SPORTS & PHYSICAL THERAPY CENTER

REGISTRATION FORM

(Please Print)

Today's date:		❑ Returning Patient	❑ New Patient
Referring Physician:	Phone ( )	Date Last Seen:	
Primary Care Physician:	Phone ( )	Date Last Seen:	

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F
Email address:				

Street address:		Social Security # :	Home phone : ( )
City:	State:	ZIP Code:	Cell phone: ( )
Occupation:	Employer:		Employer phone: ( )

Chose clinic because/Referred to clinic by (please check one box):			❑ Dr.	❑ Newsletter	❑ Insurance Plan
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Internet Database	❑ Other
Name of family/friend members seen here:					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Cell phone: ( )

INSURANCE INFORMATION

RELEASE OF MEDICAL RECORDS

I am hereby authorizing The Sports & Physical Therapy Center to request on my behalf, Medical Records and/or Health Information from past/current physicians. I understand that I may revoke this authorization, in writing, at any time. Disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization. Without my written revocation, the authorization will automatically expire upon satisfaction of the need for disclosure.

Patient/Guardian Signature ______________________________

Relation to Patient______________________________ Date: ____/____/______

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to The Sports & Physical Therapy Center. I understand that I am financially responsible for any balance. I also authorize The Sports & Physical Therapy Center or the insurance company to release any information required to process my claims.
I request and consent to the medical care and treatment procedures as determined necessary by my physician.
I have been informed and understand that the Physical Therapist providing services to me in this facility are not independent contractors and are employees of this facility unless otherwise specifically identified.

Patient/Guardian Signature ______________________ Date: ____/____/______

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE SPORTS AND PHYSICAL THERAOY CENTER
And
ITS AFFILIATED OFFICE(S) LEGAL DUITY

The Sports and Physical Therapy Center and its affiliated offices (collectively referred to hereafter as "The Sports and Physical Therapy Center) is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

The Sports and Physical Therapy Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, The Sports and Physical Therapy Center may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

The Sports and Physical Therapy Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, The Sports and Physical Therapy Center policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

The Sports and Physical Therapy Center may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Patient Information Practices at any time.

PATIENT'S 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 any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. All such requests must be made in writing to the affiliated office(s)' Privacy Office or Office Manager.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. The Sports and Physical Therapy Center will consider all such requests on a case-by-case basis, but The Sports and Physical Therapy Center is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned The Sports and Physical Therapy Center 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 Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. Further, The Sports and Physical Therapy Center will not tolerate any retaliatory acts against employees or patients who file a complaint with the Department of Health and Human Services secretary, participate or testify in an investigation or verbally oppose any actions taken by The Sports and Physical Therapy Center that are unlawful under HIPAA Administrative Simplification.

For further information on The Sports and Physical Therapy Center health information practices or if you have a complaint, please contact the following person:

David Levy, MS, OTR/L, CHT, Privacy Officer
South St. Louis Rehabilitation Institute
Hand Therapy of South St. Louis
#78 Kenrick Plaza
St. Louis, Missouri 63119
Telephone: 314.962.8020 Fax: 314.962.6570

SPORTS & PHYSICAL THERAPY CENTER

HIPAA Patient Information Consent Form

Acknowledgement

I, the undersigned, acknowledge that I was provided a copy of the current copy of The Sports and Physical Therapy Center and/or its affiliated office(s)' Notice of Patient Information Practices for my review.

I, the undersigned, have read and fully understand The Sports and Physical Therapy Center and/or its affiliated office(s)' Notice of Patient Information Practices. I understand that The Sports and Physical Therapy Center and/or its affiliated office(s) may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that The Sports and Physical Therapy Center and/or its affiliated office(s) will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Sports and Physical Therapy Center and/or its affiliated office(s)' Notice of Patient Information practices. I understand that I retain the right to revoke this consent by notifying The Sports and Physical Therapy Center and/or its affiliated office(s) in writing at any time.

____
Patient Name

____
Signature (Signature of Parent/Guardian)

____
Facility Representative Signature

____
Today's Date

____
Today's Date

Consent of Release to Other Persons

I hereby give my consent for The Sports and Physical Therapy Center and/or its affiliated office(s) to release information regarding my treatment and/or healthcare

____
Print Person's Name

____
Relationship

____
Print Person's Name

____
Relationship

Consent Expiration Date: ___________

MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you, we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain guidelines that need to be followed in order to ensure the most optimum results.

With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to reschedule an appointment, we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

The Sports & Physical Therapy Center

I have read and understand this policy:

____ ____________________________

Name Date

SPORTS & PHYSICAL THERAPY CENTER

MEDICAL HISTORY

Have you ever been told you have… (check all that apply)

- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Angina/chest pain
- ☐ Stroke
- ☐ Rheumatoid arthritis
- ☐ Pacemaker/Metal Implants
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Acquired Respiratory Distress Syndrome (ARDS)
- ☐ Emphysema
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Peripheral Vascular Disease (or Claudication)
- ☐ Headaches
- ☐ Gastrointestinal Disease
- ☐ Back Pain
- ☐ Kidney, Bladder, Prostate or Urinary Problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorder
- ☐ Depression
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Multiple Sclerosis
- ☐ Other Neurological Disorders
- ☐ Hepatitis / AIDS
- ☐ Prior Surgery:
  Explain:

Do you or have you in the past smoked tobacco? If yes, please explain.

____

____

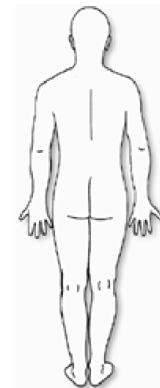
In the past, have you had or do you experience… (check all that apply)

- ☐ A change in *your* health
- ☐ Nausea/Vomiting
- ☐ Fever/chills/sweats
- ☐ Unexplained weight change
- ☐ Numbness or tingling
- ☐ Difficulty swallowing
- ☐ Changes in bowel or bladder function
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Seizures

Do you have a problem with? (check all that apply)

- ☐ Hearing
- ☐ Vision
- ☐ Speech
- ☐ Communication
- ☐ Energy
- ☐ Focusing

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different type of symptoms.



Key:

Pins & Needles = 000

Burning = XXXXX

Stabbing = /////

Deep Ache = ZZZ