CHESTERTON PHYSICAL THERAPY, INC.
Great Health Through Great Physical Therapy

Patient Registration

Are you a former patient? ☐ Yes ☐ No

First Name _____ Middle Name or Initial _____ Last Name _____

Mailing/Street Address _____

City _____ State _____ Zip Code _____

Cell Phone # _____ Home Phone # _____ Work Phone # _____

E-mail Address _____ Birthdate: mm/dd/yyyy _____

Marital Status: ☐ Married ☐ Single ☐ Other Sex: ○ Male ○ Female ○ Other

Physician Information

Referring Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Insurance Information

Who is the Policy Holder? *(Please circle)* Self Spouse Parent Other

Primary Health Insurance Company _____ Secondary Health Insurance Company _____

Name of Policy Holder _____ Policy Holder's Date of Birth (mm/dd/yyyy) _____

Have you verified your therapy benefits with your insurance? ☐ Yes ☐ No
If not, we strongly encourage you to do so.

Auto/3rd Party Auto Information

Date of Accident: _____ City/State: _____

Auto Insurance Company: _____ Claim # _____

Adjuster Name: _____ Phone # _____

Is this a lawsuit? Yes ☐ No ☐ Law Firm Name: _____

Attorney Name: _____ Attorney Phone: _____

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INFORMED CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist, and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:** I have been given the opportunity to review Chesterton Physical Therapy's "Notice of Privacy Practices" which is displayed in the reception area. This notice of privacy practices provides information on the uses and disclosures of my protected health information. I understand that this notice is subject to change, and if changes are made, a revised copy of the notice will be posted in the reception area. I also understand that if I have any questions, I may contact the Privacy Officer at (219) 926-9779.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Chesterton Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Chesterton Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Chesterton Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that Chesterton Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Chesterton Physical Therapy's administrative staff to contact other health professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Chesterton Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. **HIPAA CONSENTS:** In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

By my signature below, I certify that I have read, and I understand and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person: _____ Date: _____

Printed Name of Above: _____ Date: _____

CHESTERTON PHYSICAL THERAPY, INC.
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No-Show / Cancellation Policy

Please Read Carefully

NO SHOW FEE $50.00
(When you don't attend or call to change your scheduled appointment)

To avoid a no-show fee, you must call to reschedule your appointment before your appointment time.
Repeated No-Shows may result in being discharged from care after 2 missed sessions.

SAME DAY CANCELLATION FEE: $30
(When you call to cancel your appointment on the same day as your scheduled appointment)

Repeated cancelled/rescheduled may result in needing to schedule with a "walk-in" or same day appointment status and discharge from care after 3 cancellations.

Please provide our office with 24-hour notice to change or cancel an appointment.

Thank you for providing our office and our patients with this courtesy.

I acknowledge that I have reviewed the policy and understand that failure to complete any part of my treatment program will reduce my chances of success.

Signature of Patient/Guardian: _____ Date: _____

CHESTERTON PHYSICAL THERAPY, INC.
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Medical History

Existing or Relevant Previous Conditions

Allergies	○ Yes ○ No	Dizzy Spells	○ Yes ○ No	MRSA	○ Yes ○ No
Anemia	○ Yes ○ No	Emphysema/Bronchitis	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No
Anxiety	○ Yes ○ No	Fibromyalgia	○ Yes ○ No	Muscular Disease	○ Yes ○ No
Arthritis	○ Yes ○ No	Fractures	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Asthma	○ Yes ○ No	Gallbladder Problems	○ Yes ○ No	Parkinsons	○ Yes ○ No
Autoimmune Disorder	○ Yes ○ No	Headaches	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No
Cancer	○ Yes ○ No	Hearing Impairment	○ Yes ○ No	Seizures	○ Yes ○ No
Cardiac Conditions	○ Yes ○ No	Hepatitis	○ Yes ○ No	Smoking	○ Yes ○ No
Cardiac Pacemaker	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Speech Problems	○ Yes ○ No
Chemical Dependency	○ Yes ○ No	High/Low Blood Pressure	○ Yes ○ No	Strokes	○ Yes ○ No
Circulation Problems	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Currently Pregnant	○ Yes ○ No	Incontinence	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Depression	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Vision Problems	○ Yes ○ No
Diabetes	○ Yes ○ No	Metal Implants	○ Yes ○ No		

Fall History

Injury as a result of a fall in the past year? ○ Yes ○ No

Two or more falls in the last year? ○ Yes ○ No

Patient is at risk for falls? ○ Yes ○ No

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Surgical History

Body Regions	Surgery Type	Date

Current Medications

Drug	Dosage / Frequency	Reason

CHESTERTON PHYSICAL THERAPY
Coronavirus Disease 2019 Questionnaire

Name:_____Date: _____

Please Circle Yes or No
Feel free to explain what a yes or no answer means in the Comment Section below the question.

1. Have you traveled outside of the US in the past 30 days? Yes No
If yes, please list the countries you have visited below.
Comment:_____

2. Have you been in close contact with an individual who has traveled outside of the US in the past 30 days? Yes No
If yes, please list the countries he/she has visited below.
Comment:_____

3. Have you <u>been in close contact,</u> in the past 30 days, with an individual who has had any these symptoms?
Fever over 104° : Yes No
Persistent cough: Yes No
Shortness of breath: Yes No
If yes, have they been diagnosed and/or seen the doctor? Yes No
Comment: _____

4. Have you had any of these symptoms?
Fever over 104° : Yes No
Persistent cough: Yes No
Shortness of breath: Yes No
If yes, how long have you had these symptoms?
_____
If yes, have you been diagnosed and/or seen the doctor? Yes No
Comment:_____

If you answered yes to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability.

Please contact Chandra Singh, Administrator, at 219-926-9779 if you have questions. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019.

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Notice of Privacy Practices

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.

1. **Uses and Disclosures** We will use your protected health information (PHI) for the purposes of treatment, payment and healthcare operations.

   Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists.

   Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to view your medical record to determine that your care was necessary.

   Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

   Other Special Uses
   Our practice may use your PHI to send you an appointment reminder.

   Uses and Disclosures Required by Law
   The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

   We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

   Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2. Your Privacy Rights

Restrictions
You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications
You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.