PATIENT INFORMATION

DATE: _____

NAME: _____ AGE: _____ SEX: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE #: _____ HOME PHONE #: _____

E-MAIL ADDRESS: _____

OCCUPATION: _____ WORK PHONE: _____

EMPLOYER: _____

ADDRESS: _____

ALLERGIES: YES / NO
IF YES, PLEASE LIST: _____

ALLERGIC REACTIONS: YES / NO
IF YES, PLEASE LIST: _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

HOW DID YOU FIND OUT ABOUT US?: _____

INSURANCE INFORMATION

NAME OF POLICYHOLDER: _____ DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____ DATE OF INJURY: _____

WAS THIS AN AUTO ACCIDENT?: YES / NO WAS THIS WORK RELATED?: YES / NO

IS THIS A LEGAL CASE?: YES / NO
IF YES, ATTORNEY'S NAME: _____ PHONE: _____

HAVE YOU HAD PHYSICAL THERAPY TREATMENTS THIS YEAR?: YES / NO
IF YES, HOW MANY VISITS?: _____

HAVE YOU HAD CHIROPRACTIC TREATMENTS THIS YEAR?: YES / NO
IF YES HOW MANY VISITS?: _____

433 CASTLE SHANNON BOULEVARD, MT. LEBANON, PENNSYLVANIA 15234 (412) 344-9044 FAX (412) 344-9047

DAVID PHYSICAL THERAPY & SPORTS MEDICINE CENTER, INC.
433 CASTLE SHANNON BOULEVARD
PITTSBURGH, PA 15234-1405

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/ or disclosure of personally identifiable health information about me by David Physical Therapy & Sports Medicine Center, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in the Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised privacy notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 433 Castle Shannon Boulevard, Pittsburgh, PA 15234-1405, Attention: Practice Compliance Director.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify otherwise in writing.

   I request that the following restrictions be placed on the Practice's use and/ or disclosure of my health information (leave blank if no restrictions):_____

I understand the forgoing provisions, and I wish to sign this Acknowledgment authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____Accepted _____Denied _____Not Applicable

_____Other (explain)_____

_____ _____
Signature of Authorized Practice Representative Date

PHYSICAL THERAPY & SPORTS MEDICINE CENTER™

CONSENT FOR TREATMENT

I understand that I have been referred by my physician or I have chosen to attend without a referral through Direct Access for physical therapy service. I may be subject to various therapeutic modalities and procedures involving moist heat, ice packs, ultrasound, electric stimulation, paraffin wax, traction, therapeutic exercise, joint mobilization, light therapy, iontophoresis, massage and other organized procedures utilized by licensed physical therapists. I hereby authorize treatment to me as prescribed. (If patient is under the age of 18, a parent or guardian may sign this consent form.)

Patient Signature **Date**
Parent/Guardian

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby assign payment for services rendered to me (or my dependent). I authorize to disclose all or any part of my (or my dependent's) record to my physician and any person or corporation which may be liable for all or any part of the charges including but not limited to insurance companies, Worker's Compensation carriers, or employers.

Patient Signature **Date**
Parent/Guardian

PAYMENT POLICY

We will contact your insurance company in regards to coverage for physical therapy so that we may bill them directly. **Please be aware that you may be responsible for a deductible, co-insurance, and/or co-pay depending on your coverage.** It is the patient's responsibility to know what their insurance does or does not cover. Payment of the bill is the patient's responsibility. Payment in full is expected within 90 days or completion of care. Those accounts not paid in full after 90 days are subject to interest charges and placement with a collection agency.

Patient Signature **Date**
Parent/Guardian

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PHYSICAL THERAPY & SPORTS MEDICINE CENTER™

HABILITY OPT-IN SHEET

Great news patients!

We have recently acquired a new system that allows you to contact your Physical Therapist as needed by either phone, email or text. We will not contact you regarding your billing, copays or such issues through email or text.

This service is to make sure if you have questions regarding your care, that they can be addressed as soon as possible. Selections can be changed at any time, too. Simply circle your preferred method of contact below, initial next to it, and we'll handle the rest for you!

Talk soon!

I would like to contact my therapist by:

(please circle and below)

Text **Email**

(Office Preferred)

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