Name: First	Middle	Last
Gender: Female Male	Date of Birth	Age
SSN :		Status : Single Married Divorced Other
Cell Phone: ( )		Home Phone ( )
Address :		Email:
City:	State Zip	
Employer :		
Referring Doctor :		Date of Next appointment
Reason for Visit today :		
Do you have a pacemaker?	**Yes No**	
Was this an accident?	**Yes No**	☐Auto ☐Work ☐Other (explain below)
Date of Injury		Date of Surgery
Currently on Home Health	Yes No	
Physical Therapy this year	Yes* No	
*Where /When		
Do you currently smoke	Yes No	
SPOUSE/PARENT INFORMATION		
Last Name	First	
Telephone ( )	Relationship to Patient	
Date of Birth:	Social Security #:	
Emergency Information: Person other than spouse to notify in case of emergency. (Local friend or relative)		
Name:		
Telephone ( )	Relationship to Patient	
Primary Insurance		
Subscriber's Name		DOB
Relationship to subscriber		Social Security #
Secondary Insurance		
Subscriber's Name		DOB
Relationship to subscriber		Social Security #

If I cannot be reached, a representative of PTA can give information about my healthcare or my bills to:

Name_____

Telephone_____ Relationship_____

Please indicate below with your initials if you agree:

_____ PTA may leave a message on my voicemail concerning my appointments, billing, and or medical information.

_____ PTA may send a text message concerning my appointments.

_____ PTA may send an email message concerning my appointments/ statements to

_____ ___@ _____

PTA may release my health information to other doctors and staff who treat me. This could include healthcare providers who treat me who are not part of PTA.

PTA may release my health information to insurance companies or other companies that PTA uses to bill for services.

PTA may release my health information to companies that help PTA improve the quality and cost of care provided to patients by reviewing the health care provided by the practice.

Responsibility for Payment, Assignment of Benefits, Authorization and Medical Release

The above information is true to the best of my knowledge. I authorize Physical Therapy of Andalusia (PTA) to provide physical therapy treatment, test and procedures considered advisable by my physician. I guarantee payment in full of any and all claims and **charges in consideration for medical services rendered to me by PTA.** I authorize and demand the assignment of payment of my basic medical, major medical, third party medical, or any other medical benefits that may apply herein specified and otherwise payable to me, directly to Physical Therapy of Andalusia, Inc. I authorize PTA to release my medical information required to process my claims to my insurance company.

If for any reason the account should become delinquent, 30 days past last treatment day, I agree to pay all rebilling charges, interest of 10%, cost related to collection efforts, (a $25 processing fee) and reasonable legal fees. I have read and understand the policies as mentioned above.

I have read and understand the Physical Therapy of Andalusia payment policies.

X_____ X_____

Signature of Patient or Guardian Date

PHYSICAL THERAPY OF ANDALUSIA

TOM RIDER, PT
MEREDITH HARLOS, DPT

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION.

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Attn: Privacy Officer

Address: 1105 West Bypass
Andalusia, AL 36420

Telephone: 334 222-5785

Fax: 334 222-0181

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the *Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201.* Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of this Privacy Notice is June, 2012.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

X_____ X_____

Printed Name of Patient Date

X_____

Signature of Patient or Patient's Representative

_____

Printed Name of Patient's Representative (*if applicable*) / Relationship to Patient

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To be completed by Physical Therapy of Andalusia:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s)

_____

_____

Signature of ***Physical Therapy of Andalusia*** Representative Date

_____ _____