESS	STATE	ZIP CODE

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST NAME

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION #	GROUP #

ADDRESS	CITY	STATE	ZIP CODE	PHONE

POLICYHOLDER (if other than patient)	SOCIAL SECURITY #	RELATIONSHIP	DATE OF BIRTH

AUTH #	AUTH DATE	EXP. DATE

COPAY / COINSURANCE	DEDUCTION AMT.	MET ( ) YES ( ) NO	MAX # VISITS

ADJ / CASEWORKER	TELEPHONE #	FAX #

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	EFFECTIVE DATE	IDENTIFICATION #	GROUP #

ADDRESS	CITY	STATE	ZIP CODE	PHONE #

POLICYHOLDER (if other than patient)	SOCIAL SECURITY #	RELATIONSHIP	DATE OF BIRTH / /
(CIRCLE ONE) SCRIPT / REFERRAL	AUTH #	AUTH DATE	EXP. DATE

COPAY / COINSURANCE /	DEDUC. AMT.	MET ( )YES ( ) NO	MAX # VISITS

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:		☐ **M** ☐ **F**	**DOB:**
Previous or referring doctor:		**Referring Diagnosis:**	

PERSONAL HEALTH HISTORY

Chief complaint you are being seen for:	**Onset Date:**

Is condition due to injury/accident? ☐ Yes ☐ No If yes, please describe:

Attorney involvement? ☐ Yes ☐ No If yes, list contact information: Name:

Phone:

Does this condition effect your daily activities/ work responsibilities? ☐ Yes ☐ No First date missed from work:

Have you had prior treatment for this condition? ☐ Yes ☐ No If yes, please describe:

Recent Surgeries	Current Medications

Do you have any allergies? ☐ Yes ☐ No If yes, please list:

Have you had any unexpected weight lose or gain greater than 10 pounds in the past 3 months? ☐ Yes ☐ No

Do you have any of the following medical conditions? (Please check all that apply)

☐ Hearing Problems ☐ Pacemaker ☐ Lymphedema ☐ Diabetes ☐ Stroke ☐ Metal Implants ☐ Broken Bones

☐ Vascular Problems ☐ Pregnant ☐ Pneumonia ☐ Seizures ☐ Osteoporosis ☐ Arthritis ☐ Respiratory Problems

☐ High Blood Pressure ☐ Cancer:________________________________ ☐ Other:_______________________________

What are your goals for therapy?

*** To be completed by therapist ***

Therapist:	**Date:**
Precautions for treatment	
Other pertinent information	

Notice of Patient Information Practices

OUR LEGAL DUTY

Bresee Outpatient Physical Therapy, P.A. is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION

Bresee Outpatient Physical Therapy, P.A. uses your personal information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, Bresee Outpatient Physical Therapy, P.A. will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information Practices at any time. Our HIPPA Compliance Officer is Diana Robison. She can be reached at the office by calling (662) 842-2100

PATIENTS 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 inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Bresee Outpatient Physical Therapy, P.A. will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS

If you are concerned that Bresee Outpatient Physical Therapy, P.A. 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 HIPAA Compliance Officer, Diana Robison, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Bresee Outpatient Physical Therapy, P.A.
HIPPA Compliance Office
Attention: Diana Robison
238 Third Avenue
P.O. Box 456
Sherman, MS 38869
(662)842-2100

Consent for Treatment

I, the undersigned, a patient at Bresee Outpatient Physical Therapy, P.A., do hereby authorize Mark Bresee, P.T., and whoever he may designate as his assistant to administer treatment as is necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy Bresee Outpatient Physical Therapy will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Bresee Outpatient Physical Therapy, P.A.

Deductibles/Percentage pays and/or Co-Payments

Co-payments are to be paid at time of service, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date on the invoice. Patients are to keep payments current. ***I understand I am ultimately responsible for payments of all services rendered and associated with my account, unless other wise provided by law, and that if I fail to pay any amount due and the account is referred to a collection agency and/or an attorney, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collections of any balance due.***

Cancellation/No-Show Policy

I understand that cancellations should be made within 24 hours prior to their scheduled time, unless extenuating circumstances prevent otherwise. A $25.00 fee may be enforced for no shows or late cancellations. By signing below you are agreeing to all the above terms and conditions. Additionally I confirm that I have received a copy of Bresee Outpatient Physical Therapy's Notice of Privacy Practices.

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Patient or Legal Guardian's Signature Date

Release of Records Form

Date: ______________

By my signature below, I hereby authorize release of my medical records to Bresee Outpatient Physical Therapy, P.A.

Patient Name: ____

Date of Birth: ____

Records related to: ____

Patient's Signature: ____

Please fax records to:

Bresee Outpatient Physical Therapy, P.A.
Fax Number (662)842-2105