AVILA PHYSICAL THERAPY

PATIENT REGISTRATION

I. PERSONAL INFORMATION

Date _____ Name (Last, First) _____

Birthdate _____ Soc. Sec. Number _____ Gender: ☒ Male ☒ Female

F/T Student: ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married ☐ Other _____

Email _____ Driver's License _____

Address _____ APT#:_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone_____

Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone_____

Referring Doctor _____ Referred By _____

II. EMPLOYMENT INFORMATION

Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

III. RESPONSIBLE PARTY

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

IV. INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Company_____	Insurance Company _____
Policy# _____	Policy# _____
Group#/Claim#_____	Group # _____
Phone _____	Phone _____
Claims Address _____	Claims Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Insured Name _____	Insured Name _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Soc. Sec. _____ Birthdate _____	Soc Sec. _____ Birthdate _____

V. PRACTICE POLICY & PATIENT SIGNATURE

HIPAA NOPP Consent & Acknowledgment: I have read this office's Notice of Privacy Practices or have had it explained to me. I understand this notice and have had the chance to ask questions about any matters that I do not understand.

Patient Consent:

1. I authorize the release of any medical information necessary to process all claims, and I authorize Avila Physical Therapy, LLC to communicate with my insurance companies and other health care practitioner(s) as necessary by letter, phone, or fax.
2. If assignment is accepted, I authorize and request my insurance companies to pay directly to Avila Physical Therapy benefits otherwise payable to me. I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed "not medically necessary" by my insurance companies. Further, I understand that if an insurance claim is not paid within 45 days, I am responsible for the full amount immediately.
3. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.
4. If Avila Physical Therapy, LLC is a participating provider with my insurance companies, I understand that I am subject to the terms and conditions of my insurance policy.

Signature _____ Date_____

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Patient Information Record

1. Name: _____
2. Date of onset of symptoms: _____
3. Have you had surgery for this condition? Yes / No Date of Surgery:_____
4. What caused your symptoms?_____
5. What is your biggest complaint? _____
6. What activities could you do before, that you cannot do now due to your condition? _____
_____
7. Which activities make your symptoms worse? _____
8. Which activities make your symptoms better? _____
9. Overall, is your condition becoming worse, better, or staying the same?
_____
10. Do your symptoms change throughout the day? Yes / No
11. Have you had similar episodes before? Yes / No
12. What other health care practitioners have you seen for this condition?_____
_____
13. What diagnostic tests have you had for this condition (x-rays, MRI, nerve study, etc)? _____
_____
14. What is your goal for physical therapy? _____

Medical History

1. What medications are you currently taking? _____
_____
2. What allergies do you have _____
3. Do you have (or have you had) any of the following health conditions?

Osteoarthritis	Yes No	High Blood Pressure	Yes No
Rheumatoid Arthritis	Yes No	Heart Disease	Yes No
Back/Neck Pain	Yes No	Poor Circulation	Yes No
Osteoporosis	Yes No	Chest Pain	Yes No
Broken Bones	Yes No	Shortness of Breath	Yes No
Sleeping Difficulties	Yes No	Vision Difficulties	Yes No
Cancer	Yes No	Dizziness/LoseBalance	Yes No
Diabetes	Yes No	Severe Headaches	Yes No
Weakness	Yes No	Pain at Night	Yes No
Weight Gain/Loss	Yes No	Stroke/TIA	Yes No
Asthma	Yes No	Numbness/Tingling	Yes No
Bronchitis	Yes No	Bowel/Bladder Issues	Yes No
Seizures	Yes No	Loss of Appetite	Yes No
Depression/Anxiety	Yes No	Are you pregnant?	Yes No
Have a pacemaker?	Yes No	Do you smoke?	Yes No

4. What other health conditions do you have? _____
5. What surgeries have you had? _____
_____

Patient Signature: _____ Date

Clinician Signature: _____ Date

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Patient Functional Questionnaire

Please list 3-5 activities that you have the most difficulty performing because of your injury/condition. Please rate your level of difficulty on the scale below each question.

1._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

2._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

3._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

4._____

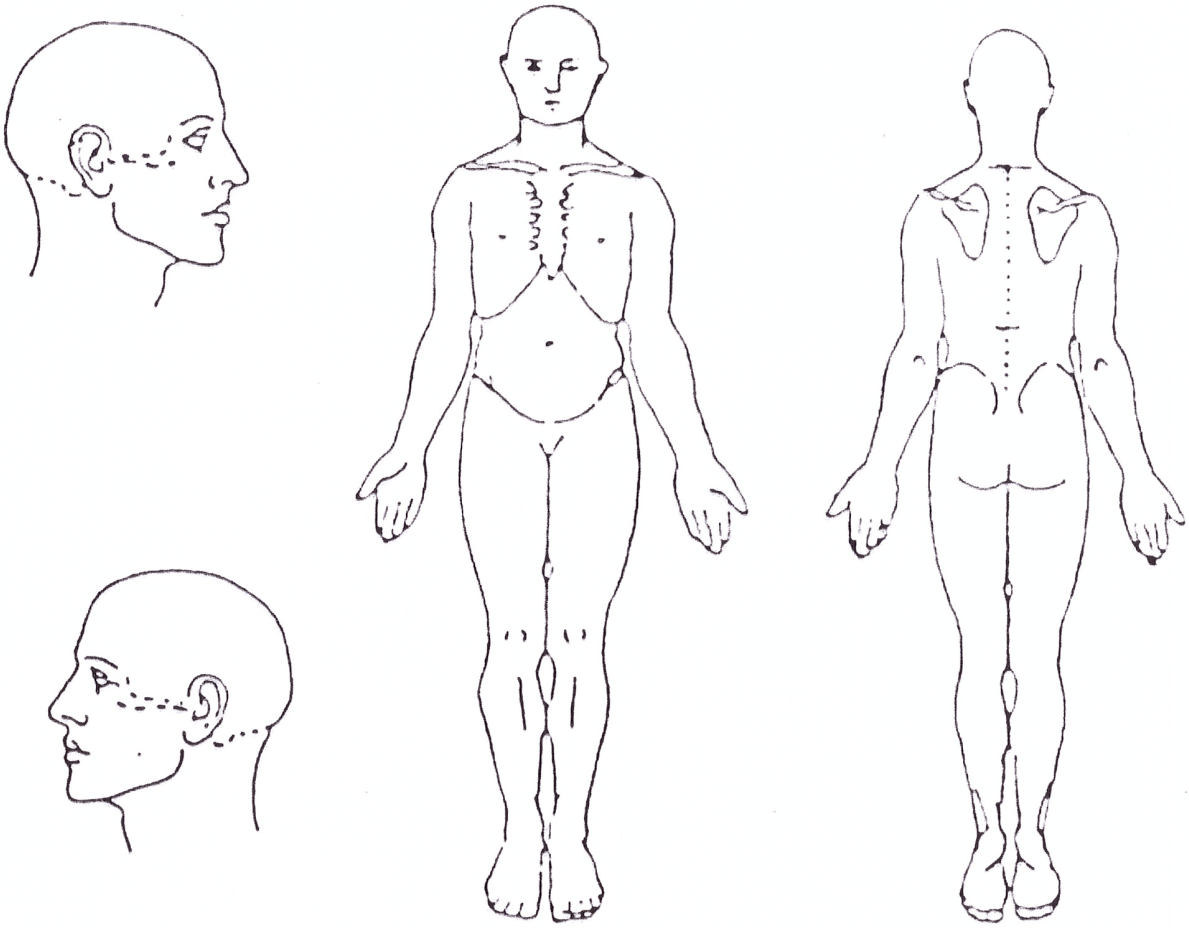
0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

5._____

0 1 2 3 4 5 6 7 8 9 10
No Difficulty Unable to Perform

AVILA PHYSICAL THERAPY

Please mark on this diagram where you are having most of your pain or other symptoms.



Please mark of the following scale how bad your pain is most of the time:

1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

Patient Name:_____ Date:_____

AVILA PHYSICAL THERAPY

Consent for Treatment and Authorization

I,_____authorize Avila Physical Therapy and its staff to perform the physical therapy treatments ordered by my referring physician. I have been informed of the reasons for treatment/procedures along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved. I also certify that no guarantee or assurance has been made as to the results or outcomes that may be obtained.

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider who referred me here. I request that payment of any insurance or other benefits be made directly to Avila Physical Therapy on my behalf for any services provided by me. I authorize the holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third party payer, state medical assistance agency, or any other governments private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer or insurance company.

I understand that any co-payment/deductible and or co-insurance is due and payable at time of service.

Signature of Patient/Guardian:_____Date:_____

Relationship to Patient:_____

Signature of Representative:_____Date:_____

AVILA PHYSICAL THERAPY

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that Avila Physical Therapy has the right to change the Notice of Privacy Practices from time to time and that I may contact Avila Physical Therapy at any time to obtain a current copy of the Notice of Privacy Practices.

Signature of Patient/Guardian:_____Date:_____

Relationship to Patient:_____

Protected Health Information (PHI) Release Authorization

Persons who are involved in your care (spouse, children, friends, etc.) may inquire about your treatment, appointments, billing, medical records, etc. Please let us know below whom we may share your PHI with:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

PLEASE NOTE THAT AVILA PHYSICAL THERAPY WILL ONLY RELEASE PHI TO THE INDIVIDUALS LISTED ABOVE

I_____ acknowledge in signing this document that I am giving Avila Physical Therapy authorization to release or discuss PHI either in writing or verbally to the Persons specified above. This authorization is good indefinitely from the signature date below unless otherwise revoked by me in writing and a copy placed in my records at Avila Physical Therapy.

Signature of Patient/Guardian:_____Date:_____

Relationship to Patient:_____

Revised 05/15

AVILA PHYSICAL THERAPY

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

Your confidential healthcare information may be released to:

- Other healthcare professionals or other treating physicians for the purpose of providing you with quality healthcare;
- Your insurance carrier and/or treating vendor for the purpose of the practice receiving payment for providing you with needed healthcare services;
- Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence;
- Other healthcare providers in the event you need emergency care;
- A public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication);
- Certain parties only after receiving written authorization from you . You may revoke your permission to release confidential healthcare information at any time.

You may be contacted by Avila Physical Therapy, LLC to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. If you are not home and/or unavailable, we may leave appointment information on your answering machine or in a message left with the person answering the phone.

We may use and disclose limited protected health information about you by having you sign in when you arrive at our office. We may also call our your name when we are ready to see you.

You have the right to restrict the use of your confidential healthcare information. However, Avila Physical Therapy, LLC. may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

You have the right to receive confidential communication about your health status.

You have the right to review any/all portions of your healthcare information upon written request within the timeframes set by law.

You have the right to request change be made to your healthcare information.

You have the right to know if certain parties have accessed your confidential healthcare information and for what purpose.

You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

Your confidential healthcare information may not be released for any other purpose that which is identified in this notice.

Avila Physical Therapy, LLC. is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients, upon request, with a list of duties or practices that protect confidential healthcare information.

Avila Physical Therapy, LLC will abide by the terms of this notice. The practice reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Any changes to this notice will be posted in our practice within 30 days of making any changes.

You have the right to file a complaint to Avila Physical Therapy if you believe your rights to privacy have been violated; please mail your complaint to the facility, in care of Anthony Avila, Privacy Officer.

All complaints will be investigated. No personal issue will be raised for filing a complaint. For further information about this Privacy Notice, please contact: Anthony Avila, Privacy Officer at 361-500-66861. Notice effective 05/20/2015.