Physical Therapy Services of Ottawa County
Patient Registration Form

Personal Information				
Name		Age		Sex
Date of birth		Single Married Widowed		
Address	City		State	Zip
Home phone	Cell phone	Work phone		
Email address				
Place of employment		Occupation		
Address	City		State	Zip
Spouse's name		Occupation		
Place of employment		Phone		
How did you hear of our office? (please circle) Physician Referral Phone Book Former Patient Family/Friend Website Other:				

Emergency Contact Information		
Name		Relationship
Home phone	Cell phone	Work phone

Reason for today's visit	
(please circle) Injury Accident Illness Other	Date of accident/injury (if applicable)
Where did your accident occur:	Referring Doctor

Insurance Information		
Primary insurance	I.D. #	Group #
Name of policy holder		
Secondary insurance	I.D. #	Group #
Name of policy holder	Driver's license # of person responsible for payment	

Assignment of benefits:
I hereby assign all medical benefits to Physical Therapy Services of Ottawa County, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signed:_____ Date:_____/_____/_____

Physical Therapy Services of Ottawa County

Medical History Questionnaire

This questionnaire is to help us understand your health status and how it may relate to your current condition. Please fill out this form to the best of your ability as this is a part of your medical record.

Name:_____ Date of Birth:____/_____/____ Age:_____

Referring Physician:_____ Family Physician:_____

Occupation:_____ Are you currently working: YES NO

Have you had surgery for this injury? YES NO If yes, date of surgery:_____/_____/_____

Please rate your pain on a scale of 0 – 10, where 0 = No Pain and 10 = Maximum Pain Tolerance

Worst:_____ Best:_____ Average:_____

Are you taking any prescription or non-prescription medications? YES NO
If yes, please circle any that apply

Anti-inflammatories Muscle Relaxers Pain Medication Other:_____

Have you had any of the following medical or rehabilitation care for this injury?

	Yes		Yes
Family Physician		CT Scan	
Occupational Therapist		X-rays	
Physical Therapist		MRI	
Neurologist		EMG/NCV	
Orthopedist		Myelogram	
Chiropractor		Other:	

Please mark any of the following conditions that you have, or have ever had:

	Yes		Yes
Asthma, Bronchitis, or Emphysema		Severe of frequent headaches	
Shortness of breath/Chest pain		Vision or hearing difficulties	
Coronary artery disease or Angina		Dizziness or fainting	
Do you have a pacemaker?		Weakness	
High blood pressure		Weight Loss/Energy Loss	
Heart attack		Hernia	
Blood clot		Epilepsy/Seizures	
Stroke/TIA		Thyroid trouble	
Pins or metal implants		Incontinence	
Joint replacement (any joint)		Bowel or bladder problem	
Diabetes		Neck injury/surgery	
Infectious diseases		Shoulder injury/surgery	
Cancer		Elbow or hand injury/surgery	
Arthritis		Back injury/surgery	
Osteoporosis		Knee injury/surgery	
Sleeping problems		Leg, ankle, or foot injury/surgery	
Do you smoke		Multiple sclerosis/Parkinson's	
Latex sensitivity/allergy		For Women: Are you pregnant?	

Patient/Guardian Signature:_____ Date:_____/_____/_____

PT initials:_____ Date:_____

Physical Therapy Services
Of Ottawa County
1 Royal Park Drive, Suite 2
Zeeland, Michigan 49464

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers.

PAYMENT means such activities as obtaining reimbursement for services, confirming insurance coverage, billing or collection activities, and utilization review.

HEALTH CARE OPERATIONS include the business aspects of running our practice such as quality assessment and improvement activities, auditing functions, cost management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Office at the above listed address:

*The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

*The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.

*The right to inspect and copy your protected health information.

*The right to amend your protected health information.

*The right to receive an accounting of disclosures of protected health information.

*The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is in effect as of April 11, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint contact:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., SW
Washington, D.C. 20201
(202)619-0257
Toll Free: 1-877-696-6775

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1 Royal Park Drive, Suite 2
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PATIENT ACKNOWLEDGMENT AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgment discussed above) that we first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our profession competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with a physician or other health care professional, or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGMENT:

I acknowledge that I have today received a copy of the Notice of Privacy Practices of Physical Therapy Services of Ottawa County.

PATIENT CONSENT:

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature Print Name

Date

FOR OFFICE USE ONLY:

The following circumstances prohibited the patient from signing the Acknowledgment:

Signature of Office Personnel Print Name

Date:_____